

My name is Ashley Weiss. I am a child and adolescent psychiatrist at Tulane School of Medicine in New Orleans, Louisiana. I specialize in first-episode psychosis. Psychosis is a symptom typically associated with onset of schizophrenia or bipolar disorder. These illnesses can have devastating consequences, from the increased risk of cardiovascular disease and premature death, to the ramifications of being marginalized by society. Why am I bringing up illnesses like schizophrenia in a hearing about mental health in high school and college students? Because this is where they start, in our young people, and *not* by any fault of their own. Adolescence is time of incredible brain maturation, and for some, this maturing process goes awry, leading to the *emergence* of severe psychiatric disorders.

So what is psychosis? Psychosis can be described as the loss of touch with reality. Examples of psychosis symptoms are hallucinations, confusion, and delusions. These experiences start small, like mis-hearing sounds as voices, or beginning to feel as if people are watching you. This paranoid feeling could then turn into a belief, a delusion, where one is *convinced* the world is literally out to hurt them. It is difficult, but necessary, to imagine what this may feel like.

Some facts about psychosis:

- 3 out of 100 people will experience psychosis in their lifetimes
 - Mostly occurring for the *first time* between 16 and 25 years old.
- For every 1 person experiencing psychosis, 6 more friends and family are directly impacted.
- In the US, the average time one experiences psychosis prior to treatment is 72 weeks
- 1 in 10 will attempt or complete suicide with the highest risk after the first episode

To give these statistics a local context:

- George Washington University enrollment is about 26,000 students
- Which means, almost 800 will experience psychosis annually and will not receive appropriate care for over a year
- Over 4500 friends and family are impacted
- Nearly 80 will attempt or complete suicide.

There is a sense of urgency because time is not on our side when it comes to psychosis and its impact on the brain. But the last 3 decades of research shows that *specialized* intervention as early as possible after psychosis onset improves outcomes across the board. There is no time to wait. The same philosophy is already accepted in stroke intervention and should be in psychosis intervention as well.

In 2015, I started the Early Psychosis Intervention Clinic in New Orleans. We have treated nearly 1000 people since we opened our doors. Our multi-disciplinary team provides coordinated specialty care, including medication management from psychiatrists, individual and family therapy, groups, and wellness coaching. All treatment is deeply individualized, with the goal of getting young people back on track, and often this means back in school.

But what we do in the clinic is not enough. Because of need for early *treatment* of psychosis, we are forced to think about early *detection*. We have a robust early detection campaign called CALM-Clear Answers to Louisiana Mental Health that aims to educate the community about psychosis, debunk myths and reduce stigma, so hopefully people will seek help for themselves or their loved ones sooner than later.

There are significant challenges and barriers that must be considered. For most people, recovery can take many many months, but time continues to pass for everyone else in their lives. Their friends have often moved on, graduated, moved away to college, or started their first job. They often feel very misunderstood and ashamed, quickly leading to loss of confidence and increased isolation. And there is a conspicuous gap in school-based recognition of the needs of these individuals, in keeping them engaged, or welcoming them back during recovery. I have multiple college students in my program who didn't know they were eligible for retroactive medical leave that may erase incompletes from transcripts, who have crushing student loan debt from the semesters they became ill. We are often the first place to provide guidance in approaching these issues.

There are financial threats to programs like ours. Although our program has committed to long-term care, most programs like ours do not go beyond 2 or 3 years, and we are realizing now that people lose their gains when they lose specialized care. But how do we pay for continued care? We have subsidized our growth through the congressional legislation mandating a portion of a SAMSHA block grant be 'set-aside' for early severe mental illness. We are appreciative of this opportunity because it covers the necessary care that is NOT covered by insurances. In our state, Medicaid and commercial insurers do not reimburse ANY of the *coordination of care services*-no case management, no record review, no coordination with community partners like hospitals and schools, no treatment team meetings-and without the coordination, the risk of relapse increases exponentially. If commercially insured, patients may have 2 co-pays a week for treatment which quickly adds up and becomes a burden. People in this age group also fall off their parents' insurance but may not qualify for Medicaid.

Barriers exist beyond the clinic. There is a pervasive lack of education (coupled with ample misinformation) about what psychosis even is. This gap in education exists in the general public but extends even to mental health professionals. Psychosis is not a topic in health education curriculums for high school or college students, even though their age-group is the *most* at-risk. Psychosis education is not a prominent part of the curriculum for those *interfacing* with the high-risk groups, for instance teachers and school-based mental health professionals. Psychosis *intervention* is far from being considered an essential part of school-based healthcare. At this point, we should not be surprised when a college freshman experiences psychosis, we should be *anticipating* this, working to disseminate knowledge about early warning signs, and strategically planning with community partners to ensure students get back on track once well.

I'm here today, to say out loud and for the record, that our youth and young adults that are the topic of this hearing are the vulnerable ones, where the *severe* mental illnesses strike. We cannot ignore this fact as a society any longer. These illnesses are *not curable* but they should not be associated with inevitable lack of productivity and institutionalization. They are not *preventable* but there are strategies to mitigate risks associated with earlier onset such as substance use. They *are manageable* but management doesn't mean doing the bare minimum. That approach has not served us well historically. A specialized approach may require a weekly meeting with their team for years, however, if that means individuals have more opportunities, more graduations, more jobs, more meaningful relationships, improved quality of life, then we are in a better place. If our communities have fewer suicides, fewer inpatient psychiatric hospitalizations, fewer ER visits, fewer people living in poverty, then we are in a better place. We collectively benefit from a progressive and more accurate narrative about psychosis, but for our young people, it is necessity. We must be *ambitious* in our commitment to these youth and young adults, so that their recovery is supported while they explore opportunities and expand their futures.