Early Identification and Intervention: Paving the Way for Change in the Treatment of Schizophrenia Spectrum Disorders

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National Association of Social Workers, Ohio Chapter
2015 Annual Conference
November 12, 2015
INTRODUCTIONS
The BeST Center was established:
- Department of Psychiatry, Northeast Ohio Medical University in 2009
- Supported by The Margaret Clark Morgan Foundation and other private foundations and governmental agencies

The BeST Center’s mission:
- Promote recovery and improve the lives of as many individuals with schizophrenia as quickly as possible
- Accelerate the use and dissemination of effective treatments and best practices
- Build capacity of local systems to deliver state-of-the-art care to people affected by schizophrenia and their families
Best Practices in Schizophrenia Treatment (BeST) Center at NEOMED

• The BeST Center offers:
  – Training
  – Consultation
  – Education and outreach activities
  – Services research and evaluation
Best Practices in Schizophrenia Treatment (BeST) Center at NEOMED

• The practices:
  1. FIRST Early Identification and Treatment of Psychosis
  2. Cognitive Behavioral Therapy for Psychosis Interventions
  3. Family-based Services
  4. Integrated Primary and Mental Health Care
  5. Cognitive Enhancement Therapy
  6. Pharmacotherapy for Schizophrenia
LEARNING OBJECTIVES
LEARNING OBJECTIVES

To provide an overview of the research and literature related to first episode psychosis and the early intervention and treatment of psychosis

• Participants will become aware of the Best Practices in Schizophrenia Treatment Center and FIRST/Early Psychosis treatment programs in Ohio

• Participants will be able to distinguish myth from reality

• Participants will learn the diagnostic criteria and symptoms of schizophrenia spectrum disorders and how to recognize early warning signs and symptoms of schizophrenia
LEARNING OBJECTIVES

• Participants will learn about research related to first episode psychosis and family history, suicidality and cannabis

• Participants will review the historical treatment of schizophrenia spectrum disorders and learn about early intervention treatment options and the rationale for early identification

• Participants will also learn about research related to duration of untreated psychosis and overall outcomes of first episode programs

• Participants will learn how they can be involved in the efforts to ensure individuals get the best treatment possible in a timely manner
SCHIZOPHRENIA: MYTHS AND REALITIES
A lot of what you see or hear about schizophrenia in the media or from others is not true.

You may hear: People with schizophrenia are dangerous.

The truth: Most people with mental illness are not dangerous, and most people who are dangerous are not mentally ill.
SCHIZOPHRENIA: MYTHS AND REALITIES

You may hear: People with schizophrenia have split personalities.

The truth: People with schizophrenia do not have split personalities.
SCHIZOPHRENIA: MYTHS AND REALITIES

You may hear: People with schizophrenia never get better.

The truth: With the right treatment, people with schizophrenia can and do improve their lives. Many people with mental illnesses enrich our lives.
SCHIZOPHRENIA: MYTHS AND REALITIES

You may hear: Schizophrenia is a result of bad parenting or weak character.

The truth: Schizophrenia is no one’s fault. No one causes it. No one is to blame for it.
I'M STILL HERE

Video times:
00:00 – 6:05
And
40:26 - 49:10
WHAT ARE SCHIZOPHRENIA SPECTRUM DISORDERS?
SCHIZOPHRENIA SPECTRUM DISORDERS

• Are serious mental illnesses which:
  - Interfere with a person’s ability to think clearly, manage emotions, make decisions and socially relate to others.
  - Are complex, long-term medical illnesses that affect everyone differently.
SCHIZOPHRENIA SPECTRUM DISORDERS

- Schizophrenia
  - Symptoms last more than 6 months

- Schizophreniform Disorder
  - Symptoms last at least one month, but less than 6

- Schizoaffective Disorder
  - Combination of schizophrenia symptoms and an affective (mood) disorder

- Psychotic Disorder Not Otherwise Specified
  - When there is inadequate information to make a Dx
SYMPTOMS OF SCHIZOPHRENIA SPECTRUM DISORDERS
POSITIVE SYMPTOMS

Positive symptoms reflect an excess or distortion of normal functions. These symptoms may include:

- **Delusions**: Beliefs that are not based in reality and usually involve misinterpretation of perception or experience.

- **Hallucinations**: These usually involve seeing or hearing things that don't exist, although hallucinations can be in any of the senses. Hearing voices is the most common hallucination among people with schizophrenia.
Positive symptoms reflect an excess or distortion of normal functions. These symptoms may include:

- **Thought disorder:** Difficulty speaking and organizing thoughts may result in stopping speech midsentence or putting together meaningless words, sometimes known as “word salad.”

- **Disorganized behavior:** This may show in a number of ways, ranging from childlike silliness to unpredictable agitation.
TYPES OF DELUSIONS
(based on a survey of > 1,100 individuals hospitalized)

• **Persecutory**: Most common (> 75%)
• **Body/Mind Control**: 59%
• **Grandiose**: 43%
• **Thought Broadcasting** (others can hear/are aware of your thoughts): 35%
• **Religious**: 28%

• Average number of delusions= 4
• 75% report more than one content category
NEGATIVE SYMPTOMS

Negative symptoms refer to a diminishment or absence of characteristics of normal function. They may appear with or without positive symptoms. They may include:

- Loss of interest in everyday activities
- Appearing to lack emotion
- Reduced ability to plan or carry out activities
- Neglect of personal hygiene
- Social withdrawal
- Loss of motivation

Negative symptoms are difficult to treat with medication and impact all aspects of the individual’s life (i.e., work, school, relationships). Many individuals are “blamed” for these symptoms (e.g., lazy).
COGNITIVE SYMPTOMS

• Cognitive symptoms involve problems with thought processes.
• These symptoms may be the most disabling in schizophrenia because they interfere with the ability to perform routine daily tasks.
• They include:
  – Problems with making sense of information
  – Difficulty paying attention
  – Memory problems
THREE PHASES OF THE ILLNESS

1. **Prodrome Phase:** The early signs are vague and hardly noticeable. There may be changes in the way some people describe their feelings, thoughts and perceptions.

2. **Active Phase:** Clear psychotic symptoms are experienced, such as hallucinations, delusions or confused thinking.

3. **Residual Phase:** Psychosis is treatable and most people recover. The pattern of recovery varies from person to person.
POSSIBLE EARLY SIGNS AND SYMPTOMS

• Having serious problems at work or school
• Feeling paranoid/suspiciousness
• Withdrawing from social interactions
• Experiencing depression or anxiety
• Sleep disturbances
• Poor concentration and attention
• Having beliefs not shared by others
• Seeing or hearing things that others do not see or hear
• Speaking or thinking in a disorganized way
WHAT CAUSES SCHIZOPHRENIA?
STRESS-VULNERABILITY MODEL

- One in five people report some problem with stress
- Stressors can be positive or negative

Daily hassles
- **Work**: poor pay, feeling rushed, arguments with co-workers
- **School**: poor grades, inability to complete homework, arguments with friends
- **Family**: unpleasant chores, arguments, dangerous living arrangements, lack of privacy

Life events
- **Work**: loss of a job, starting a new job, change in income
- **School**: failing out of school, graduating
- **Family**: getting married, getting divorced, moving, death of loved one, legal issues, victim of a crime
STRESS VULNERABILITY MODEL

Mental illnesses are “no fault” illnesses

Biological Vulnerability → Stress → Symptoms of Psychosis

Alcohol and Drug Use

(Mueser, Glynn, 1999)
STIGMA

• Nearly 2/3 of those with diagnosable mental illness do not seek treatment (Surgeon General’s report 1999).

— Why might this be true?
What is the typical response from the community?

– **Consider**: your friend’s child breaks her arm… was recently diagnosed with cancer… is hospitalized… How do you respond? What would you do?

– **Compare**: your friend’s child experiences a psychotic episode, is talking bizarrely and leaves the house in anger; is very depressed… How do you respond? What would you do?
STIGMA

• Schizophrenia appears to be the most stigmatized mental disorder
• The “second illness”: The reactions of the social environment (Finzen, 1996)
• Stigmatization is a dimension of suffering added to the illness experience leading to:
  – Social isolation
  – Limited life chances
  – Delayed help-seeking

(Schulze & Angermeyer, 2003)
STIGMA

• Negative public perceptions about people with schizophrenia:
  – Unpredictable
  – Aggressive and dangerous
  – Unreasonable
  – Lacking in intelligence and self-control

• A large portion of the general population reports it would reject entering into particular social relationships with individuals diagnosed with schizophrenia
  – Living in the same space
  – Recommending them for a job
  – Having him/her babysit children

(Schulze & Angermeyer, 2003)
NORMALIZING

• Most mental illnesses are experiences we all have, only further down the continuum

• Worry --------> Anxiety Disorder
• Sadness---- > Depression
• Mood swings--> Bipolar Disorder
• Stress ------- > PTSD
In 1993, claimed he heard strange voices in his head, "I've always had a little voice in my head, particularly when I was younger and less assured", he said.

"While onstage, during classical theatre the voice would suddenly say, "Oh, you think you can do Shakespeare, do you?" and he added;

"Recently, I was being interviewed on television and the voice inside my head said to me, "Who the hell do you think you are? You're just an actor, what the hell do you know about anything?"
MAHATMA GANDHI

- Relied on an “inner voice” for guidance

- Toward the end of his life the voice said, “You are on the right track, move neither to your left, nor right, but keep to the straight and narrow.”
WHAT IS IT LIKE TO EXPERIENCE A HALLUCINATION?

• Hallucinations can affect any of the senses:
  – Sight, smell, sound, taste, touch
  – Auditory hallucinations are the most common. Let’s take a look at Anderson Cooper’s experience

STATISTICS
AND OTHER FACTS
# INCIDENCE & PREVALENCE RATES

<table>
<thead>
<tr>
<th>County</th>
<th>U.S. Census Bureau Figures 2010 Population</th>
<th>Number of Individuals Expected to Experience a First Episode of Schizophrenia-Spectrum Disorder * Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>1,163,414</td>
<td>233-349</td>
</tr>
<tr>
<td>Cuyahoga</td>
<td>1,280,122</td>
<td>256-384</td>
</tr>
<tr>
<td>Hamilton</td>
<td>802,374</td>
<td>160-241</td>
</tr>
</tbody>
</table>

* This number reflects the range of 20-30 per 100,000 of the population
SCHIZOPHRENIA SPECTRUM DISORDERS: FACTS

- Affect approximately 2% of Americans
- Three out of every 100 people will experience a psychotic episode
- There is no difference in rates between cultures
- Both genetics and environment play a role
OTHER FACTS ABOUT SCHIZOPHRENIA

• In the United States, there are more than 2 million people living with schizophrenia.

• Onset is earlier for men (15-25) than women (25-35). Onset before age 10 and after age 50 is rare.

• 50% have a co-occurring substance abuse or chemical dependency diagnosis.
• Accounts for more hospitalizations than any other psychiatric disorder

• Cost of treatment and lost productivity is about $65 billion per year in the United States alone
STATISTICS ON SCHIZOPHRENIA

- 25% experience an abrupt onset with positive, acute symptoms only
- 75% experience a slow onset with negative, chronic symptoms
- Approximately 50% experience depressive symptoms
• Approximately 20 - 25% of the single adult homeless population suffers from some form of severe and persistent mental illness (National Resource and Training Center on Homelessness and Mental Illness, 2003)
SUICIDE

• The rate of completed suicide ranges from 5%-13% among persons with schizophrenia and other psychoses
  – Suicide attempts range between 25%-50% in psychiatric populations
• Individuals diagnosed with schizophrenia under age 28 are at higher risk
• Previous studies have identified the following risk factors:
  – Being white
  – Having a higher IQ
  – Having greater insight into the illness
  – Having a history of previous attempts
  – Being in the early stages of the illness
  – Risk is elevated shortly after the period following the first hospital admission
  – Males with schizophrenia are at a greater risk for suicide than females diagnosed with schizophrenia
  – Substance abuse

Schizophrenia Bulletin, 2010; 36(4), 880-889
SUICIDE – THOUGHTS BEHIND THE ACTION

Negative appraisals of the illness may account for the depression-hopelessness-suicide relationship (Jackson and Iqbalt, 2000)

– Loss
– Entrapment
– Humiliation
CANNABIS

• Patients who used cannabis (46.9%) had a significantly earlier age of schizophrenia onset, compared with those who did not use the drug (18.3 versus 20.8 years).
• Cannabis use was not associated with differences in symptom presentation
• However, users had a greater mean number of hospital admissions (indicating a greater risk for relapse over the 12 month follow-up period) as well as a greater mean number of hospital days

Schizophrenia Research, May 2012
CULTURE

• Schizophrenia has been observed all around the world in various countries, cultures, and races – thus, there is no doubt that it is a universal illness.

• Schizophrenia varies in many ways across the world.
  – During the diagnostic phase, psychiatrists’ racial biases or the connotations of the word “schizophrenia” in a culture’s language have been shown to influence clinical diagnoses
  – Culture of both the psychiatrist and client can impact diagnosis and treatment.
CULTURE

- There are cultural differences in the kind of delusions, and often the delusions tend to reflect the predominant themes and values of a person's culture.
  
  • Ireland: religious piety is highly valued, patients with schizophrenia often have delusions of sainthood
  • Industrially advanced countries (like America): patients' delusions tend to focus on sinister uses of technology and surveillance
  • Japan (prizes honor and social conformity): delusions often revolve around slander or the fear of being humiliated publicly
  • Nigeria (mental illness is believed to be caused by evil spirits): delusions may take the form of witches or ancestral ghosts

- Many behaviors that would be seen as symptoms of schizophrenia in the Western world are considered signs of spiritual exaltation in developing countries.
I’M STILL HERE

Video times:
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PAVING THE WAY TO UNDERSTANDING AND TREATING SCHIZOPHRENIA SPECTRUM DISORDERS

Before 19th Century
• Religious/moral condition

1930 - 1950
• Deep Insulin Coma Therapy

1950 - 1970
• Medications, psychological explanations emerge
1980 - 2000
- CBT-p
- Atypical antipsychotics
- Family Interventions

2000 - Present
- Early identification
- Comprehensive treatment
- New Generation medication and changes in dosing

First episode programs:
- Biopsychosocial framework
- Family
- Employment
- Medication
RESEARCH & DURATION OF UNTREATED PSYCHOSIS
WHY IS A FIRST EPISODE PSYCHOSIS PROGRAM SO IMPORTANT?

• People with schizophrenia often wait months to years, suffering needlessly, before a diagnosis is made and treatment begins.

• Intensive efforts to intervene early (i.e., within 2-5 years) after the onset of psychosis can disproportionately alter the trajectory of schizophrenia spectrum illnesses in comparison to the usual paradigms of care.

_Birchwood, 1998_
DURATION OF UNTREATED PSYCHOSIS

• Duration of untreated psychosis (DUP) predicts short and long-term failure to achieve remission in first episode psychosis patients… Longer DUP was the only significant predictor of non-remission at two years. (Cowan, 2010)

• “Long vs. short DUP data showed an association between longer DUP and worse outcome at 6 months in terms of total symptoms, overall functioning, positive symptoms, and quality of life…” “Patients with a long DUP were significantly less likely to achieve remission.”

Archives of General Psychiatry 2005; 62(9), 975-983)
“Patients with a longer delay in treatment of psychosis show a significant reduction in overall grey matter volume with specific reductions in the interior-orbital region.”

Schizophrenia Research 2011; 125(1), 13-20
DURATION OF UNTREATED PSYCHOSIS AND EARLY INTERVENTION

• Patients with a short duration of untreated positive or negative symptoms outperformed patients with a long duration of untreated symptoms on memory tasks and a pre-attentional visual task, but not on measures of verbal fluency, attention, reaction time, visual processing and executive functions.

• This is supportive of early intervention in order to shorten DUP to facilitate better outcome in memory and attentional domains of FEP patients.

FIRST EPISODE
PSYCHOSIS PROGRAMS
FIRST COMPREHENSIVE TREATMENT
FIRST EPISODE PSYCHOSIS COMPREHENSIVE TREATMENT

- 1992- Melbourne, Australia- Early psychosis prevention and intervention centre (EPPIC) - World’s first evidence-based care for first episode psychosis (FEP)
- Soon after, FEP services established in the UK, Europe, North America and Asia
- 2009- Newly created BeST Center selected as National Institute of Mental Health (NIMH) pilot site for Recovery After an Initial Schizophrenia Episode (RAISE) project
- 1/2010- FIRST Team in Summit County, Ohio
- 2015- 9 programs covering 13 counties

This material provided by the Best Practices in Schizophrenia Treatment (BeST) Center, Department of Psychiatry, Northeast Ohio Medical University.
330.325.6695 • www.neomed.edu/bestcenter • bestcenter@neomed.edu
FIRST: EARLY IDENTIFICATION AND TREATMENT OF PSYCHOSIS
EARLY IDENTIFICATION AND TREATMENT OF PSYCHOSIS

The early identification and treatment of psychosis is very important because it can lead to:

• Decreased severity of the illness
• Less physical, mental, psychological, social and occupational disability
• Lower risk of relapse
• Fewer forensic complications
• Reduced family disruption and distress
• Reduced need for inpatient care
• Lower health costs
WHAT IS FIRST?

• A comprehensive, team-based treatment program aimed at improving the mental health and quality of life for individuals who have experienced a first episode of a psychotic illness by promoting early identification and providing best treatment practices as soon as possible

• A partnership of community mental health agencies, local mental health and recovery boards and the Best Practices in Schizophrenia Treatment (BeST) Center at Northeast Ohio Medical University (NEOMED)
FIRST: AN ACHIEVABLE TASK

• First episode psychosis programs are:
  - comprehensive
  - integrated
  - team-based
  - inclusive of evidence-based and evidence-supported practices

• Successful first episode psychosis programs have been established in Australia, the United Kingdom, Ireland and Canada. Until recently, only a few had been established in the United States, but this number is growing.
FIRST PROGRAM TREATMENT GOALS

• Promoting recovery and resiliency
• Assisting individuals in achieving independence
• To reduce the symptoms of psychotic illnesses
• To improve individual and family functioning
• To reduce the chance of relapse
• To promote recovery and improve the long-term course of the illness
• To decrease the overall costs of treatment
CRITICAL ELEMENTS OF FEP PROGRAMS
SHARED DECISION MAKING

• The collaboration between patients and caregivers to come to an agreement about a health care decision
• Based on the premise that patients have the ability to pursue and attain their own goals, function within society and achieve recovery
• Especially useful when there is no clear “best” treatment option
• Patient-centered: individuals have a primary voice in treatment
SHARE DECISION MAKING

• Patients are involved in treatment planning and establish their own treatment goals

• Clinicians’ role: to educate patients in order to raise awareness of or increase insight into mental illness

“…acknowledges two kinds of expertise and requires the two experts to explicitly establish consensus on what the problem is, what the treatment goals are, and how they will know when the goals have been met.”

Deegan et al., Psychiatric Services (2006); 57(11), 1636-1639
CRITICAL ELEMENTS OF FIRST Interprofessional Team

Team members:

- Psychiatric prescriber
- Team Leader (also Family Psychoeducator)
- Individual Resiliency Trainers (Therapists)
- Supported Employment/Education Specialist
- Case Manager
CRITICAL ELEMENTS OF FIRST Manualized Treatment

All clients review the initial five modules in the FIRST program manuals with a team member (Individual Resiliency Trainer, Case Manager or Supported Employment/Education Specialist):

• Module 1: Introduction to FIRST
• Module 2: Assessment/Initial Goal Setting
• Module 3: Education about Psychosis
• Module 4: Medication Education
• Module 5: Coping with Symptoms

First clients can choose to work on 10 other modules with an Individual Resiliency Trainer
CRITICAL ELEMENTS OF FIRST Psychiatric Care

• Focuses on providing medications and interventions found to be most effective with individuals experiencing a first episode of psychotic illness

• Emphasizes shared decision making
CRITICAL ELEMENTS OF FIRST
Family Psychoeducation

• Provided by FIRST team leader
• Provides education about psychotic illnesses
• Assists families (as defined by the client) with problem-solving and communication
• Recognizes family members as vital members of the recovery team
• Family psychoeducation has been shown to reduce relapse rates
CRITICAL ELEMENTS OF FIRST
Individual Resiliency Training

• Focuses on clients’ goals
• Helps clients gain insight into their illness and develop tools to become independent and successful in the community
• Focuses on strengthening problem-solving abilities
• Helps clients to advocate for themselves
• Sessions are based on manualized treatment; clients choose which modules or topics they want to work on (smoking cessation, dealing with negative feelings, etc.)
CRITICAL ELEMENTS OF FIRST Supported Employment/Education

- Focuses on rapid return to or initiation of employment or education
- Takes place at community sites
- Decisions to return to work or school, including which jobs or type of education to pursue and the types of support provided by the specialist, are based on the individual's choice
- Support continues after the individual has obtained employment or returned to school
CRITICAL ELEMENTS OF FIRST Case Management

- Assists with coordination of medical and mental health care
- Educates clients on community resources and assists with integration into the community
- Provides feedback to the psychiatrist regarding clients’ medication adherence, side effects and symptoms
- Provides crisis management as needed
CRITICAL ELEMENTS OF FIRST

• FIRST does NOT encourage the individual to apply for SSI/SSDI benefits at the beginning of treatment.

• Instead, the focus is on assisting the individual to achieve employment and educational goals that will allow them to function independently.
CRITICAL ELEMENTS OF FIRST Assertive Community Outreach

• Community-based
  • Presentations to potential referral sources:
    – Hospitals, Crisis Centers, Courts, University Counseling Centers, NAMI

• Client-focused
  • Extensive efforts to engage
    – Home visits, communication with support systems
RESEARCH OUTCOMES

Early intervention services:

- Reduced hospital admission, relapse rates and symptom severity, and improved access to and engagement with treatment.

Conclusion: “For people with early psychosis, early intervention services appear to have clinically important benefits over standard care. Including CBT and family intervention within the service may contribute to improved outcomes in this critical period”

RESEARCH OUTCOMES

• Family interventions reduce relapse rates
• Cognitive behavioral therapy reduces positive symptoms
• Social skills training improves social competence
• The combination of pharmacotherapy and psychosocial interventions has been recommended for treatment of schizophrenia by practice guidelines for psychiatrists

Archives of General Psychiatry, 2010; 67(9), 895-904
FIRST OUTCOMES

Early outcomes for individuals participating in FIRST programs are promising:

• re-hospitalization rate is low

• the majority of individuals in the FIRST programs are either working and/or pursuing educational goals full-time or part-time
FIRST REFERRALS
FOR WHOM IS FIRST TREATMENT APPROPRIATE?

Eligibility Criteria

While each person will be considered for FIRST treatment services on an individual basis, FIRST is most appropriate for individuals who are:

• between 15-40 years of age -- or between 16-40 years of age in Mahoning County only;
• diagnosed with schizophrenia, schizoaffective disorder, schizophreniform disorder or other specified/unspecified schizophrenia spectrum and other psychotic disorder (including psychosis not otherwise specified);
• experiencing no more than 18 months of psychosis (treated or untreated); and
• willing to consent to participate in at least two treatment modalities that include counseling, psychiatric care, supported employment/education, family psychoeducation and case management.
FOR WHOM IS FIRST TREATMENT NOT APPROPRIATE?

FIRST is not appropriate for individuals:

- with psychotic symptoms that are known to be caused by the temporary effects of a substance or another medical condition
- with an intellectual disability that impairs their ability to understand all of the treatment components

Individuals who do not meet eligibility criteria for FIRST are referred to other treatment resources.
HOW IS THE CLIENT ENROLLED?

• Upon completion of a phone screening, if the individual appears to be appropriate for FIRST, he/she will be scheduled for a Mental Health Assessment within 72 hours.

• If the individual is appropriate for FIRST services, they individual will then be scheduled with the FIRST psychiatrist within 14 days after the assessment.

*Rapid entry into services is key*
HOW IS THE CLIENT ENROLLED?

Once the psychiatrist accepts the client into FIRST, the client needs to select a minimum of **TWO** FIRST services:

– Initial appointments with service providers are scheduled **within 72 hours**.
FIRST PROGRAMS IN OHIO

FIRST Cuyahoga County
• 216.339.1438
• Treatment Services Location: Catholic Charities Diocese of Cleveland, 1515 W. 29th St., Cleveland, Ohio 44113

FIRST Summit County
• 234.788.1646
• Treatment Services Location: Child Guidance and Family Solutions, 18 North Forge St., Akron, Ohio 44304-1317

FIRST Trumbull County
• 330.541.1732
• Treatment Services Location: Coleman Professional Services, 552 North Park Ave., Warren, Ohio 44481

FIRST Mahoning County
• 234.201.2512
• Treatment Services Location: Turning Point Counseling Services, 611 Belmont Ave., Youngstown, Ohio 44502

FIRST Portage County
• 330.676.6859
• Treatment Services Location: Coleman Professional Services – Portage County Offices, 5982 Rhodes Rd., Kent, Ohio 44240

FIRST Stark County
• 330.541.1877
• Treatment Services Location: Coleman Professional Services, 400 Tuscarawas St. West, Suite 200, Canton, OH 44702
FIRST PROGRAMS IN OHIO

FIRST Greater Cincinnati Area
• 513.354.7337
• Treatment Services Location: Greater Cincinnati Behavioral Health Services – 2 locations:
  • Hamilton County: 7162 Reading Road, Suite 400, Cincinnati, OH 45327
  • Clermont County: 1074 Wasserman Way, Batavia, OH 45103

FIRST Lucas County (Lucas and Wood Counties)
• 419.764.2773
• Treatment services Location: 905 Nebraska Ave., Toledo, Ohio 43607

FIRST Greater Lima (Allen, Auglaize and Hardin Counties)
• 330.541.8543
• Treatment Services Location: Coleman Professional Services-799 South Main St., Lima, Ohio 45804
FURTHER INFORMATION
FURTHER INFORMATION

For further information about FIRST Episode Psychosis and other best practices for schizophrenia treatment contact:

The BeST Center: 330-325-6695 or www.neomed.edu/bestcenter

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For further information about starting a FIRST Episode Psychosis program in your county and other best practices for schizophrenia treatment contact:

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CLOSING
EARLY INTERVENTION WORKS!

FIRST: PAVING THE WAY FOR CHANGE

Early Identification and Treatment of Schizophrenia is an URGENT, ESSENTIAL and ACHIEVABLE task.

Thank You For Your Interest and Efforts!