Coordinated Specialty Care for First Episode Psychosis

Manual I: Outreach and Recruitment

NIH National Institute of Mental Health

RA1SE
Recovery After an Initial Schizophrenia Episode

A Research Project of the NIMH

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Contributors:
Karen McNamara, M.S.W., L.C.S.W.-C, Ph.D., University of Maryland School of Medicir Baltimore, MD

Sapna J. Mendon, L.M.S.W., Research Foundation for Mental Hygiene, New York, NY

Sarah Piscitelli, M.A., M.H.C., Research Foundation for Mental Hygiene, New York, NY

Tom Smith, M.D., Columbia University Medical Center, New York, NY; New York State
    Psychiatric Institute, New York, NY

Susan Essock, Ph.D., New York State Psychiatric Institute, New York, NY: Department of
    Psychiatry, College of Physicians and Surgeons, Columbia University, New York, NY

Howard Goldman, M.D., Ph.D., University of Maryland School of Medicine, Baltimore, MD

Lisa Dixon, M.D., M.P.H., New York State Psychiatric Institute, New York, NY; Columbia
    University Medical Center, NY

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I. Introduction

The low incidence of schizophrenia (3 in 10,000 / year; WHO, 2012), coupled with complex differential diagnosis (White, Anjum & Schultz, 2006), make it particularly difficult to identify individuals experiencing early psychosis. Engaging individuals in appropriate treatment is further complicated by the individuals' and family members' unique and culturally-derived definition of these experiences (Bergner, Leiner, Carter, et al, 2008), their often negative perceptions about mental health services (Compton, Esterberg, Druss, et al, 2006), difficulties in cognitive processing caused by the illness that may affect the process of obtaining and storing knowledge (Beck, 2009), and stigma associated with acknowledgement of mental illness by individuals and families.

When developing an early intervention specialty clinic, it is essential to develop a structure that systematically disseminates information about the program and can facilitate a successful referral and enrollment process. This manual describes methods for outreach, steps to establishing a referral network, and guidance on evaluating and admitting individuals to a specialty clinic. Individuals partaking in such activities will be referred to in this manual as outreach and referral specialists (ORS) or as the outreach and referral team (O&R team). The O&R role is critical to the success of Coordinated Specialty Care (CSC) programs, as the ORS is typically the first point of contact a potential client may have with CSC care and play a central role in engagement. This engagement process must embody a vision of recovery and hope that communicates the program's person-centered focus, as opposed to an illness-focused approach. As will be emphasized throughout the manual, language is central to this goal. The language used by ORS should mirror that of the potential client and convey new meanings of treatment which emphasize recovery and hope.

The recommendations and resources provided in this manual are derived from the experiences of the Recovery After an Initial Schizophrenia Episode Implementation and Evaluation Study (RAISE-IES). RAISE-IES was funded by the National Institute of Mental Health (NIMH) to, in part, develop tools that would support the implementation of programs designed to provide early intervention services for people with non-affective psychoses. The Connection Program was the clinical intervention developed and evaluated in RAISE-IES. RAISE Connection Program represents an example of a CSC program recommended for first episode psychosis. This manual provides examples of practical tools and materials that can be used for outreach and referral activities as well as case narratives that highlight the experiences of RAISE-IES. Throughout the manual, 'Section Tools' are highlighted, pointing to appendices with relevant tools and information.

Note: The RAISE Connection Program was part of a research study. As a result, some of the language and procedures that are embedded in these tools would need to be modified for usual clinical practice.

II. <u>Establishing and Equipping the Outreach and Referral Team</u>

The CSC Team Leader or Program Director should designate one or more individuals who will oversee the outreach and referral (O&R) process for the program. As part of O&R, these individuals will also be responsible for initial assessments of the potential client's eligibility for the program. The designated individual(s) should be a master's level clinician (or possess a higher clinical degree) with the ability to identify primary psychosis and perform differential diagnoses for symptom profiles related to psychosis. A program may choose to identify persons within the clinical team to lead outreach and recruitment activities, or establish a separate team of individuals who will only be responsible for such activities. If outreach staff members are not part of the clinical team, they should be trained in the core concepts of the program (as outlined in the companion manual, *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation*.)

While this manual focuses on the O&R activities of team members, it is also useful to have access to senior agency leadership who may facilitate outreach and/or recruitment by strategic networking and presentations, as appropriate. For example, a senior administrator may establish contacts across organizations with other administrators within the community.

A. Training and Supervision

Section Tools:
✓ ***Examples of strengths-based language can be found in Appendix 1.***

1. Key Concepts in O&R Training.

The list below provides a general overview of the key concepts O&R team members should be familiar with before they begin their activities. Recommended readings may be found in the companion manual, *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation.*

- <u>Program Components</u>: O&R team members should have an understanding of all team roles and functions, services offered, and the general model.

- <u>Insurance and Financial Matters</u>: O&R team members should know the program's pre-determined payment structure to suitably inform providers, service seekers, and family members. Examples include: if certain services are fully covered at no cost; if medications are covered; if any insurance is accepted; and/or if there are options for an income-based sliding scale.

- <u>Psychoeducation</u>: O&R team members must be familiar with the concepts and the general literature regarding schizophrenia including early warning signs, impact on functioning, and the importance of early intervention.

- <u>Presentations</u>: O&R team members require training in how to give presentations to

various audiences. The audience may include physicians, mental health professionals, school counselors, and other professionals (e.g., police, religious authorities, etc.) Presentations may also be given at different venues in the health sector and the community.

- Evaluation: As they may be conducting eligibility evaluations/engaging in pre-screening activities, O&R team members should: understand symptoms associated with psychosis, mood disorders, and substance use disorders; know how to diagnose primary psychotic disorders and be familiar with differential diagnoses; be able to identify the onset of prodromal symptoms; and become accustomed to determining date of onset of psychosis.

- Safety and emergencies: O&R team members must be knowledgeable about emergency procedures implemented by the agency housing the specialty clinic, as well as procedures set in place within the team (e.g., contacting senior clinician in a crisis, etc.)

- Reporting requirements: O&R team members must fully understand required responses to suspected child abuse and homicidal thoughts as mandated by law.

2. *Language.* Person-centered language is an important tool for outreach and early engagement. Examples of recovery-oriented and strengths-based language are included in Appendix 1. When speaking with potential clients or family members, avoid using diagnostic terms (e.g., schizophrenia, delusional disorder) unless specifically discussing diagnoses—use the same language that potential clients or family members use when describing their experiences. O&R team members represent the first contact a potential client has with the CSC program and team. For successful engagement, it is essential that their language and approach emphasize messages of recovery and highlight a person-centered approach to treatment.

3. *Supervision*. When the clinic is first established, the O&R team will need clinical supervision to review incoming referrals and address any barriers encountered as staff attempt to establish rapport with potential clients or families. Backup supervision should be available by a senior clinician to provide assistance in addressing safety concerns and complex situations. The independence of the ORS should increase with time and experience.

B. Creating Materials and Outreach Tools

Section Tools:
- ✓ *Examples of brochures and flyers used for outreach during the RAISE Connection Program are provided in Appendices 2 and 3.*

Prior to the initiation of outreach and recruitment activities, it is helpful for the program to develop materials that help communicate information about the CSC program and serve as entry points for potential clients, family members, and other service providers to learn about and contact program staff.

- *Website:* The website should be easy to navigate and can include sub-sections for clinicians, consumers, and family members. In addition to including contact information and directions to the clinic, the program may also choose to include an inquiry form on the website, which would allow interested parties to submit requests for information about the program. The website should be kept up to date, and have an appealing look.

- *Centralized Phone Line:* The program should establish one phone number for all referral calls. This number can be routed to various outreach team members to answer calls on a rotating basis. Toll-free lines that automatically email transcribed messages to a centralized, secure email address may be an effective way to receive and respond to referral inquiries in a timely fashion.

- *Brochures and flyers:* Two types of brochures and/or flyers should be created: one to meet the needs of consumers and family members, and another to target providers. Each should include a brief introduction to the specialty clinic along with an overview of admission criteria and relevant contact information. The provider brochure can incorporate knowledge from previous research to highlight the need for early intervention, using clinical terminology to describe consumers. The consumer and family brochures should speak to the overall goals of the program and briefly describe specific program activities. Materials for consumers and family members should not use diagnostic language. Creating electronic versions are that can be easily shared via email is also helpful.

- *Supplies:* As budgets allow, purchasing items such as pens or notepads with the program name to distribute may serve as helpful reminders to referral sources.

The O&R team can work with external branding agencies to develop materials that distribute information about the new early intervention specialty program to providers, service seekers, and family members. All written information made available to the public (non-provider) should use appropriate, person-centered language to describe the program without using medical/diagnostic terms.

III. Establishing and Maintaining a Referral Network

Before creating the referral network, several characteristics of the specialty program should be identified so that the outreach team can convey this information to potential referral sources. These program characteristics include levels of program services, geographic boundaries for services, financial structure, and clinic admission criteria. When establishing the network, also consider characteristics of state-specific regulations and local mental health agency structures. For example, it is important to be informed regarding criteria for involuntary status; confidentiality regulations and standards for working with minors; and accessibility of different levels of care that are provided by state hospitals, general psychiatric units, partial hospital and/or day treatment programs, respite care, peer services, outpatient services, and private practice offices. Additionally, the O&R team should be knowledgeable about financial and insurance systems within the state.

Section Tools:

✓ *A flip chart, letters, and newsletter articles can be found in Appendices 5, 17, and 18.*
✓ *Guidelines for creating an Outreach Tracking System and a template can be found in Appendices 12 and 13.*

A. Communications Strategies

Outreach activities should encompass efforts that will facilitate connections to specialty clinics as early in the individual's illness as possible. The O&R team must expand these efforts beyond institutions, to reach the larger community. Understanding the cultural norms of residents in the area surrounding the clinic can be beneficial to reaching a larger audience and engaging individuals in early intervention services. In addition to using various materials and tools as previously described, the following methods can also be used to communicate information about the specialty clinic:

- *Presentations:* Presentations about the program and its services should be customized to separately target consumers, families, and mental health professionals using terms that are meaningful to them. Presentations should provide some education about first episode psychosis (e.g., etiology, effects of illness, impacts on functioning, etc.), and why early intervention is thought to be important. Flip charts of presentations serve as a visual tool to facilitate discussion during small staff presentations and/or to use during initial meetings with potential clients and families.

- *Newsletters:* A new specialty clinic may choose to write an article specifically for newsletters. The O&R team may approach existing organizations (who already circulate news briefs to their listservs) to include the article in their newsletter.

- *Host Websites:* Reach out to larger institutions that provide resources on their websites and request that information about the new specialty clinic be placed on their host website. Examples include: Schizophrenia.com; local NAMI website; and the website for the host agency of which the clinic is a part (e.g., larger hospital or university

system).

- *Social Media:* Social media and the internet can be used in a variety of ways. The target audience may consist of anyone who may benefit from receiving user-friendly information. The specialty clinic may choose to distribute academically oriented research articles, information on current affairs as it relates to psychosis and early intervention, blog posts highlighting specific topics of interest, etc. Whether using Facebook, Twitter, or other social media outlets, the specialty clinic's objective should be to disseminate information to the public and offer general resources when appropriate.

B. Outreach Tracking System

The O&R team should implement and maintain systems to track all the outreach activities and referrals. Tracking allows for an evaluation of the impact and staff time required for different activities. This can be designed as a database (i.e., using a program such as Access), or through the use of Excel spreadsheets. Elements that should be included in the outreach tracking system include:

- Organization/Agency Name
- Specific units/departments
- Names of particular agency contacts and relevant contact information
- Tracking outreach: date/name/type of activity (presentation, email, etc.) and plans for follow up

C. Referral Network and Outreach Activities

The O&R team should identify the potential referring organizations within the clinic's geographic boundaries. Any local organizations that may encounter potential clients should be included in this original list. All relevant information for such organizations should be stored in the Outreach Tracking System.

O&R team members should conduct initial outreach activities using both top-down and bottom-up tactics, approaching both executive administrators and staff providing direct services at potential referring institutions. Whether the initial contact occurs via administrators or front-line staff, the outreach staff should attempt to inform staff at all levels about the clinic services.

Establishing rapport with referral organizations occurs in three stages: Orientation, Uptake, and Optimization. During the Orientation stage, the outreach team focuses on establishing initial contact with the referral source and orienting key staff members to the specialty clinic program and services. The Uptake stage describes the period of time when initial referrals are received by the specialty clinic. Open communication with referral sources ensures that initial referrals occur successfully and the referral process is working. Any impediments in the referral process may cause a referral source to stop sending referrals. The third stage, Optimization, describes the process used to maintain a stream of referrals. This stage ensures that ongoing communication

occurs to identify regular referral personnel and orient new personal to the specialty program.

D. Outreach Process: When, How, and How Much

- Start introductory outreach activities prior to the launch of the new program. Organizations and individuals should be notified once the program can begin considering new referrals and offering screening and intake appointments.

- Determine level of outreach

  - *Mailings only:* Send letters or emails describing the clinic services and referral instructions on a scheduled basis. Mailings may include a supply of flyers and brochures. "*Meet and greet" sites*: Target a selected number of clinicians and sites for once/twice-yearly visits from the outreach team and presentations about the study.

  - *"Enriched outreach" sites:* Visit high-yield referral sites on a regular basis to develop a familiar and collegial relationship with the site clinical staff.

- Work with high-volume referral sources to establish customized procedures to facilitate referrals. Consider facilitating potential client screening and referral through mechanisms such as regular attendance at staff meetings or by monitoring electronic medical records when possible.

- Identify organizations that are sending fewer referrals than anticipated. Additional contact may be required to provide further training and/or to identify and remove any barriers. Maintaining regular contact also allows opportunities to present to new staff and re-orient existing staff about program services, admission criteria, and the referral process.

- Expand the referral network slowly to ensure that the clinic can adequately respond to most referrals.

Case Narrative 1: Like Speaks to Like: The Importance of Outreach Within Disciplines

Whenever possible during the implementation study, a psychiatrist and social worker would give presentations as a team. Having both a psychiatrist and a social worker present was beneficial throughout the course of the presentation. While a psychiatrist was able to provide more in-depth information from a medical perspective, a social worker was able to provide greater detail about key psycho-social components. Presentations would often start with the psychiatrist speaking about the onset and course of psychotic disorders, an overview of currently available treatments, and the importance of early intervention. The social worker would follow up with a description of the comprehensive services offered by the RAISE Connection Program, along with guidelines for making a referral. The overall nature of the presentation consistently blended research and clinical concepts. When appropriate, presenters integrated a mental health systems perspective to provide a bigger picture about health care

services and costs in the state. Because audiences were mostly composed of psychiatrists, psychologists, and social workers, each with varying interests, having a psychiatrist and social worker present provided a platform for a discussion that engaged persons from all of these disciplines.

Case Narrative 2: Combining Education with Outreach

The Connection Program Team Leader contacted an inpatient unit at a community hospital and described the clinical research service. The inpatient team wanted to hear more and invited the Connection Team representatives to a staff meeting. The outreach staff told the inpatient leadership that a Connection Team senior psychiatrist would attend the meeting and provide an overview of the project and its relevance to the hospital's work. The hospital leadership agreed to schedule the visit for a staff meeting that had a brief agenda, to allow for an overview of first episode psychosis, the Connection Team services, and open discussion.

The staff meeting was informal and attended by a mix of psychiatrists, social workers, and nurses. It began with a 15-minute presentation by the RAISE Connection Program senior psychiatrist covering:

- *The emerging focus on prevention and early intervention throughout mental health;*
- *The needs of adolescents and young adults with first episode psychosis for education and employment support;*
- *The potential to limit disability in this population with comprehensive early intervention*
- *The importance of engaging families and support persons in the care of these individuals.*

Open discussion followed with hospital staff members describing patients with first episode psychosis and the difficulties they experience with treatment and follow-up. The Connection Team senior psychiatrist acknowledged the hospital staff experiences and reinforced the above principles. The Connection Team outreach staff followed with a detailed but brief (5-minute) description of the services provided by the Connection Team. The hospital staff was enthusiastic and gave further examples of how these services could meet the needs of selected patients. The meeting ended with the Connection Team outreach staff providing written and verbal information regarding eligibility and contact information. The Connection Team senior psychiatrist offered to provide a grand rounds presentation on first episode psychosis if the hospital wished in the future, and also suggested a follow-up visit to the staff meeting within 3 to 6 months.

Case Narrative 3: Information Dispersion: Exponential Return on Outreach Efforts

The outreach and recruitment committee initially anticipated the use of different modalities to announce the start of the Connection Program. In addition to conducting outreach via presentations, emails, letters, and phone calls, the committee collaborated with media specialists to establish other methods of advertising. Together we designed a poster intended to be placed in several subway stations and/or bus stops; and also created an advertisement to be placed in local newspapers. In addition to printed advertisements, the committee sought to use digital advertising through social media websites. Subsequent to the initial recruiting period, the outreach and recruitment committee learned that many providers were hearing about the program either directly from presentations or from other colleagues. The committee soon learned that emails and flyers were being passed to several other organizations and providers, including those we had not made a connection with directly. With the success of receiving numerous referrals, the committee conclusively determined that the use of formal advertising was not necessary at this time.

E. Description of Outreach by Institution Type

1. *Key Concepts for Mental health Facilities (e.g., Psychiatric Inpatient Units; Emergency Rooms; Crisis Response Teams; Outpatient Clinics):*

- Presentations given at inpatient units should be offered on a regular basis. The objective is to cater to the needs of providers who often develop disposition plans with short notice. The O&R team should offer to visit regularly even if only for the purpose of checking in during team meetings. During visits, the O&R team should: encourage providers to call the team as early as possible about a potential new client; emphasize that the ORS can come to the unit to meet with the potential client and family members prior to discharge; offer to be a resource in case the potential client does not meet admissions criteria following an evaluation.

- Some hospital systems may have a centralized referral call center which anyone seeking services may call to inquire about the services offered within that institution. It is important for the O&R team to connect with staff within such referral call center systems. Staff fielding calls should be given adequate information about the specialty clinic and admission criteria.

- Emergency room outreach activities should focus on making the referral process easier—set up systems collaboratively from the start to help ensure a streamlined process.

- Presentations and check-ins with mobile crisis teams, partial hospitalization programs, and other outpatient clinics may happen less regularly. ORS staff members should inform outpatient providers that should a potential client be deemed admissible, a transfer of care would need to take place around the time of intake into the specialty clinic.

- All facilities should be provided with written materials designed for consumers and families to be placed in waiting rooms and/or distributed as providers see fit.

Case Narrative 4: Electronic Medical Record Reviews

Two challenges in establishing a potentially high yield referral source are timely identification and referral for individuals experiencing first episode of psychosis (FEP). Staff members of the referring organization require training to identify individuals experiencing FEP, and many sources, such as inpatient units, require rapid referrals for discharge planning. Outreach staff leveraged electronic medical record technology to expedite identification of individuals experiencing FEP and their referral to the Connection Program.

The outreach team identified a large local hospital as a potentially high yield referral source. Existing chart reviews were already being conducted to approach individuals for research, and the Connection Program team developed procedures to facilitate client referrals to the CSC program. A designated chart reviewer who was employed by the Hospital Center received a list of medical record numbers for current patients based on age and diagnosis, including Brief Psychotic Episode, Psychosis NOS,

Schizophreniform, Bipolar I with Psychotic Features, Major Depression with Psychotic Features, Delusional Disorder, and Schizophrenia. The chart reviewer examined admission and psychiatric treatment history in detail to determine whether this individual appeared to be experiencing FEP. When the outreach staff identified an individual who may be eligible for the Connection Program, they sent an email to the attending psychiatrist, social worker, and discharge coordinator indicating that an individual on their caseload may be eligible for the Connection Program and providing the medical record number of the potential client. The outreach team received a copy of these emails, and an outreach team member would contact the treatment team to offer an onsite presentation of services for the individual and their family members.

This process not only allowed the outreach team to target their efforts towards specific individuals experiencing FEP, but it served to identify which healthcare professionals regularly encountered individuals experiencing FEP in their practice. Once potentially high yield healthcare professionals were identified, the outreach team could provide presentations about available services and offer in service education. This strategy offered the Connection Program as a potential solution for discharge planning and established a collaborative relationship with the referral source.

Case Narrative 5: Concerns About "Stealing" Patients

Program presentations were met with suspicion by some clinicians who were concerned that the program was attempting to "steal" patients from their clinic. The O&R Team addressed these concerns in several ways. First, they emphasized that they were not interested in having individuals change service providers if it was not clinically appropriate. For example, if the potential clients were doing well in their current care, it may not be clinically appropriate for them to come to the Connection Program at this time. Second, the services available through the Connection Program were reviewed, with the emphasis that additional services would be available to the potential clients and their families. Services such as employment assistance, case management, and family psychoeducation were unlikely to be available to their clients outside of the Connection Program. Third, the O&R team emphasized the importance of engaging individuals with early psychosis in treatment and with the level of community outreach available through the Connection Program. Fifth, the O&R team emphasized that early psychosis is a low incidence condition. The actual number of individuals eligible for these specialized services would represent a very small portion of the providers' entire caseload. Finally, the O&R team continued to affirm the clinician's judgment about whether or not the Connection Program was a good fit for the client. The result was that when most clinicians understood the full range of services available at the Connection Program, they were pleased to offer the program to their client as a treatment alternative.

Some clinicians, particularly private practice psychiatrists, hoped to retain clinical care of their client and refer the potential client to the Connection Program for therapy, case management, supported employment/education services, and recovery coaching. Similarly, family members may request that existing providers maintain treatment while an individual participates in the Connection Program. Fully integrated, comprehensive care through the Connection Program team provides many treatment advantages. Therefore, the Connection Program model requires that participating individuals receive available services (e.g., psychiatry, therapy) from the Connection Program team. This may have business implications to some practitioners; however, the client benefits of the integrated treatment model may often result in referrals even in these cases.

2. *Key Concepts for Colleges and Schools:*

- Presentations at colleges should target college counseling centers and student disability offices that may both serve as gatekeepers to more intensive services. Material should be customized to address the kind of encounters these professionals may have with potential clients (i.e., educating them about early warning signs as they relate to functioning and performance in school).

- Presentations at high school and state education systems also require focus on the kind of encounters teachers and guidance counselors may have with high school students. Given the large number of schools, O&R team members can encourage administrators to pass on introductory information about early intervention services to officials at local schools. Interested parties can receive more focused presentations targeting a group of educators and/or counselors within their school or district.

- Outreach may be directed towards local medical, nursing, psychology, and social work schools. Students of these disciplines often circulate among multiple service providers and may facilitate further dissemination of information.

3. *Other Potential Sites for Outreach*

- Professional, Family, and Consumer Organizations. These organizations are often contacted by persons seeking support or additional services. ORS staff members need not provide specific details about the program's eligibility criteria and/or referral process; rather, emphasize that the CSC program can be presented as a resource to individuals and families who are seeking treatment for symptoms that are characteristic of psychosis.

- Research studies conducting ongoing schizophrenia and/or other related research. While evaluating study participants, researchers at such programs may learn that the individual may be in need of further clinical services. In such cases, the CSC program may be a resource.

- Existing FEP and prodromal clinics. While conducting outreach, ORS staff members should highlight the potential for a reciprocal relationship. For example, re-directing callers to other FEP or prodromal clinics if the potential client is eligible, or if the CSC reaches capacity.

- General practitioners. Based on interest level, customize presentations to meet the needs of a general practitioner. For example, it may be necessary to provide more detailed psychoeducation regarding early warning signs, symptoms, clinical acuity; how to approach the subject of treatment with his or her patients and family members, etc.

- Places of worship, substance abuse programs, social service programs, or criminal justice systems. Professionals at these institutions would benefit from a more nuanced outreach strategy aimed at helping them interact appropriately with the persons they encounter within their roles.

Case Narrative 6: Differences Between Medical and Non-medical Outreach

Outreach to clinical settings (e.g., hospitals, mental health clinics) differed from outreach to non-clinical settings (e.g., colleges/schools, community groups). Clinicians wanted information about treatment options for their patients and were also interested in opportunities for clinical consultation regarding complex cases. Clinicians and clinical leaders were interested in opportunities for continuing education and were open to scheduling grand rounds or staff conferences. In contrast, outreach efforts to non-clinical settings were tailored to the characteristics of the program. For example, school counseling centers were not interested in learning about psychotic disorders (more than one college counseling program emphasized that their students did not have such disorders). Community-based advocacy or organizer groups were also keenly aware of stigma associated with serious mental illness. Outreach to these groups focused on how the Connection team could be a resource to assist their students/residents/family members to accomplish shared goals, such as educational, work, or other goals that may improve quality of life.

F. Outreach to Complex Organizations

Administrative Services Organizations. Start with presentations to state and local level directors, and learn how to approach distributing information across the state's mental health network. Subsequent outreach can be delivered as appropriate. If any state or local agencies offer mental health referrals to families or clients, the specialty clinic can be included on these agencies' resource lists. Poster presentations at conferences sponsored by the state or local mental health associations can also be used to reach a wide variety of providers and identify new potential referral sources.

Affiliated HMOs. Working with Health Maintenance Organizations (HMOs) adds a third party to the referral process (i.e., the HMO care manager). The outreach staff should keep two goals in mind: 1.) provide enough tools to the care managers who will facilitate referrals of individuals involved in care management programs, and 2.) learn how information can be disseminated by the HMO throughout its provider network so that providers can initiate referrals independent of the HMO care manager. Many HMOs are large entities with numerous public and private sector contracts, and outreach staff may need to make initial contacts with HMO regional directors or other senior leaders to obtain approvals to work with care manager teams.

During presentations with care managers, it is important to convey how the outreach team can facilitate this process for care managers and providers. Outreach team members should work collaboratively with care managers to streamline the process of identifying individuals in need of services, and sufficiently linking them to services. We recommend monthly calls with area administrators and care managers to develop a system to simplify the process, and to address any challenges that may arise.

Case Narrative 7: Establishing a Relationship with HMOs and Working with Care Managers

In New York, the outreach team along with a senior clinician had the opportunity of piloting a collaboration with a local Behavioral Health Organization (BHO). BHOs are managed by larger health maintenance organizations, and target behavioral health services. During initial contacts by the senior psychiatrist to a BHO regional director, information about the Connection Program was provided, including knowledge about specific services and the kinds of people who would be referred to the program. Subsequently, it was agreed upon to have monthly check-in phone calls. A social worker from the outreach team also joined these monthly calls. During this process, the two members of the Connection Program and the BHO regional director began planning for ways to get care managers involved in the process. Once the regional director had sufficient information about the program, the proposed collaboration between this BHO and the Connection Program was shared with a local area director. The plan was to then give a presentation to local area directors, and meet with direct care managers to provide detailed information about the program and walk them through the process of making a referral. A one-page flyer was created for care managers to refer to as a quick guide to know when to call outreach and enrollment staff. This flyer would be helpful as a reference when care managers receive calls from hospitals or other service providers looking for a resource for the admitted patient.

IV. Client Screening, Evaluation, and Admission

Client screening, evaluation, and admission encompass the identification, early engagement, evaluation for admission, and clinic admission of individuals experiencing early psychosis.

Potential clients entering the specialty clinic pass through four stages: 1) Initial Contact, 2) Prescreening, 3) Evaluation for Admission, and 4) Intake and Admission. Figure 1 provides an overview of each step. While the figure provides time estimates, the ORS Team should always be aware that potential clients and family members may require additional time prior to making decisions for a variety of reasons. Remain mindful of the importance of allowing potential clients to move at their own pace when making decisions. The ORS team can offer support by being available to answer questions and encouraging potential clients to remain in contact. During the screening and evaluation period, it is important for the ORS to not act as a primary clinician and to appropriately convey that the potential client is not in treatment at the specialty clinic.

Figure 1: Outreach, Referral, and Admission Overview
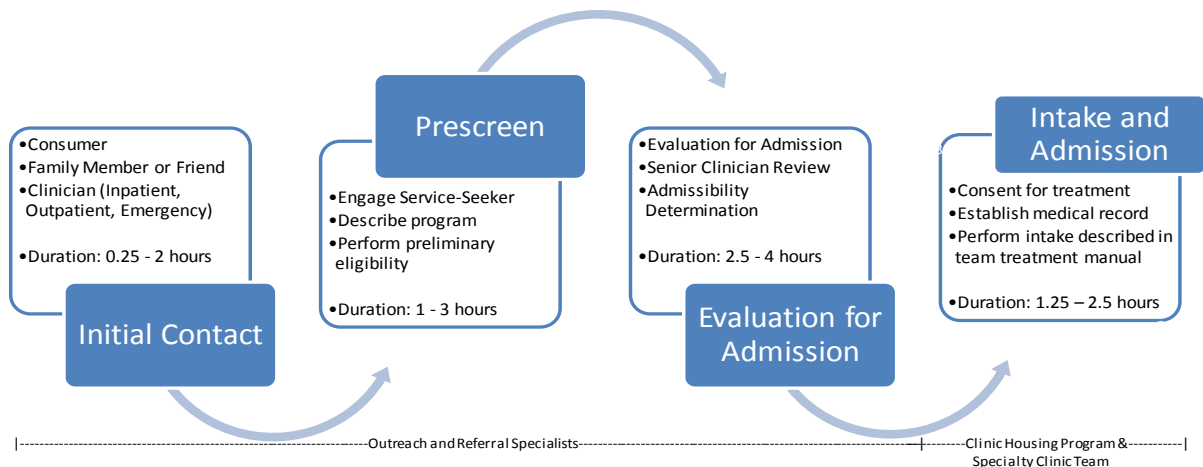
Section Tools:

- ✓ *Diagrams and templates for referral screening and evaluation forms can be found in Appendices 6-9.*
- ✓ *Sample Flip Chart (for providing psychoeducation) can be found in Appendix 5.*
- ✓ *Guidelines for creating a Potential Client Tracking System and a template can be found in Appendices 12 and 14.*
- ✓ *A sample resource list and referring out diagram can be found in Appendices 10 and 11.*

A. Creating Procedures and Tools for Referral and Evaluation

Prior to conducting evaluations for admission, procedures and tools should be established to help track and collect information regarding potential clients. It is also important to have available resources and procedures for managing individuals who are not eligible for the CSC program.

- **Potential Client Tracking System (PCTS).** Systems for keeping track of all referrals received should be implemented and maintained by the O&R team. The PCTS can be designed as a database (i.e., using a program such as Access), or Excel spreadsheets. At a minimum, the system should include:

  - ➤ Date of referral
  - ➤ Name of person calling and relationship to potential client
  - ➤ Name of organization
  - ➤ Outcome of referral (Screening/Evaluation in Progress; Intake; Referred Out-Not eligible; No Response/Refused; Referred Out-Waitlist)
  - ➤ Multiple rows (with space for dates) to reflect multiple contacts for the same service seeker

- **Resources List (for Re-directing Individuals and Emergent Situations):**
  - o Area emergency resources, including Lifenet phone numbers
  - o For clinics and programs, include the following information:
    - ▪ Organization name and relevant specific programs within organization
    - ▪ Location, contact phone numbers, and names of specific people with whom a relationship has been established
    - ▪ Population served, including age range and conditions treated
    - ▪ Insurance requirements and fees
    - ▪ Catchment area requirements
    - ▪ Services offered (e.g., individual, medication management, groups, vocational services, etc.)
    - ▪ Referral/Intake process (include any forms the program may require to be completed)

- **Referral Screening Packet.** Screening packets should be developed and maintained by the O&R team. Referral screening forms should highlight key demographic and clinical information received during initial contacts. A comprehensive referral screening form can be used to inform the eligibility evaluation.

- **Evaluation Form/Narrative.** An evaluation form will clearly identify the factors that lead to admissibility or inadmissibility. A program may also choose to capture information regarding an individual's pathway to care from the time of onset to the date of enrollment in an early intervention clinic. Questions eliciting such information can be asked and noted on the evaluation form. For persons eligible for enrollment, using an evaluation narrative is recommended to provide descriptions and context related to factors leading to admissibility, including history of hospitalizations,

substance use, and any other information the ORS feels appropriate to note. Such a narrative can be helpful for other team members to read prior to meeting the potential client.

- **Waitlist Procedure.** Whether or not the specialty clinic will maintain a waitlist should be pre-determined and should integrate the host agency's policies. If a waitlist is maintained, the following should be used as a guideline:

  o Inform the potential client about the waitlist, and provide a potential date for evaluation based on anticipated openings.

  o Encourage the potential client or family member to seek interim services, and provide sufficient referrals. Encourage individuals to remain in contact periodically to check for openings.

  o Contact potential clients based on date of referral once the clinic is able to offer evaluations. If the potential client has already established care and needs are being met, refrain from disrupting treatment.

- **Safety Procedures.** See Section II.A: *Training and Supervision*

B. Directing Flow of Referrals

Incoming referrals may go in one of two directions: meeting with the ORS for an evaluation or being redirected elsewhere. The ORS team member will have to redirect referrals for the following situations: 1) the ORS immediately learns that the potential client is not appropriate for the program or the individual declines to proceed further, 2) the clinic is at capacity, and/or 3) an emergent situation is apparent. For all other referrals, an evaluation should be considered.

1. Emergent Situations

During initial contacts with a potential client or family member, if an emergent situation is apparent, the ORS should proceed cautiously. Ideally, the individual may be encouraged to contact their current service provider for further assessment/guidance. If the individual is not currently in care with another mental health professional*,* the ORS must use their clinical judgment and redirect the individual appropriately. This may include providing information to the nearest emergency room, or advising the caller to contact emergency services. At minimum, the ORS should provide any additional information for local mobile crisis teams and/or crisis centers.

2. Redirecting Referrals

The ORS team may learn that a potential client does not meet criteria for admission during initial contacts, prescreening, or upon completing an evaluation. Information about alternative treatment providers should be provided whenever possible.

Providing alternative referrals entails knowledge of the potential client, such as diagnostic information, insurance and financial ability, pertinent demographics, and geographic location. The ORS also needs to have a basic understanding of programs in the area, their requirements, and their referral process. If the ORS identifies a need for alternative referrals during the screening process, it is helpful to capture any supplemental information that could lead to a more appropriate referral. For example, if the ORS learns that a young potential client is not interested in treatment but is struggling with high school courses, or would like to apply to college, it may be valuable to identify a program that may offer education and employment support in addition to clinical treatment. The ORS staff should make efforts to facilitate introductions as appropriate while providing alternative referrals to callers. This helps maintain connections with area providers for the referral network. For potential clients and family members, this practice may help make their transition between agencies more seamless. Some factors to consider when making referrals include:

- *Level of Care Needed*: Inpatient, residential or long-term care, partial hospitalization or continuing day treatment programs, individual outpatient (psychiatrist and other mental health professionals)

- *Insurance/Financial Ability*: Does the potential client have insurance? Does he or she have out of network benefits? Do the potential client and/or family members have the means to pay for services out of pocket?

- *Geographic/Location Needs*: Does the potential client need services close to home/work/school? Can he or she travel independently?

- *Specialty Programs*: Are there clinics or programs in the area that address the potential client's diagnostic features (i.e., substance use programs, anxiety disorder clinics, etc.)

- *Supportive Services*: Consider what you have learned about the potential client, and what is important to him or her. Might they benefit from any of the following: Education and employment services, social skills building, groups, targeted treatment (i.e., cognitive-remediation)

C. Stages of Referral and Evaluation

1. *Initial Contact*

The goals of initial contacts are to: a) establish/maintain rapport; b) describe key elements of clinic services c) identify decision makers and supports (e.g., potential client alone, potential client with parent/guardian; other family or supports); d) determine the potential client's level of interest; and e) proceed with prescreening or redirect as indicated.

- **Self-Referral.** Self-referrals occur when potential clients, their friends, or their family members learn about the specialty clinic on their own through a variety of sources, and initiate the first phone call to the specialty clinic. Initial calls by adults seeking services for themselves can be addressed accordingly (see goals of initial contact above). Some precautions need to be taken when speaking with minors, parents of minors or adults, and others who may be calling on a client's behalf. In these situations it is important for the ORS team member to provide information about the program, while refraining from asking many questions about the individual seeking services. O&R team members should try to connect with the client as early as possible, and decisions about evaluation appointments should be made in collaboration with the potential client and other persons involved in their care. Parents or legal guardians must be present for meetings with minors.

- **Clinician Referral.** Clinicians referring clients include providers, school counselors, and other health professionals. Initial contacts with clinicians should largely follow the same goals described above, with the following additional guidelines:

  o Review all available relevant records. The ORS should try to gain additional contextual information (regarding important events and symptoms), and discuss any aspects of the potential client's history that may need further clarification.

  o If concerns arise regarding admissibility to the CSC program, the ORS should identify concerns with the provider, and make a plan for alternative referrals.

  o Whenever possible, encourage a meeting with the potential client prior to a formal intake evaluation appointment, and encourage clinicians to join a portion of such meetings.

  o The ORS should inform the referring clinicians that transition of clinical care does not occur upon referral; rather, transfer of care is coordinated between the CSC team and the referring clinician *after* the client has enrolled in the program. The precise timing of transfer of clinical care needs clear communication so that both the referring clinician and the CSC team know which provider should be collaborating with the individual on their treatment decisions at any given time.

2. Prescreening

Prescreening potential clients consists of providing psychoeducation and appropriately describing services offered by the CSC team. Prescreening may occur naturally during the initial contacts by phone, in-person meetings prior to the evaluation, or just before the evaluation itself.

The goals of prescreening are to: a) establish/maintain rapport with the potential client; b) describe key elements of CSC services; c) review the program admission criteria with the potential client and his or her supports; d) determine the potential client interest; and e) briefly ascertain whether the individual meets criteria for admission and determine next steps (conduct an evaluation or refer out). The goal of successful prescreening is to decrease the number of individuals referred for full evaluation who are unlikely to meet program eligibility requirements. If admission seems likely, the ORS should begin coordinating next steps for possible intake with the clinical team.

Providing psychoeducation. It is important to provide some degree of education about first episode psychosis and why early intervention is thought to be important. Individuals and families are often in crisis during the early stages of engagement and/or may have difficulty understanding the depth of what it means to have psychosis and what recovery may entail. Connecting the topics covered in psychoeducation to what is important to individuals and families may facilitate early engagement by placing program services into context with the potential client's needs. For example, if a younger client would like to return to school, discuss the supported education services offered. Consider using a flip chart (with relevant information and visual graphics) that may facilitate discussion about FEP and early intervention services.

Describing the specialty clinic services. The ORS should briefly describe the CSC program services to interested individuals using plain, non-medical language, preferably the language that the potential clients use to describe their experiences.

The presentation of specialty program services should be personalized, integrating information acquired previously, the potential client's level of understanding regarding treatment, and his or her interest in learning more about specific services. The following should be used as a guide but can be adapted for each CSC program:

- Describe the program as being designed to provide comprehensive care for individuals who have recently had unusual or disturbing experiences. Highlight that the program is founded on recovery-oriented principles, and is designed to help adolescents and young adults reach their optimal level of functioning.

- Provide brief descriptions of all team members. Try to use examples to describe how each team member can help (e.g., focusing on an Individual Placement and Support (IPS) role if potential client is having trouble going back to school, or describing social skills training if the individual is describing withdrawal/isolation).

- o Psychiatrist: Medication management

- o Team Leader (TL): Clinician who provides supportive therapy and coordination of care

- o Recovery Coach: Clinician who provides skills training and substance abuse counseling, if indicated

- o Education and Employment Specialist: Professional who provides services based on an IPS model

- o Outreach and Referral Specialist: Clinician who will coordinate initial evaluations.

- Other factors to emphasize:

  - o Number and types of visits and services vary based on treatment needs and can change over time depending on what clients and family members find helpful.

  - o Services are provided based on a shared-decision making model (e.g., the team will collaborate with service seekers to develop treatment plans).

  - o If a particular service is not directly provided by the local team, advise the potential client that the team can help link potential clients with services in the community.

3. *Evaluation for Admission.*

The ORS conducts evaluations for admission in person with the potential client. Once the ORS gathers sufficient information to determine admissibility, the ORS discusses the potential client with a designated senior clinician or follows the protocol designed by the early intervention program for making final admission determinations. During the process, the ORS team member or the senior clinician may request additional information to facilitate admission determination (such as medical records or corroborative information from family members/primary supports).

Evaluation for admission interviews can take place at the specialty clinic or at another site mutually agreeable to the potential clients and the ORS. Regardless of the location, the evaluation for admission should take place in a private and quiet room where the potential client will feel comfortable answering personal questions. If the potential client is a minor, he or she should attend this meeting with a parent or guardian so that the parent or guardian can give written permission for the evaluation for admission; the evaluation, however, should be conducted without the parent or guardian present.

To minimize evaluation burden, the ORS team should make the evaluation as brief as possible, while obtaining key information to inform admission determination. Focus on the clinic admission criteria while listening to the potential client and establishing rapport. Determining a diagnosis and initiating treatment are not the goals of the evaluation. This evaluation should inform decisions on whether the specialty clinic services fit the potential client's needs. This activity should not be confused with an intake, although information obtained during this evaluation may be used at intake. There are three steps involved in the evaluation process: obtaining releases of information and family contact forms, the evaluation itself, and a determination for care.

Step 1: Obtaining the Release of Information and Family Contact Forms. Releases should be obtained as early as feasible, based on the clinical judgment of the ORS. Convey to the potential client that although it is not mandatory to provide consent to obtain previous records or speak to family members, it can be helpful in case the ORS are not able to fully clarify what was happening; in turn, this additional information will be helpful in determining whether the program will fit his or her needs.

Step 2: Evaluation Process. Admission determinations should occur within 24 hours from the time of evaluation. To reduce the burden on the potential client, the ORS should keep in mind that the purpose of the evaluation is not to make an *exact* diagnosis; rather, it is to obtain enough information to determine whether the individual meets all admission criteria for the program. The ORS should review the Referral Screening Form (See *Appendix 7*) along with available medical records prior to the evaluation, and focus on areas of uncertainty (i.e., confirming qualifying symptoms of psychosis and clarifying substance use and mood symptoms). Once the evaluation is complete, the ORS can complete the Evaluation Form (See *Appendix 8*).

Potential client evaluations for admission can be done using an evaluation form or a tool such as the Structured Clinical Interview for DSM (SCID). Given the challenges of determining the onset of psychotic symptoms as well as the differential diagnosis between affective and non-affective disorders with psychosis, a systematic approach such as using the SCID is highly recommended. The SCID can be modified to fit the diagnostic criteria for CSC programs. For example, the RAISE Connection program used the "SCID modified for RAISE Connection," or SCID-RV, which was developed by modifying the SCID-IV to include criteria from the Symptom Onset of Psychosis Scale. The SCID-RV establishes the presence of psychotic symptoms, date of onset, and whether the symptoms are attributable to drugs or medical conditions. The mood disorders module is included to identify when psychosis is due to a depression or manic episode meeting full affective syndrome criteria (as opposed to those with sub-threshold depressive symptoms). The SCID- RV has guidelines for determining the presence of psychosis (a rating of "3") that were adapted from the definition of psychosis in the Structured Interview for Prodromal Syndromes (SIPS rating scale).

Considerable training can be required to conduct a SCID interview, depending on the experience and skill set of the individual who is administering it. Review of the case examples of the differences between prodromal symptoms and criterion psychotic symptoms is helpful. Interviewers should observe several SCID interviews and then have a chance to practice while being observed. As the SCID has been modified for DSM-V and continues to be updated,

programs wishing to use the SCID should contact the American Psychiatric Association or Michael First, M.D., at Columbia University Medical Center (Mbf2@columbia.edu) for more information.

During the evaluation, frame events using a timeline. The timeline can be completed with the potential client and can be a useful tool in obtaining information about significant events. Examples of events to identify on a timeline include: Important life events (e.g., graduations, moving, jobs, etc.); previous treatment/hospitalizations; date of onset; course of substance use, if applicable; notable mood symptoms, if applicable.

The section below describes expected components of the admission evaluation and specifies the admission criteria used for the Connection Program. This list should be adapted to the admission criteria for a new specialty clinic.

a) History. Gain an understanding of the potential client's overall life history (i.e., school/work history, noting any gradual decline in functioning when applicable).

b) Previous hospitalizations and/or treatment for psychiatric symptoms or conditions. Note that some programs limit the total duration of exposure to antipsychotic medications as part of inclusion criteria. The evaluation process must be part of obtaining detailed information about previous treatment.

c) Symptoms of psychosis and related indicators. For each of the potential client's symptoms, investigate:

- The level of their symptom intensity (frequency),
- The impact on their behavior, and
- Whether the individual experiences a reduced awareness that their unusual perceptual experiences and/or delusions are symptoms: that is, they believe their delusions to be real despite the contrary.

Additionally, symptoms must have an impact on behavior and/or they must be intense enough that they occur at least intermittently or the client is preoccupied with them. Date of onset should be determined for each symptom. Symptoms to investigate include:

- Delusions of reference—belief that others are taking special notice of them or talking about him or her; belief that references to the person are being made on TV or in reading material.

- Persecutory delusions—belief that he or she is being attacked, harassed, persecuted, or conspired against.

- Grandiose delusions—belief that he or she possesses special powers, exaggerated importance (rich or famous), or relationship with a deity.

- Somatic beliefs—belief that his or her body is grossly distorted or that there has

been a change or disturbance in appearance or functioning.

- Other unusual delusions—for example, unusual religious experiences, belief that he or she must be punished for something (guilt), belief that partner was being unfaithful (jealousy), or belief that he or she is in a relationship with someone famous.

- Mind control (insertion/withdrawal)—belief that thoughts and/or actions are under the control of an external force. Individual may complain of thoughts being placed into head and/or thoughts being taken out of their head.

- Thought broadcasting—belief that others can hear their thoughts or read their mind.

- Sensory experiences that are not shared by others (as above). Can include any sensory modality: auditory, visual, tactile, olfactory, and/or gustatory.

d) Substance use. Determine:

- Which substances are being used and the usual pattern of use.

- Whether alcohol, sedatives, hypnotics, and/or anxiolytics and the periods of significant increase or decrease coincide with onset of symptoms of psychosis.

- Qualifying symptoms of psychosis must be present in the absence of substance intoxication and/or withdrawal

e) Presence of mood symptoms (focus on temporal relationship between mood symptoms and onset of symptoms of psychosis)

- Major Depressive Episode—five or more of the following symptoms with impact on functioning for a period of 2 weeks or greater (1 or 2 must be present):

  1) Depressed mood most of the day, nearly every day
  2) Markedly diminished loss of interest in activities that are usually enjoyable
  3) Significant weight change (loss or gain)
  4) Insomnia nearly every day
  5) Increase in action or movement (psychomotor agitation) or decrease in action or movement (psychomotor retardation) nearly every day
  6) Fatigue or loss of energy
  7) Feelings of worthlessness or excessive guilt
  8) Diminished ability to concentrate or indecisiveness
  9) Suicidal ideation and/or suicidal attempt

- Mania—persistently expansive or irritable mood, plus three or more of the following symptoms with a distinct period (at least 1 week):

    1) Inflated self-esteem or grandiosity
    2) Decreased need for sleep
    3) Pressured speech
    4) Flight of ideas/racing thoughts
    5) Distractibility
    6) Increase in goal-directed activity or increase in action or movement (a.k.a. psychomotor agitation)
    7) Excessive engagement in pleasurable risk-taking behaviors

- Qualifying symptoms of psychosis must be present and primary with an absence of mood symptoms for at least 2 weeks.

f) General medical condition (exclusion criterion)

- Indicate any prominent symptoms of psychosis due to the direct physiological effects of a general medical condition, including neurological conditions (including traumatic brain injuries), endocrine conditions, metabolic conditions, autoimmune disorders with central nervous system involvement.

g) Duration of psychotic symptoms

- The rules for determining date of onset should be specified within the evaluation protocol. CSCs can establish their own rules regarding eligibility; the RAISE Connection Program required psychosis to be present for greater than one week and less than 2 years.

Step 3: Final Determination and Next Steps. Given the challenges of making accurate diagnoses of individuals who are early in psychosis, programs should have a supervisory strategy that takes staff experience and expertise into account. One possibility is that for the first 6 months of the program, the ORS reviews all cases, including those that appear more straightforward, with a senior clinician. When the senior clinician is satisfied that the ORS is making accurate determinations of straightforward cases, the senior clinician can empower the ORS to make independent decisions. At that point, the senior clinician should discuss and provide evidence for that judgment with program leadership. Alternatively, the senior clinician can also decide to review all cases with the ORS.

Admission determinations should be made as quickly as possible, ideally within 24 hours following the evaluation. If determining admissibility is delayed due to the need to obtain more information, communicate this appropriately to the potential client, family members, and providers. In extreme circumstances, reviewing an individual's evaluation may be delayed; however, this process should not extend beyond 1 week following evaluation.

If the potential client meets admission criteria, the ORS must inform the potential client, family

members, and any providers involved in care. At this time, the ORS should also be prepared to offer options for a clinical intake appointment and to facilitate introductions as appropriate.

If the potential client does not meet admission criteria, the ORS should inform the potential client, family members, and providers involved in care. When speaking with potential clients and family members convey that the program is not a good fit and that services attained elsewhere may be more appropriate. This conversation should be had with utmost sensitivity. Connections to other resources must be facilitated appropriately. See *Section IV.B.2: Redirecting Referrals.*

4. Intake and Admission

Notably, conducting an intake is not necessarily the responsibility of an ORS, unless the program assigns that role to the ORS. If the individual coming in for services has not already met the clinical team, the ORS should facilitate such introductions prior to the intake appointment. Additionally, the ORS must convey any information that may be helpful for the clinical team to know about the newly admitted individual (i.e., tips for engagement, special circumstances, any challenges that may have come up during the evaluation process). The ORS should also ensure that the clinical team has the following information:

- Evaluation Form
- Evaluation Narrative
- Relevant contact information for potential clients, family members/primary supports, and providers
- Any medical records obtained during evaluation

Case Narrative 8: Balancing Intake Workload

The Connection Program found that sometimes, several weeks would pass where no potential clients were ready for admission to the program. Other weeks, two to three individuals would require intake appointments. The rate of potential client admissions may need to be balanced based on potential client treatment needs and staff availability.

New FEP clients often require intensive services, and the team may be unable to receive multiple new consumers within the same week. The clinical team felt comfortable with one admission per week. Two admissions per week were a stretch, but they could be performed, especially if there were no admissions in the prior week.

The team found it helpful to orchestrate potential client admissions to manage the flow of clients into the clinic based on each potential client's needs. For example, a potential client being discharged from inpatient treatment to the program may take admission priority over potential clients coming from existing outpatient treatment. Individuals in existing outpatient treatment may be able to delay their admission by extending outpatient treatment.

In Maryland, the team offered a regular, weekly intake day to facilitate coordinating intake flow with the ORS. The ORS could then schedule admissible potential clients for admission as slots were available. The ORS could also work with the referrers and the potential clients to set realistic expectations about intake dates who were already in existing treatment.

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Appendix	Title	Content and Purpose
1	Person-Centered Language	Examples of person-centered, recovery-oriented language for use in ORS training.
2	Potential Client Brochure	Brief introduction about the Connection Program, describes what participation may entail and speaks to overall goals of the program.
3	Family Flyer	Brief introduction about the Connection Program, describes what participation may entail and speaks to overall goals of the program to family members.
4	Sample Potential Client Contact Form	A form completed by the potential client to initiate contact with the specialty clinic.
5	Flip Chart Sample	Provides information about what symptoms may appear, what is happening in the brain, why early engagement is important. Describes the early intervention program and its services.
6	Sample Screening and Redirecting Referral Diagram	An alternate sample diagram describing the process of determining whether or not an individual meets clinic admission criteria, and offering suggestions for external referral sources based on results.
7	Referral Screening Packet	A packet containing a cover sheet and the referral screening worksheet.
8	Evaluation Form	A form that documents the results of an evaluation for admission. Filed with the medical records.
9	Evaluation Narrative	A narrative to be written by the ORS and delivered to the team. Provides a summary of information collected during the prescreening and evaluation processes.
10	Resources List Template	A template for collecting information on local referral sources. Helpful for constructing alternate referral sources and emergency contacts for the ORS fielding incoming referrals.
11	Redirecting Referrals Diagram	A diagram of factors to consider when redirecting referrals, such as level of care, insurance, geographic location, available specialty clinics, and types of services required.
12	Establishing Outreach and Potential Client Tracking Systems	A document outlining system considerations, recommended data collection, and suggested reporting features for a Referral Network Outreach Tracking System and Service Seeker Tracking System.
13	Outreach Tracking Template	A template for a simple outreach tracking log.
14	Referral Tracking Template	A template for a simple potential client referral tracking log.

Item	Material	Content and Purpose
15	Commonly Used Substances	A list of illicit substances that can be reviewed with the service seeker when performing evaluations to determine whether substance use is concurrent with onset of symptoms of psychosis.
16	Psychosis Associated with General Medical Conditions	A list of medical conditions that may be associated with symptoms of psychosis that can be reviewed with the potential client when performing evaluations to assist in screening whether a general medical condition may have precipitated symptoms of psychosis.
17	Blast Letter to Providers (sample)	Sample blast email to providers to announce program services.
18	Brief for the Maryland Coalition of Families for Children's Mental Health Newsletter	Sample article for the Maryland Coalition newsletter.

Appendix 1. Person-Centered Language

The Glass Half Empty…The Glass Half Full	
Deficit-based Language	**Strengths-based, Recovery-oriented Alternative**
A schizophrenic, a borderline	A person diagnosed with schizophrenia who experiences the following…
An addict/junkie	**A person diagnosed with an addiction that experiences the following…
Clinical Case Manager	Recovery Coach/Recovery Guide (*I'm not a case, and you're not my manager!*)
Front-line staff/in the trenches	Direct care/support staff providing compassionate care
Substance abuse/abuser	Person with an addiction to substances; substance use interferes with person's life
Suffering from	Working to recover from; experiencing; living with
Treatment Team	Recovery Team, Recovery Support System
LMHA Local Mental Health AUTHORITY	Recovery and Wellness Center
High-functioning vs. Low Functioning	Person's symptoms interfere with their relationship (e.g., work habits, etc.) in the following way…
Acting-out	Person disagrees with Recovery Team and prefers to use alternative coping strategies
Self-help	Recovery support groups/mutual aid groups
Unrealistic	Person has high expectations for self and recovery
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis; does not agree that they have a mental illness pre-contemplative stage of recovery
Weaknesses	Barriers to change; needs
Unmotivated	Person is not interested in what the system has to offer; interests and motivating incentives unclear; preferred options not available

Deficit-based Language	Strengths-based, Recovery-oriented Alternative
Resistant	Not open to… Chooses not to…Has own ideas…
Clinical decompensation, relapse, failure	Person is re-experiencing symptoms of illness/addiction; an opportunity to develop and/or apply coping skills and to draw meaning from managing an adverse event: Re-occurrence
Maintaining clinical stability/abstinence	Promoting and sustaining recovery
Untreated alcoholics	People not yet in recovery; pre-contemplative/contemplative stage of recovery
Prevent suicide	Promote life
Puts self/recovery at risk	Takes chances to grow and experience new things
Non-compliant with medications/treatment	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; Has a crisis plan for when meds should be used; beginning to think for oneself
Minimize risk	Maximize growth
Consumer (in addictions community)	Person in recovery, person working on recovery
Patient (in mental health community)	Individual, consumer, person receiving services
Treatment works	Individual, consumer, person receiving services
Treatment system	Recovery Community
Discharged to aftercare	Connected to long-term recovery management
Enable	Empower the individual through empathy, emotional authenticity, and encouragement
Frequent Flyer	Takes advantage of services and supports as necessary
Dangerous	Specify behavior
Manipulative	Resourceful; really trying to get help
Entitled	Aware of one's rights
DTO/DTS/GD	Describe behaviors that render one danger to self/others, etc.

Deficit-based Language	Strengths-based, Recovery-oriented Alternative
Baseline	What a person looks like when they are doing well
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities
Grandiose	Has high hopes and expectations of self
User of the system	Resourceful; good self-advocate

Content of table derived from the following sources:
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Appendix 2. Potential Client Brochure

Who is conducting the Connection Program?

The Connection Program is a research study led by Columbia University and the University of Maryland, offered at locations in Maryland and New York.

The Connection Program is being funded in whole or in part with Federal funds from the American Recovery and Reinvestment Act of 2009 and by the National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services, under Contract No. HHSN-271-2009-0020C.

How can I learn more?

Please call (888) 864-5458 to find out more about the Connection Program.

Or visit our website at:
www.connectionprogram.org

Or E-mail to:
connection@psych.umaryland.edu

Connection Program
Helping people live their best lives

Phone: (888) 864-5458

E-mail: connection@psych.umaryland.edu

Web site: www.connectionprogram.org

Does this sound like you?

- *Hearing or seeing things that others don't*
- *Having thoughts or beliefs that appear to you or others as strange*
- *Withdrawing from family and friends*
- *Feeling fearful or suspicious of others*

If left untreated, these thoughts, feelings or behaviors can become worse over time.

You can feel better.

Care and treatment can help.

Call (888) 864-5458 to find out more.

Connection Program
Helping people live their best lives

What is the Connection Program?

The Connection Program is a research study for adolescents and young adults who have recently had unusual thoughts and behaviors, or who have started hearing or seeing things that others do not.

The Connection Program provides treatment for people who have these symptoms.

What is the goal of the Connection Program?

The goal of the Connection Program is to help you cope with these experiences and improve your ability to work or go to school, live independently, and have enjoyable relationships.

Who can participate?

You may be eligible to participate in the Connection Program if you:

- Are between the ages of 15 and 35

- Have been experiencing unusual thoughts and behaviors, or hearing or seeing things within the last 2 years that others don't

- Are willing to have evaluation by a health professional

What does participation involve?

If you choose to participate in the Connection Program, you will receive treatment including:

- Care and support for up to 2 years, based on your needs and preferences

- Help finding a job or returning to school, substance abuse treatment, family education and support, and other services as needed

- Medication treatment, if you or your doctor decide that it is needed

- Interviews every 3 months to 6 months to monitor how you are feeling

33

Appendix 3. Family Flyer

Connection Program

Helping people live their best lives

Does this sound like someone you love?

- Hearing or seeing things that others don't
- Having thoughts or beliefs that appear as strange
- Withdrawing from family and friends
- Feeling fearful or suspicious of others

If left untreated, these thoughts, feelings or behaviors can become worse over time.

Care and treatment can help.

What is the Connection Program?

The Connection Program is a research study for adolescents and young adults who have recently had unusual thoughts and behaviors, or who have started hearing or seeing things that others do not. The Connection Program evaluates treatment for people who have these symptoms.

What is the goal of the Connection Program?

To help people cope with these experiences and improve their ability to work or go to school, live independently, and have enjoyable relationships.

Who can participate?

People may be eligible to participate in the Connection Program if they:

- Are between the ages of 15 and 35
- Have been experiencing unusual thoughts and behaviors, or hearing or seeing things within the last 2 years that others don't
- Are willing to have evaluations by a health professional

What does participation involve?

If people choose to participate in the Connection Program, they will receive treatment involving:

:

- Care and support services for up to 2 years, based on needs and preferences
- Interviews every 3 to 6 months to monitor how participants are feeling

Who is conducting the Connection Program?

The Connection Program is led by Columbia University and the University of Maryland, offered at locations in Maryland and New York. The Connection Program is being funded in whole or in part with Federal funds from the American Recovery and Reinvestment Act of 2009 and by the National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services, under Contract No. HHSN-271-2009-00020C.

How can I learn more?

Please call (888) 864-5458 to find out more about the Connection Program.

Or visit our website at: www.connectionprogram.org

June 2011

Appendix 4. Sample Potential Client Contact Form

Date _____   Recruitment Team Member _____

PERSONAL CONTACT INFORMATION
Name: _____
    First   Middle   Last

Address: _____
    Street Address   Apartment # or P.O. Box #

_____
    City   State   Zip Code

	Preferred Number:	OK to leave message?	OK to identify ourselves as part of Connection Program?
Phone: _____ (home)	( )	( )	( )
_____ (cell)	( )	( )	( )
_____ (work)	( )	( )	( )

Best days and times to contact: _____

Email Address: _____

Minor: Yes _____ No _____ (If yes, must collect parent/guardian contact information below)

···

PARENT/GUARDIAN CONTACT INFORMATION
Family Member Name: _____
    First   Middle   Last

Relation to Potential Participant: _____

Address: _____
    Street Address   Apartment # or P.O. Box #

_____
    City   State   Zip Code

	Preferred Number:	OK to leave message?	OK to identify ourselves as part of Connection Program?
Phone: _____ (home)	( )	( )	( )
_____ (cell)	( )	( )	( )
_____ (work)	( )	( )	( )

Best days and times to contact: _____

Appendix 5. Flip Chart Sample

Connection Program

A research study for people who have recently started:

- Experiencing unusual thoughts or behaviors, or
- Hearing or seeing things that other people do not

June 2011

What is Psychosis?

Symptoms may include:

- Unusual thoughts or beliefs that appear strange to you or to others
- Feeling fearful or suspicious of others
- Seeing, hearing, smelling, tasting or feeling things that others don't
- Disorganized, "odd" thinking or behavior
- Strange bodily movements or positions

What Causes Psychosis?

There are many possible causes for psychosis. Some of these include:

- Medical problems, such as epilepsy
- Substance use

(continued)

What Causes Psychosis? *(continued)*

There are many possible causes for psychosis. Some of these include:

- Severe depression
- Extreme elation or irritability (also known as Mania)
- Primary psychotic illnesses

John Forbes Nash received the 1994 Nobel Prize in Economics while he was a Senior Research Mathematician at Princeton University.

The movie *A Beautiful Mind* is loosely based on his biography.

The Soloist is based on the true story of **Nathaniel Ayers**, a musical prodigy who developed schizophrenia while attending Juilliard. Mr. Ayers has lived homeless in the streets of downtown LA, playing the violin and cello.

Nathaniel Ayers   Actor, Jamie Foxx

These Experiences may Affect Your Life

Positive Symptoms
Delusions
Hallucinations
Disorganized speech

Negative Symptoms
Flat facial expression
Lack of motivation
and interest
Social withdrawal

Quality of Life
School or Work
Interpersonal relationships
Taking care of yourself and being independent

Difficulty Thinking
Attention
Memory
Cognition

Substance Abuse

Mood Symptoms
Such as
Depression
and Anxiety

Why Early Identification Could be Important

Early recognition and early treatment of psychotic disorders may:

- Prevent or minimize disability

- Reduce the personal, social, and economic strains

- Offer the best chance for typical progress in school, work, and in the development of social skills

Outcomes May Improve With Early Treatment

Some research shows that earlier treatment produces better outcomes:

- Better response to medications that treat psychosis

- Better outcomes for social and vocational rehabilitation

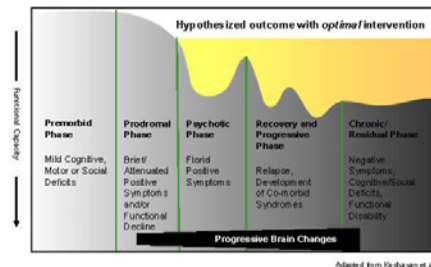- Greater impact for psychological therapies that target symptoms, behavioral adaptation, and quality of life

Preventive Intervention in Psychotic Illness

Hypothesized outcome with *optimal* intervention

Functional Capacity

Premorbid Phase	Prodromal Phase	Psychotic Phase	Recovery and Progressive Phase	Chronic/ Residual Phase
Mild Cognitive, Motor or Social Deficits	Brief/ Attenuated Positive Symptoms and/or Functional Decline	Florid Positive Symptoms	Relapse, Development of Co-morbid Syndromes	Negative Symptoms, Cognitive/Social Deficits, Functional Disability

Progressive Brain Changes

Adapted from Keshavan et al

The First Episode Dilemma

Insurance may not provide the coverage needed for adequate treatment

You need a diagnosis to qualify for many services

You can't get a diagnosis until you've been sick for a while

Often multiple diagnoses occur, or even misdiagnosis

You need treatment even when the diagnosis is still unclear

The Connection Program offers services early, without the need for a diagnosis

Connection Program

Helping people

live their

best lives

The Connection Program

- The Connection Program is a research study that provides treatment services

- Sponsor: National Institute of Mental Health (NIMH)

- In collaboration with the Department of Health and Mental Hygiene (DHMH) and the New York State Office of Mental Health (OMH)

The Connection Program

Investigators:

Lisa Dixon, M.D., M.P.H (Columbia University)
Melanie Bennett, PhD. (University of Maryland)

Collaborators:

Columbia University
University of Maryland School of Medicine
New York State Office of Mental Health / RFMH
Maryland Health Services Department of Health and Mental Hygiene

Connection Program Objectives

- **Goal:** To help develop treatments that can improve the ability of individuals experiencing psychotic symptoms to work, go to school, live independently, and have enjoyable relationships

- Assess clinical, functional, and economic outcomes of the treatment

- If the treatments are successful they could be implemented to help many people in the future

Taking Part in a Study is *Voluntary*

- You do NOT have to participate

- If you decide to participate, you have the right to withdraw at any time

The Treatments are Located at Community Mental Health Centers:

- Maryland location:
  - **Carruthers Clinic (University of Maryland)**

- New York locations:
  - **Psychiatric Institute**

Connection Program

- Services based on your needs provided by a small Team of people: social worker, psychiatrist, skills trainer, employment specialist

- The Team will work with you to find out what services would be most helpful to you and to provide as many of those services as possible from within the Team

- Support provided for up to two years

Treatment Services and/or Referrals

- Illness management coping strategies
- Medication treatment
- Education assistance
- Employment assistance
- Housing assistance
- Substance abuse
- Family support
- Suicide prevention
- Physical health
- Trauma support

Who can Participate in the Connection Program?

You may be eligible to participate if you:

- Are between the age of 15 and 35
- Have started experiencing unusual thoughts and behaviors, or hearing or seeing things within the last 2 years
- Are willing to have evaluations by a health professional

(continued)

Who can Participate in the Connection Program? *(continued)*

You may be eligible to participate if you:

- Meet the criteria of an evaluation that will be conducted by a member of the research team
- Will be available for participation over the next year

You will be Unable to Participate if You:

- Have psychosis which is caused by substances, a mood disorder or a medical or neurological illness
- Have a serious or chronic medical illness that
  - Significantly impairs functioning independent of psychosis, OR
  - Is the reason you are applying for or receiving disability benefits
- Have an intellectual disability
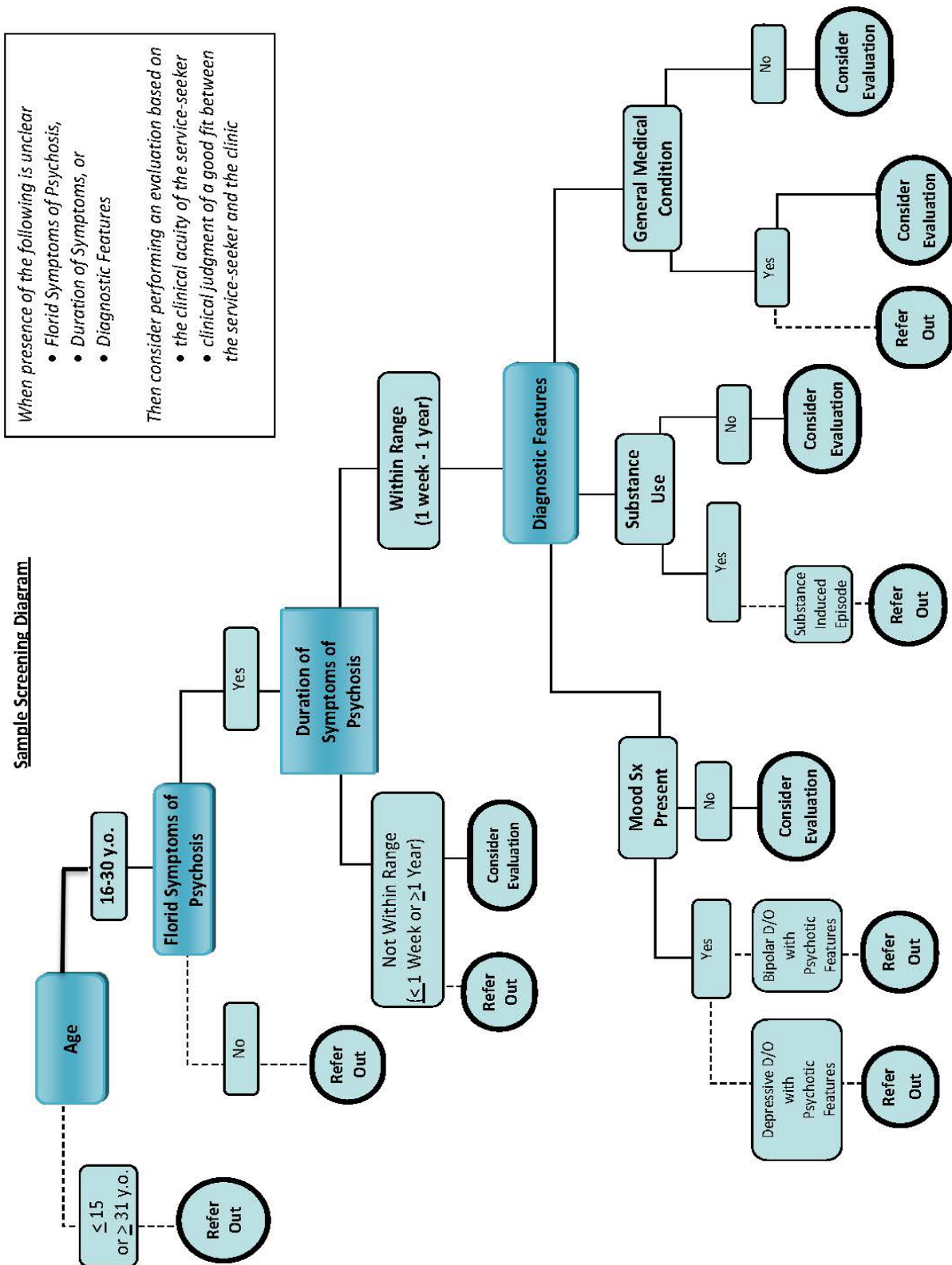
You do not Need to Have Health Insurance

- If you do not have health insurance, all study services will be provided at no charge
- If you have insurance, it may be billed for the services it covers

For More Information:

- Please call the Connection Program at 888-864-5458
  or
- Email: connection@psych.umaryland.edu
  or
- Visit our website at: www.connectionprogram.org

Appendix 6. Sample Screening and Redirecting Referral Diagram

When presence of the following is unclear
- Florid Symptoms of Psychosis,
- Duration of Symptoms, or
- Diagnostic Features

Then consider performing an evaluation based on
- the clinical acuity of the service-seeker
- clinical judgment of a good fit between the service-seeker and the clinic

Sample Screening Diagram

Appendix 7. Referral Screening Packet

Outreach and Recruitment Specialist:

Date Received:

Name:	DOB:	Gender:
Street Address and Phone Number:		
Caller Name and Contact: Calling from (providers only): How did they hear about The program?		Relationship to Potential client:
Parent/Guardian or Family Member: Contact:		Relationship to Potential client:
Parent/Guardian or Family Member: Contact:		Relationship to Potential client:
<u>NOTES</u>		

Providers: you may choose to complete this form, or use it as a guide for the type of information the Outreach and Recruitment Team will need to determine whether an evaluation will proceed.

O&R Team: Only minimal information is required if Evaluation is likely

POTENTIAL CLIENT NAME:

REFERRING PROVIDER INFORMATION

Name:	Position and Organization (specify):
Office Phone Number:	**Email:**
If you are not the potential client's psychiatrist, please provide name and contact information for the psychiatrist:	

Referral Date:	Does potential client speak English? ☐ Yes ☐ No If no– potential client speaks:
Is the potential client aware of and in agreement with this referral? ☐ Yes ☐ No	
Indicate the degree to which the potential client's family/caregiver is involved in treatment:	☐ Low ☐ Moderate ☐ High
Reason for Referral:	

CURRENT PSYCHIATRIC SYMPTOMS

Describe symptoms of psychosis that the potential client has reported/demonstrated over the past 1 year (include onset and course of qualifying symptoms, and any self-harm, suicide attempts, or violent behavior):

Identify other psychiatric issues the potential client has reported/demonstrated over the past 1 year (time frame should highlight a temporal relationship to symptoms of psychosis):	
☐ **Depression**	**If yes, describe symptoms and time frame:**
☐ **Mania**	**If yes, describe symptoms and time frame:**
☐ **Substances**	**Indicate type(s), time frame, amount, and frequency:**
☐ **Other**	**Describe:**

Please indicate whether the potential client has any of the following cognitive deficits:	
☐ **Intellectual and Developmental Disabilities**	**If yes, indicate severity:**
☐ **Learning Disorder**	**If yes, indicate type:**

PSYCHIATRIC HISTORY

Please provide a brief psychiatric history, including relevant information regarding (1) psychiatric hospitalizations, and (2) current and past medications

Please describe any known family psychiatric history:

RELEVANT MEDICAL HISTORY

Please describe any relevant medical history:

WORKING DIAGNOSIS (if obtained via medical records or from a provider):

Primary Diagnosis	
R/O:	
R/O:	

ADDITIONAL INFORMATION

Please provide any additional information that may be relevant to this potential client's treatment (especially potential client strengths, as well as important psychosocial history, family involvement, etc.):

Appendix 8. Evaluation Form

Dimension	Criterion	Check if criterion is met
Age	**Date of Birth** **Current Age**	____/____/____ ____ ____
IQ	**No history of IQ<70**	☐
Qualifying Symptoms of Psychosis o **Reduced Awareness that Unusual Experiences or Unusual Beliefs are Symptoms** **AND** o **Symptom Intensity and/or Impact on Behavior** **lasting at least a week**	**Check symptoms meeting criteria** ☐ **Beliefs of Reference** ☐ **Persecutory Beliefs** ☐ **Grandiose Beliefs** ☐ **Somatic Beliefs** ☐ **Other Unusual Beliefs** (Include unusual religious beliefs, beliefs of guilt, jealous beliefs, and erotomanic beliefs): ☐ **Beliefs of Being Controlled** (Include thought insertion or withdrawal): ☐ **Thought Broadcasting** ☐ **Unusual sensory experiences not shared by others. Check all that apply** ☐ **Auditory** ☐ **Visual** ☐ **Tactile** ☐ **Other** (includes Gustatory and/or Olfactory)	

Duration of Illness	Qualifying symptoms of psychosis began less than 12 months ago. Provide date of onset (using date of earliest qualifying symptom)	Date of Onset ____/____/____ Age (at the time of onset) ___ ___
Qualifying Diagnostic Criteria	**Symptoms of psychosis not due to substance abuse** - **Symptoms of psychosis not accounted for by a primary mood disorder** - **Symptoms of psychosis not due to a general medical condition**	☐ ☐ ☐
DSM-V Diagnosis	☐ **Schizophrenia (295.90)** ☐ **Schizoaffective Disorder (295.70)** __ **Bipolar Type** __ **Depressive Type** ☐ **Schizophreniform Disorder (295.40)** ☐ **Delusional Disorder (297.1)** ☐ **Other specified schizophrenia spectrum and other psychotic disorder (298.8)** ☐ **Unspecified schizophrenia spectrum and other psychotic disorder (298.9)**	
Proximity/Availability:		

Timeline (optional)

Date: Start/Stop	Symptoms of Psychosis	Mood Episode	Substance Use	General Medical Condition

Eligible for Program
☐ **No (indicate Reason**

☐ **Yes: Proceed to Enrollment**

Outreach and Recruitment Coordinator

Print Name:_____   **Date: _____/_____/_____**

Signature:_____

Senior Clinician

Print Name:_____   **Date: _____/_____/_____**

Signature:_____

Appendix 9. Evaluation Narrative

Name: _____

Date of birth: _____/_____/_____

Date of Evaluation: _____/_____/_____

Evaluating Clinician: _____

DEMOGRAPHICS AND HISTORY: age, current living situation, and current and recent educational or employment status

[blank box]

MEDICAL HISTORY: current non-psychiatric medications and medical conditions

[blank box]

OUTPATIENT PSYCHIATRIC TREATMENT HISTORY: emphasis on past 6 months

[blank box]

PREVIOUS HOSPITALIZATIONS and/or treatment for psychiatric conditions (including medication)

QUALIFYING SYMPTOMS OF PSYCHOSIS (symptom, brief description, and date of onset)

RELEVANT SUBSTANCE USE (including temporal relationship to onset of psychosis)

CURRENT AND PAST MOOD EPISODES (including temporal relationship to onset of psychosis)

[empty box]

If applicable, CORROBORATIVE INFORMATION (include source of information)

[empty box]

*Append copies of any medical records received during evaluation process

Appendix 10.   Resources List Template

Area Emergency Rooms (including psychiatric emergency programs
Local Emergency Department/Nearby Transportation (i.e., subway lines)

_____

Local Emergency Department/Nearby Transportation (i.e., subway lines)

___

Mobile Crisis teams and Psychiatric Emergency phone numbers

Psychiatric Emergency: 1-800-555-1212

Community District or Location/Main contact/phone #s:

_____

Community District or Location/Main contact/phone #s:

_____

Clinics and Programs
- Organization name: _____

- Specific program/unit within the organization: _____

- Location and contact phone numbers (it can be helpful to include names of specific people you have talked to/established rapport with):
    Main contact: _____

    Phone #'s: _____

    Email: _____

- Population served (i.e., children, adolescents, adults): _____

- Insurance requirements and fees (if applicable): _____

- Catchment area requirements (if applicable): _____

- Services offered: Individual? Groups? Medication management? Supportive services?
    _____

- Conditions treated, including what they specialize in:
    _____

Appendix 11.   Redirecting Referrals Diagram
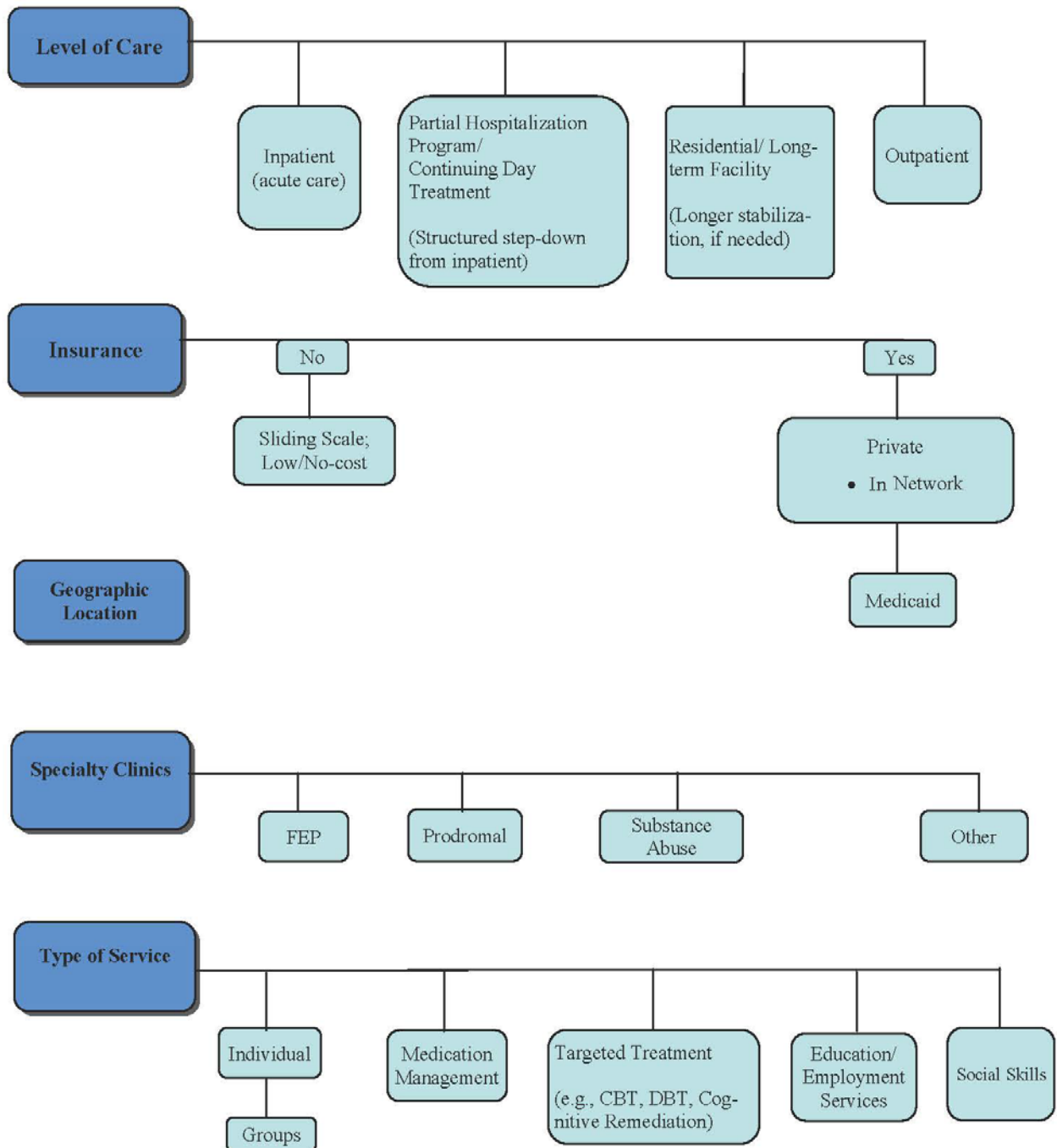
Appendix 12. Establishing Outreach and Potential Client Tracking Systems

Two forms of tracking help to inform successful outreach: tracking outreach activities to your referral network and tracking potential client referrals received. These two sources of information will track where referrals are coming from, and which types of outreach activities are most successful. Table 1 provides an overview of the pros and cons of different tracking methods.

Table 1: Tracking Methods

Tracking Modality	Easy to Implement	Easy to search	Shared Entry	Reporting Capacity
Pen and Paper	🟩	🟥	🟥	🟥
Word Document	🟩	🟩	🟨	🟥
Basic Spreadsheet	🟩	🟩	🟨	🟨
Automated Spreadsheet	🟥	🟩	🟨	🟩
Database	🟥	🟩	🟩	🟩

Pen and paper systems are easiest to implement; however, they can be difficult to search. Maintaining current records becomes difficult if shared across multiple individuals, and any reporting must be generated by hand. Both word processing documents and basic spreadsheets ease implementation and facilitate searches for specific potential clients or referral organizations. However, only one person can be updating a word processing document or spreadsheet at any given point in time. Basic spreadsheets have improved reporting capacity over word documents, but staff will need to be familiar with the spreadsheet software in order to generate reports. Automated spreadsheets will take more time to implement in exchange for improved reporting. However, only one individual can update the tracking system at a time. A database will take more time to implement; however, it will provide the most functionality.

Choose a method to track potential referral sources and outreach activities. Methods for tracking outreach and referral activities may vary by available technology at each organization and the number of individuals responsible for tracking outreach activities and service. Be sure to check existing systems at the clinic to determine if they can be expanded to include this work.

Establishing an Outreach Tracking System (OTS)

Develop a tracking system to monitor all outreach contacts and establish processes for making initial contact with potential clients to facilitate understanding the flow of referrals. Use this information to optimize the referral network as it grows. This tracking system should contain a list of organizations in the referral network and a list of activities performed at each organization.

Reporting. The OTS can be created to generate reports listing all recent outreach activities. It can also list organizations, the assigned ORS, and information about the last contact. This can remind the ORS to follow up with referral organizations periodically. It can also be used to schedule annual presentations, and maintain standard mailing and email lists of the referral network. Information from the Potential Client Tracking System can be combined with the RNOTS to provide information on which referral sources and outreach activities yield potential client referrals.

Data to Collect. Information on the organizations should be collected, as well as information on each outreach activity. Consider collecting the following information for each organization:

- Organization or Provider Name
- Organization or Provider Address and Contact Information, including email.
- Staff Names and contact information including phone numbers and emails
- Outreach activities conducted for that organization
- A planned date of next contact with each organization
- An assigned staff member, if establishing the referral network is to be distributed across multiple outreach staff members

Tracking types of outreach activities helps indicate which types of activities work successfully for different organizations. It can also notify staff member of the last outreach activity and times for follow up. For each outreach activity, consider tracking outreach activities using the following categories:

- Date of Activity
- Type of Activity
    - Individual Call: a telephone call between an outreach staff member and an individual contact at a potential referral source.
    - Individual Email: an e-mail exchange between an outreach staff member and an individual contact at a potential referral source.
    - Check-in: An outreach team member makes an onsite visit with at least one individual contact at a potential referral source.
    - Brochures: Distribution of brochures or flyers via standard mail, e-mail or in person to a potential referral source
    - Team Meeting: An outreach team member attends a staff or team meeting of professionals at a potential referral source.
    - Grand Rounds
    - Presentation
    - Blast Emails
    - Other
- Notes regarding the outreach activity, such as levels of interest or the names of outreach and referrer staff members involved

Populate the tracking system using the professional networks of individuals on the outreach and specialty clinic team. Develop a list of potential referral sources and contact

names of individuals and organizations that may encounter potential clients.

Establishing a Potential Client Tracking System (PCTS)

The early engagement process often requires multiple contacts with potential clients, family members, and clinicians over a period of days or months. As a result, a method for tracking the progression of individuals through the outreach and admission process becomes essential for effective follow up with potential clients. The Potential Client Tracking System (PCTS) helps the ORS and the clinical team follows the status of referred potential clients through the clinic admission process.

Reporting

The PCTS can be created to generate reports listing the referrals in process, the assigned ORS, and information about the last contact. This allows the ORS to follow up with potential clients, families, and clinicians in appropriate timeframes. The ORS and the clinical team can communicate regularly (e.g., weekly) about pending referrals, their stage in the evaluation and admission process and their anticipated admission date. This allows the ORS and the treatment team to effectively guide the potential client through the evaluation and admission process as quickly and seamlessly as possible.

Data to Collect:

If the PCTS will contain identifying potential client information, the system must be stored in compliance with HIPAA regulations. For each potential client referred, the outreach team may consider tracking the following descriptors:

- Person making initial contact: the individual who initially contacted the program about services, such as potential clients, family members, or clinicians;
- Potential client name
- Contact information
- Referred by: the institutions or sources suggested or arranged contact with the program;
- "Heard about from": How did the Person Making Initial Contact hear about the program? This includes both outreach methods (presentations, e-mails) and intermediaries, such as outpatient clinicians, community organizations, or the outreach staff member;
- Outreach method: the outreach mechanism that informed individuals making initial contact about the program;
- Disposition: the final status of each potential client indicating whether referral resulted in an admission, the individual did not meet admission criteria, or the individual refused.
- Notes

These data describe which initial contacts, outreach methods, and referral sources were most effective for potential clients based on the ratio of potential clients to admissions for that category. They provide information about which referral sources are sending

potential clients to the program, which outreach activities may be most effective, and who is contacting the program with referrals. This information can inform future decisions for optimizing and maintaining the referral network.

Appendix 13.   Outreach Tracking Template

Name of Organization:

_____

Specific Department or Unit:

_____

Location and Main Phone #:

_____

Specific person(s) of interest, title/role, and their direct contact information (i.e., Sheila Johnson, MSW; discharge coordinator; phone#, email address)

Name: _____

Phone #: _____

Email: _____

Tracking Outreach

Date of Contact	ORS Name	Type of Outreach	Follow-Up Plan

Appendix 14. Referral Tracking Template

Date of Referral	Caller Name and/or Name of Potential Client	Organization (providers only)	Outcome of Referral (Screening/Evaluation in Progress; Intake; Referred Out- Not eligible; Referred Out-Waitlist

Appendix 15.   Commonly Used Subs**tances**

*Adapted from the Structured Clinical Interview for DSM-IV Axis 1 Disorders
(SCID-RV)*

Sedatives-hypnotics-anxiolytics: ("downers")
Methaqualone (Quaalude, "ludes"), barbiturates, secobarbital (Seconal, "reds," "seccies," "dolls"), butalbital (Fiorinal), ethchlorvynol (Placidyl, "jelly-bellies"), meprobamate (Miltown, Equanil, "happy pills"), diazepam (Valium), alprazolam (Xanax), clonazepam (Klonopin), flunitrazepam (Rohypnol, "roofies"), gamma-Hydroxybutyric acid (GHB), temazepam (Restoril), flurazepam (Dalmane), chlordiazepoxide (Librium), lorazepam (Ativan), triazolam (Halcion), Ambien, Sonata, Lunesta

Cannabis:
Marijuana ("pot", "grass", "weed", "reefer"), hashish ("hash"), THC

Stimulants: ("uppers")
Amphetamine (Benzedrine, Adderall, "bennies," "black beauties"), "speed", methamphetamine ("crystal meth," "crank," "ice"), dextroamphetamine (Dexedrine, "greenies"), methylphenidate (Ritalin, Concerta, Metadate, Focolin, "Vitamin R"), prescription diet pills

Opioids:
Heroin ("smack," "dope"), morphine, opium, methadone (Dolophine), dextropropoxyphene (Darvocet, Darvon), codeine, oxycodone (Percodan, Percocet, OxyContin, Roxicet), hydrocodone (Vicodin, Lorcet), fentanyl (Duragesic, "percopop"), meperidine (Demerol), hydromorphone (Dilaudid)

Cocaine: Snorting, IV, freebase, crack, "speedball"

Hallucinogens: ("psychedelics")
LSD ("acid"), mescaline, peyote, psilocybin (mushrooms), MDMA ("STP," "Ecstasy")

Dissociative Anesthetics (includes PCP)
PCP ("angel dust", "peace pill"), ketamine ("Special K," "Vitamin K")

Other:
Steroids, solvents (paint thinners, gasoline, glues, toluene), gases (butane, propane, aerosol propellants, nitrous oxide (laughing gas, 'whippets')), nitrites (amyl nitrite, butyl nitrite, "poppers," "snappers"), DXM (DM, "Robo"), over-the-counter sleep or diet pills, ephedra, atropine, scopolamine

Appendix 16.   Psychosis Associated with General Medical Conditions

Patients with psychotic symptoms that can be attributed to one or other medical illness will be excluded. Determination of a cause effect relationship between a medical illness and psychosis is not always easy. However such a relationship can be inferred by the presence of a temporal relationship between onset of the medical illness and the onset of psychosis, and between the offset or treatment induced remission of the medical illness and the resolution of psychotic symptoms. The following medical/ neurological illnesses are well known to be associated with psychotic symptoms.

1. Epilepsy

2. Head trauma

3. Dementias

4. Cerebrovascular disease, such as stroke or arteriovenous malformations

5. Hydrocephalus

6. Demyelinating diseases, such as multiple sclerosis

7. Huntington's disease

8. Wilson disease

9. Parkinson's disease

10. Autoimmune diseases, such as systemic lupus erythematosus

11. Infections such as viral encephalitis (e.g., herpes simplex, HIV infection), neurosyphilis, CNS-invasive parasitic infections (e.g., cerebral malaria, toxoplasmosis, neurocysticercosis), and tuberculosis

12. Endocrinopathies such as hypoglycemia, Addison's disease, and Cushing's disease

13. Space-occupying lesions (e.g., tumors, cysts)

14. Nutritional deficiencies such as niacin deficiency (pellagra), vitamin B^{12} deficiency (pernicious anemia)

15. Metabolic diseases such as homocystinuria, phenylketonuria

16. Chromosomal abnormalities such as sex chromosomes (e.g., Klinefelter syndrome, XXX syndrome), Fragile X syndrome, and velocardiofacial syndrome.

17. Congenital diseases (e.g., corpus callosal agenesis, Chiari malformation)

Appendix 17. Blast Letter to Providers (sample)

Dear Colleagues,

I am pleased to inform you about the **RAISE Connection Program**, a clinical research study to help individuals who have experienced an initial psychotic episode.

The RAISE Connection Program is for individuals aged 16-35 who have experienced psychotic symptoms for at least one week in the prior two years. All study participants will receive comprehensive care for up to 2 years, using evidence based practices delivered by a clinical team specialized in early psychosis. Services offered include: psychiatric treatment, medication management, help with finding a job or returning to school, substance abuse treatment, family education and support, and other support services as needed. Participants who are uninsured will receive study services without charge. The study is being conducted at the Washington Heights Community Service, located at the New York State Psychiatric Institute in New York City.

Research suggests that the sooner treatment is initiated after a first episode of psychosis, the more likely the person will experience significant recovery. The goal of the Connection Program is to promote engagement and participation in treatment, foster recovery, and reduce or prevent disability.

To learn more or to refer a potential participant, please contact Sapna Mendon, the RAISE Project Manager, at 212-543-6736 or *mendons@nyspi.columbia.edu* or visit our website at *www.connectionprogram.org*. Patients and their families are also encouraged to call for information.

Sincerely,
Ilana Nossel, M.D.
Department of Psychiatry
College of Physicians and Surgeons, Columbia University

Appendix 18.   Brief for the Maryland Coalition of Families for Children's Mental Health Newsletter

Teens and young adults who develop schizophrenia may experience problems with hearing voices, paranoid or unusual thoughts, disorganized speech and behavior, as well as a significant decline in performance at school or work. Comprehensive, early intervention for this type of mental illness is important because it may be when problems are most responsive to treatment. The National Institute of Mental Health (NIMH) is funding the RA1SE Connection Program* to evaluate the best early interventions and treatments for individuals experiencing early psychosis.

The RA1SE Connection program is a research study that is evaluating early treatment interventions for adolescents and young adults who have experienced the onset of psychosis within the last two years. This study is being conducted in New York and Maryland. In Maryland, the study is being conducted at the Carruthers Clinic of the University of Maryland Community Psychiatry Program in Baltimore. The treatment assists the teen and family in obtaining needed services and emphasizes joint decision making between consumers and providers. The study will closely monitor how each adolescent or young adult is functioning socially and academically. Services are provided for up to two years. From this study, we hope to learn how treatments delivered in the earliest phases of illness can prevent disability among individuals with psychosis.

Your teenage or young adult family member may be eligible for the study if they are at least 15 years old and have had the onset of psychosis within two years. Information about the RA1SE connection program is available at *www.connectionprogram.org*, 888-864-5458 or *connection@psych.umaryland.edu.*

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