

The Promise of Early Intervention for Psychosis

Summarized by Thomas T. Thomas

Early detection of mental illness and the attempt to prevent or intervene before an initial psychotic episode is a relatively new concept in mental health care. **Shelley Levin, PhD**, Regional Director of Staff Development for [Telecare Corporation](#), was our speaker on January 23. She discussed research findings that support early intervention programs, the key ingredients of such programs, and their outcomes, as well as efforts in California to implement early intervention programs.

Headquartered in Alameda, California, Telecare is one of the largest providers of adult mental health care in the country, managing 70 mega-programs in five states. In Alameda County, Telecare runs programs at Villa Fairmont in San Leandro and manages Gladman Mental Health Rehab Center and Sausal Creek Outpatient Stabilization Services in Oakland. Levin, who has been a professor of social work, said she was currently shifting her professional focus from staff development to prevention and early intervention, and that Telecare was interested in supporting such programs.



SHELLEY LEVIN, PHD

The approach in mental health care is changing from treatment to recovery, she said. Simply not having symptoms is no longer enough. Recovery involves rebuilding your life, gaining back the friends and job and life roles you lost to serious mental illness. “But what if there was nothing to recover from? What if you could prevent the loss, so there was no need of recovery?”

The Mental Health Services Act, passed in California with Proposition 63 in 2004, provides money from a tax on personal incomes over \$1 million to be used by each county for providing mental health services. The money is provided in five different categories that are being released at different times. The first category, Community Services and Support (CSS), has already been apportioned. The second, Prevention and Early Intervention (PEI), is now ready to be released. Other future categories include Innovation, Capital Facilities and Information Technology, and Education and Training.

In order to obtain this money, counties are required to submit to the state program plans that have been developed with community input including consumers, families, and advocates. The funding levels vary with yearly tax receipts, but estimates for 2007-09 place Alameda County’s share at \$11.5 million for PEI, Contra Costa at \$7.2 million, and Berkeley, which runs its own mental health services but will have a share in Alameda County’s portion, at \$993,000. Levin noted that these are not insignificant amounts. And at least 51% of the money must be spent on individuals under 25 years old—which includes the

adolescent years that are the most likely time for an individual's first psychotic episode and so a target for prevention and early intervention.

The PEI funds may be used for a wide variety of programs, but they must include one or more "key community needs," such as addressing disparities in access to mental health services, the psycho-social impacts of trauma, stigma and discrimination, suicide risk, and at-risk children, youth, and young adult populations. The funding must also address one or more of the "underserved cultural populations," such as children and youth who are in stressed families, exposed to trauma, at risk for school failure, at risk of or experiencing juvenile justice involvement, and individuals experiencing the onset of serious psychiatric illness. That last category is a prime target for PEI programs, but it must compete with other populations that have advocacy groups, and those groups—especially child advocates—can be very organized.

The importance of early intervention relates to the maintenance of a person's life roles. "We all have lots of life roles," Levin said. Student, employee, member of a religious community, friend—these and other roles are influenced by a person's experiences related to the onset of psychosis. For example:

- **Cognitive impairments** can influence the life role of student and employee, leading to failure and loss of work.
- **Social influences**—especially at ages 15 to 25, when most psychiatric illnesses start—can influence a person to withdraw from the roles of student and friend as well as avoid seeking treatment.
- **Symptoms** such as hearing voices and being unable to concentrate can influence all of these roles.

Usually, people develop their life role functions and add new life roles as they grow up and get older. But for people in the 15-to-25 age group, the onset of serious mental illness can cause their life roles to stall: they drop out of school, lose friends, become incarcerated or homeless. These effects usually happen with the onset of psychosis.

Mental illness is currently defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), which provides the behavioral labels that fit a diagnosis—and without a diagnosis, a person usually can't get mental health services. But most of these labels have criteria related to time: symptoms must persist for a number of months before the label applies. "A young person can lose so much in life roles before he or she can get a diagnosis and access to services," Levin said. Usually, also, parents, family, and friends know there is something wrong before the diagnosis and the first psychotic break. The period between symptom onset and treatment—known as the duration of untreated psychosis (DUP)—averages a year in the U.S.

"The DUP is related to how people will do for the rest of their lives," Levin said. "The longer the DUP, the worse people do, and the worse the prognosis." She admitted that clinicians don't know why this is so but suspect it has something to do with neurotoxins. "If we can make the DUP shorter, it will help people for the rest of their lives."

Early intervention means moving access to services up to the first episode of psychosis. Then the DUP disappears and people can get better. Early

intervention can change the course of an illness and put the person on course to increasing his or her life roles as student, worker, friend, and family member.

“What if you could intervene earlier?” she asked. “What if you offered treatment during the at-risk mental state [ARMS], the point at which friends and family are saying ‘I know something’s wrong?’ Then you can delay the onset of psychosis.” She noted that we are not yet in a position to prevent the psychosis entirely, although that would be ideal. “At present, the best we can do is offer services one year before the people meet the criteria for illness.”

The aims of early intervention are to:

- **Preserve or retain** life role functioning—keep the young person in school, at work, associating with friends, involved with his or her faith, connected to people.
- **Teach** the person skills and strategies for coping with the illness and moving forward with his or her life. The person may or may not need to take medication, but medication doesn’t mean abandoning life roles.

“If we start treatment at the ARMS stage rather than at the onset of criteria stage,” Levin said, “then 80% of the people who experience a first psychotic episode don’t need hospitalization but can get treatment in the community. They still have psychosis, but it is managed and there’s not a state of crisis involving anxiety, physical force, and the police. We avoid the crisis because the person is already connected with doctors and the mental health community, and he or she can avoid the emotional cost.”

Levin said that the United States generally does not have PEI programs, except at a few university research centers. For example, there is a program at UCLA, but it doesn’t extend to the community and won’t treat people using drugs and alcohol. “The rest of the world does better. The U.S. is one of the few developed countries without universal medical care and so has no universal mental health care. Our public mental health services can’t even serve the people who need care, let alone focus on prevention and early intervention. We have become a ‘fail first’ system.”

She noted that in countries with universal health care, and in certain U.S. health care systems like Kaiser Permanente, they realize that the person with a mental illness is going to be with them for life, and so it’s better to provide early treatment. Australia, England, Canada, Mexico, Brazil—all have early intervention programs. “And these programs work. Providing services at the first onset of psychosis significantly improves role functioning. They’re effective,” Levin said.

“And early intervention programs cost a third to half of what the usual course of treatment costs, because these services take place in the community and not in a hospital. It’s cheaper to provide the service up front, and the patient does better.”

What can NAMI members do to promote prevention and early intervention? Levin suggested they go to their county’s Proposition 63 planning meetings. (NAMI-East Bay’s President Liz Rebensdorf is already active in these meetings. Other members’ support would be welcome!) They can speak out for providing services at the moment a person experiences the onset of serious mental illness. She also shared a number of websites that provide useful information:

- California Department of Mental Health, http://www.dmh.ca.gov/Prop_63/MHSA/
- International Early Psychosis Association, <http://www.iepa.org.au>
- Get Help Early, <http://www.gethelpearly.ca/home.htm>
- Support for Families, <http://www.psychosissupport.com/>
- Additional resources, <http://www.telecarecorp.com>

After her talk, Shelley Levin took member's questions.

Q. What approaches are available to support prevention and early intervention?

A. Common sense tells us that there are many approaches, each one different. We can provide a case manager with a small case load—10 to 15 people at most. We can go out into the community, where the young people are. They usually won't come into the clinic because of social influences. We can get young people trained to address the issue, because they can relate to the at-risk population better than an older psychiatrist or other authority figure. We can educate families to recognize developing symptoms, and we can provide them with support in crisis. We can work with the school system to identify at-risk students. We can work on the cognitive deficiencies, to keep the young person in school or at work. And we can support substance abuse programs, because 15 to 25 is the prime age for experimentation.

Q. When is it appropriate to intervene? Isn't there a risk of overreacting?

A. We're pretty good about perceiving when people are in serious trouble, and that's the time to try to connect with them, before they withdraw. It's not usually dangerous to maintain a connection with an at-risk young person. This is better than waiting until the situation becomes awful.

Q. Is Telecare starting any of these PEI programs?

A. Right now, there is Proposition 63 money available through the state to fund them, but each county has to decide it wants PEI programs and submit a proposal. Telecare would be happy to work with them on a proposal. But friends and family members need to go to the community planning meetings and speak up for prevention and early intervention.