Addressing Structural Disparities in Early Intervention

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Why do we need it?

Disadvantage Predicts Psychosis Onset

When Social and Environmental Adversity Causes Schizophrenia

Susan M. Essock, Ph.D.

This important report by Kirkbride and colleagues (1), in this issue of the Journal, looks at how the incidence of young adults with first-episode psychosis varies across a section of England (East Anglia; population 2.4 million). Early-intervention services for people with psychosis are so well established in this part of England that it is safe to assume that all individuals with first-episode psychosis are seen by one of the six specialized early-intervention programs operating in the area. This means that the incidence of new referrals to these programs reflects the corresponding incidence of individuals with newly emerged psychosis in the underlying population. Essentially, the authors were able to examine information from all individuals with newly emerged psychotic disorders across a broad landscape of urban and more rural areas.

One of the product of this modeling effort is the finding available to states to implement evidenced-based early-intervention services for people with early psychosis, what the RAISE model calls coordinated specialty care for psychosis (9-11). First, the findings of Kirkbride and colleagues mean that we will need more coordinated specialty care teams for the same population density in the most disadvantaged neighborhoods because the need for teams is a function of neighborhood adversity.

The sobering conclusion is that extremes of social and environmental adversity greatly increase the risk of nonaffective psychoses such as schizophrenia.
Structural Disadvantage?

- Community structures & group inequalities as primary factors shaping outcomes
  - Poverty
  - Residential segregation
  - Exposure to violence
  - Lack of opportunities
  - Housing precarity
- Disproportionately affect minority groups
Who do our services “best” treat? What needs are best met?

- Psychosis
- Substance Use
- Disruptions to School/Work
- Poverty
- Neighborhood Disadvantage
- Structural Racism
- Trauma
- Undocumented Status
- Housing Instability

[Diagram showing overlapping circles for Psychosis, Substance Use, Disruptions to School/Work, and other factors.]

[USF University of South Florida logo]
Front Line Provider Views

- **Sample**: Peer specialists (x4), program leads (x2), family specialists (x2), social workers/counselors (x6), nurse practitioner (x1)

- **Interviews**: provider views of the way in which structural disadvantage & race/ethnicity are handled in US EIP programs

- **Caveat**: heterogeneity of programs!
### Themes

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<tr>
<th>Theme</th>
<th>Description</th>
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<tr>
<td>Psychosis focus as a double edged sword</td>
<td>Increased training in psychosis a strength, but medicalizes the model, reifies a focus on symptoms rather than structural context</td>
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<td>Unintended consequences of diagnostic criteria</td>
<td>Emphasis on diagnosis seen as at odds with other services such as Wraparound &amp; ACT that emphasize needs/level of needs</td>
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<td>Hierarchicalization within the team</td>
<td>Specialized practices (diagnosis, CBTp or IRT) fuel existing hierarches, again supporting symptom focus (case management subordinate); de facto also mirrors subordination on the basis of race/ethnicity/disability (most likely to be unlicensed staff)</td>
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<td>Trauma under-emphasized</td>
<td>Perceived lack of trainings &amp; competency in trauma-focused practices &amp; trauma informed care</td>
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<td>No tools/support for addressing manifestations of trauma in symptom content</td>
<td>Frequently encounter traumatic events/disadvantage manifesting as themes of psychosis – no tools to deal with this; perception that standard CB approaches are inadequate</td>
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<td>Links between social factors, adversity &amp; symptoms not present</td>
<td>Model(s) not emphasizing connectedness between symptoms and context</td>
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Solutions

- **Increased resource allocation** (stepped up supports) for *high risk* (disadvantaged) clients
  – EPPIC/Orygen Youth Health, Melbourne

- **Programmatic recalibration** – emphasize social & structural determinants of health, meeting structural needs

- **Asking hard questions** – re consequences of strong emphasis on psychopathology & diagnosis

- **Training Strategies** – structural competency (next slide)
Structural Competency

Framework Aims
(1) Awareness and understanding of the structural conditions that shape behavioral health & service-related experiences and outcomes;
   (1) Includes entanglements of social/structural experiences in/within/as symptoms
(2) Fluency in alternative vocabularies of structure, intersectionality, and cumulative disadvantage;
(3) Provider/program capacity to engage in structural, interventions and change projects
References & Resources


• van Nierop, M., Viechtbauer, W., Gunther, N., Van Zelst, C., De Graaf, R., Ten Have, M., ... & OUTcome of Psychosis (GROUP) investigators. (2015). Childhood trauma is associated with a specific admixture of affective, anxiety, and psychosis symptoms cutting across traditional diagnostic boundaries. *Psychological Medicine, 45*(6), 1277-1288.
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