OnTrackNY

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# Outreach and Recruitment Manual

Adapted in part from the Recovery After an Initial Schizophrenia Episode-Implementation and Evaluation Study (RAISE-IES)

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# I. Outreach

This section will provide an overview of methods that can be used to conduct strategic outreach. Sub-sections will also include tools (e.g. forms and diagrams) for the Outreach and Recruitment (O&R) team to use during the outreach process.

## A. Outreach materials

The Outreach and Recruitment team should utilize various materials for the purpose of distributing information about OnTrackNY to providers, service seekers, and family members. Please note that all written information made available to the public (non-provider), should as much as possible use benign and appropriate language to describe the program without using specific terms (e.g. Schizophrenia, Psychosis, etc.). The following materials can be used as outreach tools at the discretion of the local O&R team (see Appendix and local site binder):

1. **Brochures:** Both types of brochures should provide a brief introduction to OnTrackNY, locations, and relevant contact information (including website URL).
   - **Participant brochures:** Include overall goals of the program, who the team is made up of and what they can provide
   - **Provider brochures:** Include more in depth clinical information about eligibility criterion, background about FEP and early intervention
2. **Postcards:** Postcards can be used as mailings and should contain minimal information (e.g. program name, who it is intended for, how to contact the O&R team, and website URL).
3. **One-page flyers**
   - **Participant flyers:** Description of services offered by the program, and how to contact the O&R team for an evaluation
   - **Provider flyers:** Provide a brief summary about services, eligibility criterion, and how to make a referral
4. **Flip-chart:** In a slide format, this visual tool can provide information about FEP, kinds of symptoms, brief neurobiological overview, why early treatment is important, and description of services offered by OnTrackNY programs. This can be revised to meet the needs of the target audience (i.e. providers, patients, and family members). The sample can be followed to create a flip-chart and/or a PowerPoint presentation.
5. **Website:** The website should be easy to navigate and can include sub-sections for clinicians, patients, and family members. By including an inquiry form on the website, interested parties can directly submit requests for information about OnTrackNY programs. The website can also include an “additional resources” page where interested parties can find links to other informative websites and/or additional support services in the community
6. **Outreach and Recruitment Work Plan:** The O&RC should maintain and regularly update a work plan to summarize key domains, action items, and plans for follow-up. This work plan should be reviewed with the team and/or during supervision.

## B. Potential referral sources

The following list describes types of referral sources. Each OnTrackNY program can identify unique referral sources within reasonable proximity to their site.

1. Mental Health clinics
   - Adult and adolescent inpatient units
   - Adult and adolescent outpatient clinics (including PHP and CDT programs)
   - Emergency Departments (including CPEPs), and mobile crisis teams
2. Schools: area colleges, and high schools (can utilize sources at the Board of Education)
3. Community, and consumer & family organizations
4. Other collaborators
   - Prodromal clinics
   - Other FEP clinics
   - Health Maintenance Organizations/Behavioral Health Organizations

## C. Types of outreach

Initially, a blanketed approach can be used to spread information to a wide range of referral sources within geographic proximity. It may be helpful to target hospitals and/or providers affiliated with the local OnTrackNY site. Over time, outreach efforts can be customized based on yield of referrals. When possible, initial contacts should be made by staff members known to referral sources. To optimize initial engagement, presentations can be given by a psychiatrist and a member of the O&R team. Outreach and Recruitment Coordinators (O&RCs) can then follow-up with referral sources regularly (see Appendix for Stages of Engagement).

- Individual calls and emails; blast emails: Emails should include one-page flyers, brochures, and/or referral forms when appropriate
- Check-ins and Team meetings: Once a relationship with a referral source is established, the O&RC can begin regular in-person check-ins to provide information, answer questions, etc. Brochures/postcards and one-page flyers should be distributed.
- Presentations and Grand Rounds: Should be customized to the audience (i.e. more education based vs. clinically focused). Brochures, and one-page flyers should be available
- Articles in newsletters

## D. Tracking

A tracking system should be developed and implemented at each site in order to track outreach efforts. This can also be used as a database to store all relevant contact information for each referral source. The following information should be captured for each referral source (see Appendix for Outreach Tracking template):

## Contact Information

- Name of Organization
- Specific department or unit
- Address
- Phone numbers
- Specific persons to contact, title/role, and their direct contact information (i.e. Sheila Johnson, MSW; discharge coordinator; phone #, email address)

## Tracking Outreach

- Date of contact
- Name of ORS team member
- Brief notes (who you met with, any specific challenges that came up)
- Type of outreach (i.e. Team meeting presentation, check-in, email, etc.)
- Follow-up plan (e.g. JT will check-in in 1 month when resident's start)

# II. Referrals and Evaluation

This section will provide an overview for staffing, receiving new referrals, screening, and evaluation. Sub-sections include various forms and diagrams (in appendices) to be used as tools and/or reference guides throughout various stages of recruitment.

## A. Staffing for initial evaluations and review

The Team Leader/Program Director (TL/PD) must designate someone who will oversee the Outreach and Assessment process and determine who can conduct screening and eligibility evaluations for program intake. The designated individual(s) should be a master's level clinician (or possess a higher clinical degree). Each site may have multiple individuals who can contribute to these activities, but one person, the Outreach and Recruitment Coordinator (O&RC), should be in charge of its oversight. Any individual designated to take part in outreach and recruitment will be a part of the Outreach and Recruitment Team (ORT). In addition, the TL/PD and program psychiatrist should designate who will serve as the final senior diagnostician to determine program eligibility. The TL/PD, program psychiatrist, or other agency clinician, if desired, can serve in that role. The senior diagnostician should be experienced in the evaluation of psychosis. If an agency or program does not have someone who is sufficiently experienced or has someone who wishes to get further training in how to differentiate non-affective psychosis from other conditions, the OnTrackNY central staff can recommend resources for additional training.

## B. Summary of the process

The referral process includes two steps; screening is followed by evaluation and enrollment. The latter is a confirmation that the service seeker meets all eligibility criteria. The sections below will provide detailed information about how to address specific items during the referral, screening, and evaluation process. Given the varying nature of referrals and information that is being provided by the caller, it is important for the O&RC to note that process of screening may differ for each new referral. To help guide this process, the O&R team should thoroughly understand the program's eligibility criteria and symptoms meeting criteria (see Screening Diagram), so that the next steps can easily be determined. For example, all new calls should be documented on a Screening Cover Sheet. Thereafter, if relevant and significant information is being provided, the O&RC can start completing a Referral Screening Form. The level of detail on this Referral Screening Form will vary based on what records are received, and whether or not the screener thinks that eligibility and an evaluation is likely. If an evaluation is likely, brief key points can be noted on the Referral Screening Form, without the need to provide extensive details about symptoms and psychiatric history.

## C. Describing OnTrack NY

1. **Briefly describe the program:** Whether speaking to providers, service seekers, or family members, it is important to describe OnTrackNY as a program designed to provide comprehensive services to those in the early stages of psychosis. The program is founded on recovery oriented principles, designed to help adolescents and young adults reach their optimal level of functioning.

2. **Provide brief descriptions of all team members**
   - Psychiatrist: Medication management and treatment
   - Nurse: Supports medication management and wellness
   - Team Leader (TL): Oversees all administration of program
   - Primary Clinician: Master's level clinician who provides supportive therapy and coordination of care
   - Recovery Coach: Master's level clinician who provides social skills training
   - Education and Employment Specialist: Individual who provides services based on the Individualized Placement and Support (IPS) model
   - Outreach and Recruitment Coordinator: Master's level clinician who will coordinate initial evaluations, and provide support to the TL and recovery coach as appropriate.
3. **Other considerations**
   - Use the same language that the service seeker or family member is using (i.e. without labeling psychosis or schizophrenia).
   - When speaking with service seekers and family members, use examples to describe how each team member can help. If the O&RC has learned any information about the service seeker's is struggles, it may be helpful to incorporate specific examples of a particular service (e.g. focusing on IPS role if service seeker is having trouble going back to school, or describing social skills training if the individual is describing withdrawal/isolation).
   - Describe flexibility around intensity of treatment: a service seeker may be seen a few times a week, or may only be seen once a week. Visits can change over time depending on what is helpful for the service seeker and family members. Also include team's ability to meet service seekers in the community as needed.
   - The O&RC may choose to emphasize that services are provided based on a shared-decision making model (e.g. the team will work collaboratively with service seekers and family members as appropriate to develop treatment plans).
   - Encourage a meeting with the service seeker and the O&RC prior to the evaluation. This is especially encouraged when the service seeker is hospitalized to support connection to care.
   - If applicable, advise the caller that the team can help link them with services in the community if a particular service is not directly provided by the OnTrackNY team.
   - Advise the caller that services are designed to be comprehensive. If the service seeker is currently in care, it will be necessary to discuss transferring care (O&RC should discuss this with all parties involved.

## D. New referrals

This section provides information about the kinds of calls the O&R team will receive, key points to keep in mind about the overall process, and tracking referrals. This section will overlap significantly with Section E (Screening and Initial Engagement).

**Section Tools (in Appendix and local site binder): Screening Packet (a1); Referral Tracking (b3); Service Seeker Flyer (a3); Provider Flyer (a4); Signed Release Form; Screening Flow Chart (b4); Outreach and Recruitment Work Plan (b1)**

1. Tracking referrals: When a new referral is received, the O&RC should start filling out a Screening Cover Sheet to the best of their ability, even if only minimal information is known (date, caller name, call back phone #). Guide to tracking referrals:
   - Excel sheet (see Appendix): Date of referral, Caller name and/or Name of service seeker, Disposition (i.e., screening/evaluation in progress, no response, ineligible during pre-evaluation activities, ineligible post-evaluation, refused during pre-evaluation activities, refused post-evaluation, program capacity- referred out, enrolled), and Name of O&RC. All members of the O&R team will be responsible for updating their own calls on a regular basis.
   - Screening cover sheets should be accessible to all members of the local O&R team. Cover sheets can be saved or uploaded to a secure shared network. Alternatively, if only handwritten cover sheets are being used, documents can be stored in a locked filing cabinet.
2. Calls from providers (i.e. inpatient & outpatient providers, college counselors, community organizations)
   - Providers may contact the O&R team to obtain information (without a particular service seeker in mind). The O&RC should provide information about the program, and offer to email/mail written information (i.e. one-page flyer or brochure) for future reference. The O&RC can also offer to give an in-person presentation on a specified date, or during a regular team meeting.
   - For providers calling to make a referral: the O&RC should provide information about OnTrackNY, including a description of the services offered, and the evaluation/intake process. In addition to obtaining information about the service seeker, providers should be told that the service seeker will be given an intake appointment within 7 days of the evaluation (if eligible). If the service seeker is not eligible, the O&R team will assist in facilitating a new referral. The O&RC can follow-up with the provider by sending written information (one-page flyers), and encourage them to pass it along to the service seeker and/or family members if appropriate. If an evaluation/eligibility seems likely, the O&RC should offer to meet with the service seeker and/or family members prior to the evaluation appointment (i.e. in the hospital). *Note: if service seeker is a minor, a parent or legal guardian must be present.
   - The O&RC may send the Referral Screening form to both Inpatient and Outpatient providers. Providers can choose to complete the form themselves and return it to the O&R team by fax or email (secure networks only). If providers choose not to complete the form, they can use it as a guide to refer to when sending medical records (especially helpful for outpatient providers). Alternatively, all relevant medical records can be sent to the O&R team (admission notes, and discharge summaries or most recent progress notes indicating description of symptoms).
3. Contact from service seekers or family members: The O&R team may receive calls or emails from service seekers themselves, family members, or friends of those seeking services.
   - Clinical Acuity: when speaking with a family member or service seeker, the O&RC should use their best clinical judgment in regards to emergent cases, and assessing need for services if an

emergent situation is evident. The O&RC should not attempt to continue with the evaluation process if the situation appears urgent. Emergency room and crisis response information should be provided to the caller (see Appendix for Resources List).

- The O&RC should provide information about OnTrackNY, and obtain any information that is being provided (with the exception of minors, see note below). Whenever possible, service seekers and family members can be encouraged to visit the clinic in person, even prior to the evaluation appointment.
- If the O&RC is contacted by email; the O&RC can acknowledge the email, and send a one-page flyer describing the services being offered. The person requesting information should be encouraged to contact the O&RC by phone to further discuss the program and their individual needs.

*NOTE: when speaking with minors, it is permissible to provide information about the program; however, the caller should be advised that the O&R team will need to speak to a parent or legal guardian before moving forward with the evaluation process.

## E. Engagement and initial screening

While engagement begins during the initial conversation, screening may take place simultaneously during the initial conversation or may continue over several calls and in-person visits. Certain factors can be considered during the screening process that may help rule out eligibility immediately (see Appendix for Screening Diagram). Such factors, including age, diagnostic features, and duration of symptoms can all help the O&RC determine how to proceed. During this initial screening, the O&RC can determine whether to conduct an evaluation, consider an evaluation, or refer out to an external resource. Of note, if the O&RC learns information during this process and determines that it is likely this person may be eligible, all available information should be solicited (i.e. medical records, and corroborative information), and the screening form should be completed (see Appendix and local site binder). During the initial screening process, if it seems likely that the service seeker will be evaluated and deemed eligible, the O&RC should begin planning for potential intake by contacting the Team Leader.

**Section Tools (in Appendix and local site binder): Screening Packet (a1); Screening Flow Chart (b4); Signed Release Form**

The following factors can be used as a guide when new referrals are received by a provider, family member, or service seeker:

1. **Age (16-30):** If the service seeker is not within the specified age range, the O&RC should make an alternate referral (see Referral guide). If the service seeker is within the age range, further pieces of information should be obtained.

2. **Qualifying Psychotic Symptoms**

- Delusions: Delusions of reference, Persecutory delusions, Somatic delusions, Delusions of

grandiosity, other delusions (guilt, jealousy, etc.), Thought broadcasting, and/or Mind control
- Hallucinations: Auditory, Visual, Tactile, Olfactory, and Gustatory
- To qualify, all psychotic symptoms must be accompanied by lack of insight, and meet threshold for intensity and/or impact on behavior. Alternatively, a score of 4 or more on a PANSS delusions or hallucinations item would indicate a qualifying symptom.

3. **Duration of symptoms:** service seekers will either fall into "within range" or "not within range"
- Not within range: If the O&RC determines that the service seeker is not within range because the duration of symptoms is greater than one year, under one week or the duration of symptoms is greater than one year. If the presence of psychotic symptoms is uncertain or the duration of symptoms is under one week, the O&RC may still consider doing an evaluation, or may make an appropriate referral to another program.
- Within range: If the service seeker is within range for Age and Duration of symptoms, continue noting any Diagnostic features and determine if an evaluation is appropriate.

4. **Diagnostic features:** During the screening process (prior to evaluation), information obtained regarding diagnostic features should be considered carefully. An especially challenging aspect of this evaluation process is whether substance abuse or mood symptoms account for the qualifying psychotic symptoms. When speaking to a provider, diagnoses and rule outs may be clear (as they will have supplemental information from lab results and medical workups). When speaking with a service seeker or family member, if terms related to mood symptoms and substance use are being discussed, the O&RC should especially consider conducting an evaluation unless it is clear that the service seeker was recently diagnosed with a substance-induced psychotic disorder or mood disorder with psychotic features.
- Presence of Mood Symptoms: If mood symptoms are not present, the O&RC should proceed with an evaluation. If it is clear that the diagnosis of a Mood disorder with psychotic features (i.e. Depressive disorder with psychotic features or Bipolar disorder with psychotic features) is likely, the O&RC should make an appropriate referral. If the diagnosis is unclear despite the presence of mood symptoms, the O&RC should proceed with an evaluation.
- Presence of Substance Use: If substance use is not present, the O&RC should proceed with an evaluation. If the O&RC receives information (from a provider) stating that the condition is definitely a substance-induced psychotic episode, the O&RC should make an appropriate referral. If it is unclear whether or not the psychotic episode is substance-induced, the O&RC should proceed with an evaluation.
- General Medical Condition: If it is evident that there is a general medical condition present, and its temporal relationship to the onset of psychotic symptoms is clear, an appropriate referral should be made. Otherwise, the O&RC should proceed with an evaluation.

5. **Geographic Proximity:** During the screening process, it is also helpful to consider geographic proximity. The service seeker should reside within a reasonable distance from the clinic.

## F. Determining eligibility

**Section Tools (in Appendix and local site binder): Evaluation Form (a2); Evaluation Narrative (a3); Timeline Form (a4); Commonly Used Substances (b5); Substance Use Assessment (b6); Signed Release Form**

Evaluations can be done using an Evaluation form or a SCID (clinician or research version). Eligibility should be determined within 24 hours from the time of evaluation. To reduce the burden on the individual, the O&RC should keep in mind that the purpose of the evaluation is not to make a diagnosis; rather, it is to obtain enough information to determine whether the individual meets all eligibility criteria for OnTrackNY. While determining eligibility, it is important to obtain any available corroborative information (from past and present providers, and family members). To obtain such information, release forms should be used as directed by local site administrators. If further corroborative information is needed, the service seeker and all parties involved should be notified that a decision will be made within 24-48 hours.

### Evaluation Process

At this time, the O&RC should have a completed Screening Cover Sheet and a Referral Screening Form. The O&RC can review the Referral Screening Form along with any medical records prior to the evaluation. During the evaluation meeting with the service seeker, the O&RC can use the Evaluation Narrative and focus on areas of uncertainty (i.e. confirming qualifying psychotic features, clarifying substance use, and mood symptoms). Once the evaluation is complete, the O&RC can complete the Evaluation Form. The evaluation assessment is outlined below:

**a)** History: it is helpful to gain an understanding of the individual's overall picture (i.e. school/work history, noting gradual decline in functioning when applicable)

**b)** Previous hospitalizations and/or treatment for psychiatric conditions

**c)** Psychotic Symptoms and Related Indicators
For each symptom, consider the level of intensity (frequency), impact on behavior, and lack of insight.

***Lack of insight (belief held with delusional conviction) must be present. Additionally, either impact on behavior and/or intensity (symptoms occur at least intermittently or a preoccupation with belief) must be evident. Date of onset should be determined for each symptom.***

Alternatively, a score of 4 or more on a PANSS delusions or hallucinations item would indicate a qualifying symptom.

- Delusions of reference—belief that others are taking special notice of them, talking about them, references on TV, reading material, etc.
- 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 to a deity
- Somatic delusions—belief that his or her body is grossly distorted, change or disturbance in appearance or functioning
- Other (religious, guilt, jealousy)—unusual religious experiences, belief that he or she must be punished for something (guilt), belief that partner was being unfaithful, 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 experience 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
- Hallucinations: Auditory, Visual, Tactile, Olfactory, and/or Gustatory

**d)** Substance Use

- Type of substance and usual pattern of use
- Focus on Alcohol, Sedatives, Hypnotics, and/or Anxiolytics
- Focus on periods of significant increase or decrease in relation to onset of psychotic symptoms
- Qualifying psychotic symptoms must be present in the absence of substance intoxication and/or withdrawal

**e)** Presence of Mood Symptoms (focus on temporal relationship to onset of psychotic symptoms)

- 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
    3. Significant weight change (loss or gain)
    4. Insomnia nearly every day
    5. Psychomotor agitation or 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 psychomotor agitation
7. Excessive engagement in pleasurable risk-taking behaviors

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

**f)** General Medical Condition

- Prominent psychotic symptoms due to the direct physiological effects of a general medical condition
- General Medical Conditions include: Neurological conditions (including traumatic brain injuries), Endocrine conditions, Metabolic conditions, Autoimmune disorders with central nervous system involvement

## G. Senior clinician review

**Section Tools (in Appendix): Evaluation Form (a2); Timeline Form (a4); Evaluation Narrative (a3)**

For the first 6 months of the program, the O&RC should review all cases including those that appear more straightforward with the senior clinician. When the senior clinician is satisfied that the O&RC is making accurate determinations of straightforward cases, the senior clinician can empower the O&RC to make independent decisions. At that point, the senior clinician must discuss and provide evidence for that judgment with the OnTrackNY central oversight. The senior clinician can also decide to review all cases with the O&RC. The oversight is due to the importance and difficulty of making accurate diagnoses of individuals who are early in psychosis. The O&RC, or person conducting the eligibility evaluation, should be prepared to review the case with the following information (optional: Evaluation Narrative and/or Evaluation Form):

1. Pertinent demographic information
2. Context description (e.g. currently hospitalized since **/** following ER visit for acute psychotic symptoms)
3. Psychotic symptoms; onset and duration of symptoms; brief description of symptoms; highlight any major depressive episodes and/or manic episodes with a temporal relationship to psychotic symptoms; highlight any substance abuse with a temporal relationship to onset of psychotic symptoms.

## H. If the service seeker is eligible

If the service seeker meets all eligibility criteria, next steps can proceed as follows to ensure a timely intake. When the service seeker is determined to be eligible for the program, the O&RC should notify him or her, family members, and service providers as appropriate. An intake should be

scheduled within 7 days. Intake appointments should be offered and adjusted based on clinical need (i.e. urgency, discharge date, etc.). If the team leader has not been directly involved in the evaluation process with the service seeker thus far, the O&RC should make every effort to facilitate an introduction between service seekers, family members, and the team leader prior to the intake proceeding.

## I. Making referrals

If service seeker is not eligible, refer out: The O&R team can use the "Making Referrals" Diagram (see Appendix) for guidance on factors to consider when making a referral. When possible, the O&R team should try to provide 2-3 referrals. When referring service seekers, family members, or providers to other programs, it will be helpful to facilitate a connection with the program where the service seeker is being referred. Each site must customize a resources guide that is readily available to all O&R team members.

**Section Tools (see Appendix and local site binder): Resources List template (b10); Re-directing Referrals Diagram (b8); Re-directing Referrals Webinar is available through the Center for Practice Innovations Learning Management System**

1. Factors to consider when making referrals
   - Level of Care that is 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 service seeker have insurance? Do they have out of network benefits? Do the service seeker and/or family members have the means to pay for services out of pocket?
   - Geographic/Location needs: Does the service seeker 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 service seeker's diagnostic features (i.e. substance use programs, anxiety disorder clinics, etc.)
   - Supportive services: Consider what you have learned about the service seeker, 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)
2. Resources list should include the following (see Resources list template):
   a) Area emergency rooms and/or CPEPs
   b) Mobile crisis teams and Lifenet phone numbers
   c) Clinics and programs
      - Organization name
      - Specific programs 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)

- 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

## J. Waitlist procedure

If the clinic reaches capacity, a waitlist should be implemented. If there is an anticipated opening in the clinic (within 1-2 weeks), consider conducting an evaluation. Otherwise, the following steps should be taken:

**See Section I "Making Referrals"**
**Section Tools (see Appendix and local site binder): Resources List Template (b10); Re-directing Referrals Diagram (b8)**

a) Briefly describe the program to callers who are unfamiliar with the services offered

b) When speaking to providers, service seekers, or family members, advise them that the clinic is at capacity and provide other referrals as appropriate. Facilitate connections to referral sources whenever possible.

c) For providers: Encourage them to forward OnTrackNY contact information so that the service seeker and/or family member can contact the O&R team if a need for services should arise in the future

d) For service seekers or family members: Encourage them to seek appropriate services at this time. The O&RC should also advise the caller to contact OnTrackNY programs at a later date if appropriate services are not established.

e) Using the Referral tracking system, the O&R team can select "Re-directed referral: capacity" as the disposition, and briefly describe what the plan is to follow-up (e.g. Referrals provided, caller will re-contact if needed). Notes should indicate that this person may have otherwise been eligible for the program.

# III. Appendix

## a) Forms

a.1. Screening Packet (cover sheet and referral screening form)
a.2. Evaluation Form (including Pathways to Care and DUP)
a.3. Evaluation Narrative
a.4. Timeline Form

## b) Tools and Diagrams

b.1. Outreach and Recruitment Work Plan (sample)
b.2. Outreach Tracking (template)
b.3. Stages of Engagement Diagram
b.4. Sample Screening Diagram
b.5. Commonly Used Substances
b.6. Substance Use Assessment (sample)
b.7. Sample Timeline Diagram
b.8. Redirecting Referrals Diagram
b.9. Flip Chart
b.10. Resources List (template)
b.11. Supplemental Readings

# Screening Cover Sheet

## Outreach and Recruitment Coordinator:

## Date Received:

| | | |
|---|---|---|
| Name: | DOB: | Gender: |
| Street Address and Phone Number: | | |
| Caller Name and Contact:<br><br>Calling from (providers only):<br><br>How did they hear about OnTrackNY? | | Relationship to Patient: |
| Parent/Guardian or Family Member:<br><br>Contact: | | Relationship to Patient: |
| NOTES | | |

## Referral Screening Form

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

### Patient name:

## Referring provider information

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

| | |
|---|---|
| Referral Date: | Does the patient speak English?<br><br>Yes ☐ No ☐ - Patient Speaks: _____ |
| Is the patient aware of and in agreement with this referral?<br>Yes ☐ No ☐ | |
| Indicate the degree to which the patient's family/caregiver is involved in treatment:<br><br>Low ☐ Moderate ☐ High ☐ | |
| Reasons for referral: | |

## Current psychiatric symptoms

| Describe psychotic symptoms that the patient has reported/demonstrated over the past 2 years (include onset and course of qualifying symptoms, and any self-harm, suicide attempts, or violent behavior): | |
|---|---|
| | |
| Identify other psychiatric issues the patient has reported/demonstrated over the past 2 years (time frame should highlight a temporal relationship to psychotic symptoms): | |
| ☐ **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 patient 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 patient's treatment (especially patient strengths, as well as important psychosocial history, family involvement, etc.): |
| --- |
| |

**Outreach and Recruitment Coordinator**

**Print Name: _____Date: _____/_____/_____**

**Signature: _____**

OnTrackNY: Evaluation Form

**OnTrackNY**
**EVALUATION FORM**

**Client (last, first):** **Date:**

| Dimension | Criterion | Check if criterion is met |
|---|---|---|
| Age | Date of Birth/Current Age | ___/___/_____<br>____ ____ |
| IQ | No history of IQ < 70 | ☐ |
| **Qualifying Psychotic Symptoms**<br><br>Lack of Insight + Intensity and/or Impact (assessment duration: at least one week) | **Check symptoms meeting criteria**<br>☐ **Delusions of Reference**<br><br>☐ **Persecutory Delusions**<br><br>☐ **Grandiose Delusions**<br><br>☐ **Somatic Delusions**<br><br>☐ **Other Delusions** (Include religious delusions, delusions of guilt, jealous delusions, and erotomanic delusions)<br><br>☐ **Delusions of Being Controlled** (Include thought insertion or withdrawal)<br><br>☐ **Thought Broadcasting**<br><br>☐ **Auditory Hallucinations**<br><br>☐ **Visual Hallucinations**<br><br>☐ **Tactile Hallucinations**<br><br>☐ **Other Hallucinations** (Include Gustatory and/or Olfactory) | |
| **OR**<br>---<br>A score of 4 or higher for Delusions and/or Hallucinations on the PANSS (assessment duration: at least one week) | **OR**<br>---<br>☐ **PANSS score of 4 or higher for Hallucinatory Behavior** (4, Moderate: Hallucinations occur frequently, but not continuously, and the patient's thinking and behavior are affected only to a minor extent) | |

| | | |
|---|---|---|
| | ☐ **PANSS score of 4 or higher for Delusions** (4, Moderate: Presence of either a kaleidoscopic array of poorly formed, unstable delusions or of a few well-formed delusions that occasionally interfere with thinking, social relations or behavior) | |
| Duration of Illness | Qualifying psychotic symptoms began less than 12 months ago. Provide date of onset (using date of earliest qualifying symptom) | Date of Onset<br>___/___/___<br>Age (at time of onset)<br>_____ |
| Qualifying Diagnostic Criteria | Psychotic symptoms not due to substance abuse<br>- - - - - - - - - - - - - - - - - - - - - -<br>Psychotic symptoms not accounted for by a primary mood disorder<br>- - - - - - - - - - - - - - - - - - - - - -<br>Psychotic symptoms not due to a general medical condition<br>- - - - - - - - - - - - - - - - - - - - - - | ☐<br><br>☐<br><br>☐ |
| DSM-V Diagnosis | ❑ Schizophrenia: 295.90<br>❑ Schizoaffective D/O: 295.70<br>___ Bipolar type<br>___ Depressive type<br>❑ Schizophreniform D/O: 295.40<br>❑ Delusional D/O: 297.1<br>❑ Other specified schizophrenia spectrum and other psychotic disorder: 298.8 | |

| | |
|---|---|
| | ❑ Unspecified schizophrenia spectrum and other psychotic disorder: 298.9 |
| Proximity/Availability: | |

**Eligible for OnTrackNY**

☐ **No (indicate reason):**

☐ **Yes: Proceed to Pathways to Care and DUP Form**

**OnTrackNY**
**PATHWAYS TO CARE AND DURATION OF UNTREATED PSYCHOSIS FORM**

## PATHWAYS TO CARE

Document all professional help ending with evaluation for OnTrackNY. Indicate all responses based on the pathways to care key.

| ***Date of Contact***<br><br>*(with service provider)* | ***Service Provider / Form of Help*** | ***Main Reason for Seeking Help*** | ***Source of Referral*** |
|---|---|---|---|
| pcdate1p<br><br>_____/_____/_____ | pcserv1p | pcreas1p | pcsource1p |
| pcdate2p<br><br>_____/_____/_____ | pcserv2p | pcreas2p | pcsource2p |
| pcdate3p<br><br>_____/_____/_____ | pcserv3p | pcreas3p | pcsource3p |
| pcdate4p<br><br>_____/_____/_____ | pcserv4p | pcreas4p | pcsource4p |
| pcdate5p<br><br>_____/_____/_____ | pcserv5p | pcreas5p | pcsource5p |
| pcdate6p<br><br>_____/_____/_____ | pcserv6p | pcreas6p | pcsource6p |

| **date1stadmit**<br><br>_____/_____/_____ | Date of first hospitalization for psychosis |
|---|---|

**Pathways to Care KEY**

**Service Provider/Form of Help**

0 = OnTrackNY
1 = Emergency Room (indicate if hospitalized)
2 = Psychiatrist
3 = Psychologist or Other Mental Health Clinician
4 = Family Care Doctor/Primary Care Physician
5 = School Counselor
6 = School Teacher
7 = Clergy/ Minister/ Preacher/ Church
8 = Child Welfare or Protective Services
9 = Law Enforcement (police, detention centers, juvenile courts)

10 = Other (specify): _____

**Reason for contact with service provider**

1 = Hallucinations
2 = Delusional Beliefs
3 = Paranoia
4 = Depression
5 = Social Withdrawal
6 = Suicidal Ideation or Suicide Attempt

7 = Other (specify): _____

**Source of referral to service provider (indicate who initiated contact)**

1 = Self
2 = Family member
3 = Significant other or Friend
4 = Teacher

5 = Other (specify): _____

**DURATION OF UNTREATED PSYCHOSIS**

1) Date of Onset (based on qualifying psychotic symptoms that determined eligibility for OnTrackNY)

_____/_____/_____ (use this date of onset as a marker for the following questions)

2) Has the person received treatment in the form of psychotherapy?

_____ Before onset of this psychotic episode, approximate start date _____/_____/_____

_____ After onset of this psychotic episode, approximate start date _____/_____/_____

_____ No psychotherapy

3) Has the person received antipsychotic treatment?

_____ Any antipsychotic medications given prior to onset of qualifying psychotic symptoms, approximate start date _____/_____/_____

_____ Two weeks or more of antipsychotic medications after onset of this psychotic episode, approximate start date _____/_____/_____

_____ Less than two weeks or no antipsychotic treatment after onset of this psychotic episode

**Evaluating clinician**

- **Reviewed with Senior Clinician: ____/____/_____**
- **Reviewed decision with client and/or responsible parties: ____/____/_____**

**Print Name: _____**

**Signature: _____**

**Senior Clinician**

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

**Signature: _____**

# Evaluation Narrative

Name: _____

Date of birth: _____/_____/_____

Date: _____/_____/_____

Evaluating Clinician: _____

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

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

QUALIFYING PSYCHOTIC SYMPTOMS (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)

If applicable, CORROBORATIVE INFORMATION (include source of information)

*Append copies of any medical records received during evaluation process

## Timeline Form (optional)

| Date: Start/Stop | Psychotic Symptoms | Mood Episode | Substance Use | General Medical Condition |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**OnTrackNY**
**Outreach and Recruitment**
**Work Plan (sample)**

**Date**:

| RECRUITMENT | DETAILS AND/OR ACTION ITEMS | NEXT STEPS/NOTES |
|---|---|---|
| Referral Data | • 80% of referrals were from inpatient unit, discuss strategies to disseminate information more broadly | • Sarah and Megan will re-contact/re-visit other agencies: by 11/30/2014 |
| Ineligible referrals | • 7 of 10 referrals from x agency were ineligible, re-strategize presentations with providers | • Megan will set-up a time to attend small group/team meeting (discussion will focus on eligibility criteria/referral process): by 11/15/2014 |
| **OUTREACH** | **DETAILS AND/OR ACTION ITEMS** | **NEXT STEPS/NOTES** |
| Database | • Database includes agencies within a 5-mile radius; discuss further expansion<br>• Need to troubleshoot technical difficulties with updating contacts | • Sarah will continue adding contacts to database<br>• Karen will address technical problems |
| Developing new contacts | • x hospital has a new adolescent unit — need to establish contact and give presentation<br>• x college has not returned calls to O&RC — discuss a new approach | • Sarah will reach out to administrator, then follow-up with direct care providers to set-up a presentation: by 11/30/2014<br>• Mike will follow-up with an email to Director of counseling center |
| Maintaining existing contacts | • All area hospitals have new residents and interns starting—re-visit to provide information to new staff<br>• Colleges are beginning a new semester—good time to re-visit counseling centers and student services offices | • Sarah will follow-up and set-up a meeting with residents/new students: by 10/1/2014<br>• Megan will mail materials, and contact area colleges to set-up presentations |

| | | |
|---|---|---|
| Mass e-mail<br>Mass mailings | • Send mass e-mail to area outpatient programs with new information, reminding them of services offered<br>• Send all high school counseling centers one-page flyers | • Mike to send mass e-mail<br>• Sarah to follow-up with mass mailing |
| Materials | • Brochures<br>  o Patients/Families<br>  o Provider<br>• Flyers<br>  o Patients/Families **error on first page, need to correct<br>  o Provider<br>• x hospital requested more pt/family brochures to place on unit | • Karen to address errors<br>• Sarah to mail and e-mail as needed |
| Media | • Ads<br>• Articles<br>• Announcements | |
| Website | • Links from other sites<br>• Links to other sites<br>• Articles/resources → to increase hits | • Karen will follow-up getting information on schizophrenia.org |

**NOTES:**

## 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 | O&RC Name | Type of Outreach | Follow-Up Plan |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
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| | | | |
| | | | |

## STAGES OF ENGAGEMENT

Developed at the Division of Mental Health Services and Policy Research
And the Centers for Practice Innovation
New York State Psychiatric Institute, New York, NY

| **Phase** | **Goal** | **Activities** | **Responsible Persons** |
|---|---|---|---|
| Orientation | Establish contact with providers | Initial calls to administrators and providers<br>Email brochures/one-page flyers<br>Schedule visit to give a presentation<br>Establish contact person for information sharing | Psychiatrist, O&RC |
| Uptake | Successfully complete initial referral and ensure referral process works | Ensure referral process/information are routinely available to providers and discharge planners<br>Make monthly phone calls to contact person to review referral process<br>Send thank-you emails following referrals | Psychiatrist, O&RC |
| Optimization | Establish and maintain stream of referrals | Identify provider 'champions'<br>Orient new providers as indicated (rotating residents, medical students, interns, etc.)<br>Regular in-person check-ins | O&RC |

## REFERRAL TRACKING (template)

| Name/Initials | Ref. Date | Referring Organization | Type | How Did They Hear About OnTrackNY? | Eval. Date | Inpatient Discharge Date | Enrollment Date | Disposition | Disposition Notes | Additional Contacts/Notes |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
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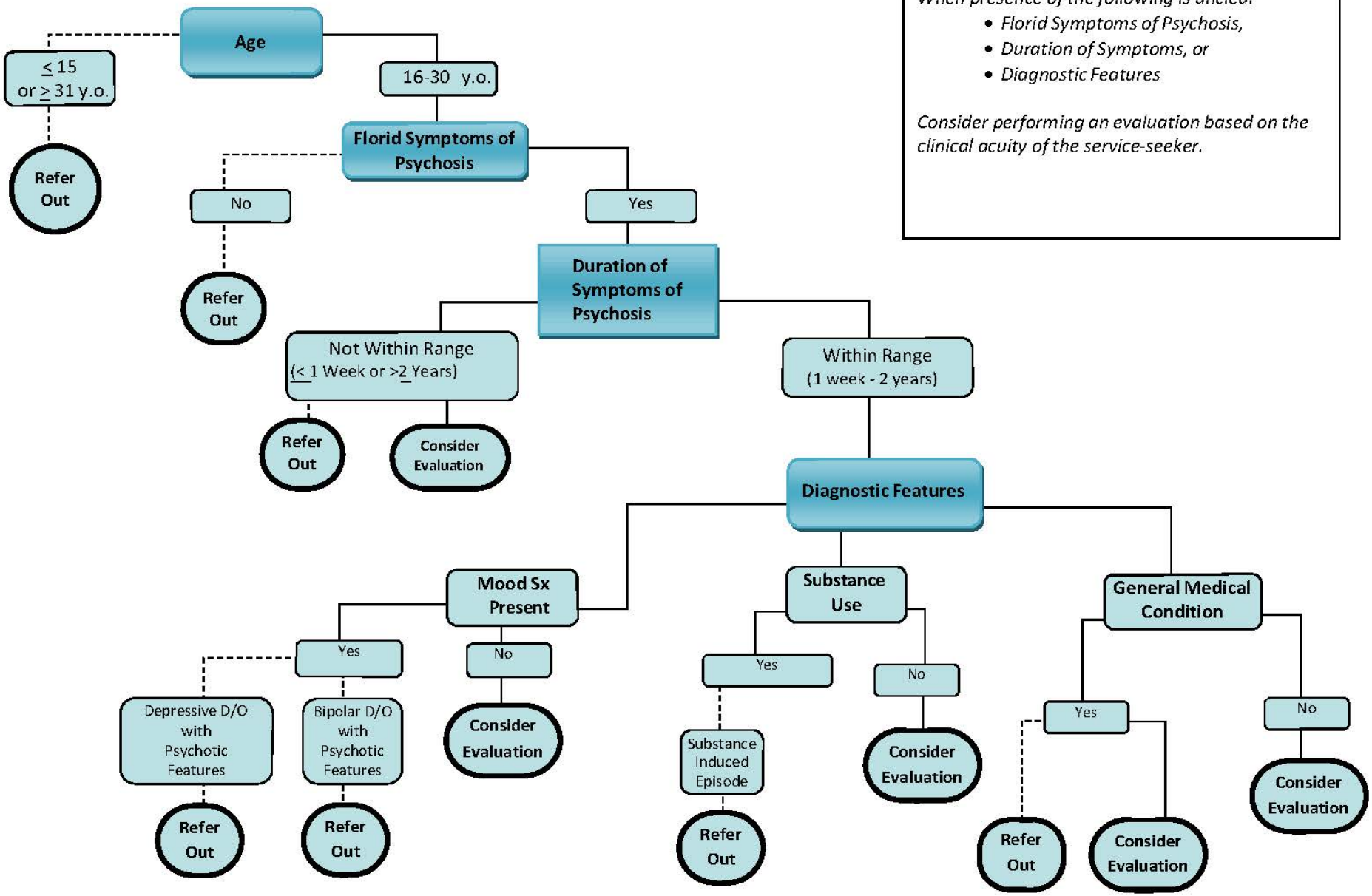
| | | | | | | | | | | |
| | | | | | | | | | | |

**Sample Screening Diagram**



## COMMONLY USED SUBSTANCES

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”)

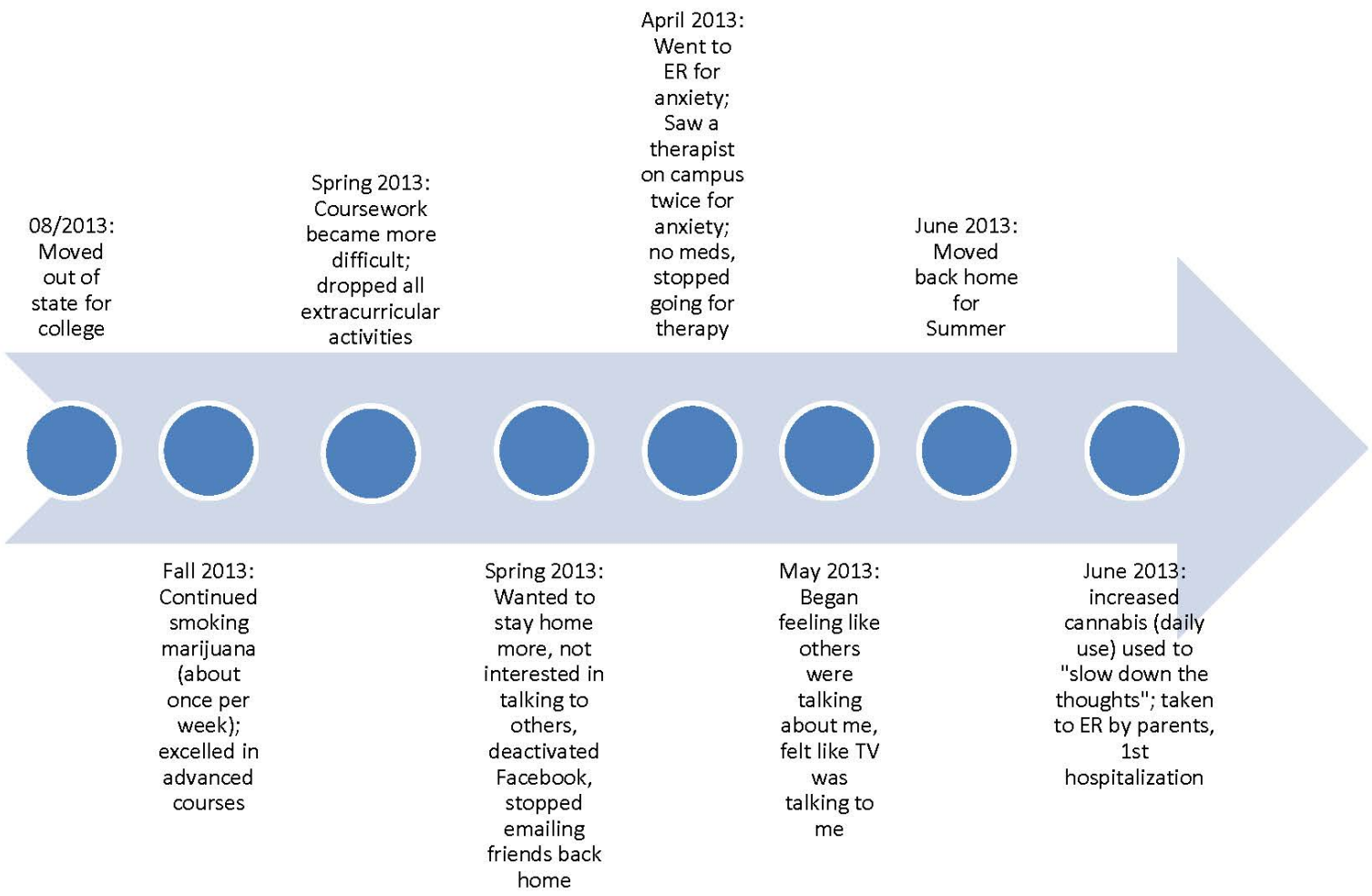
### Other:

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

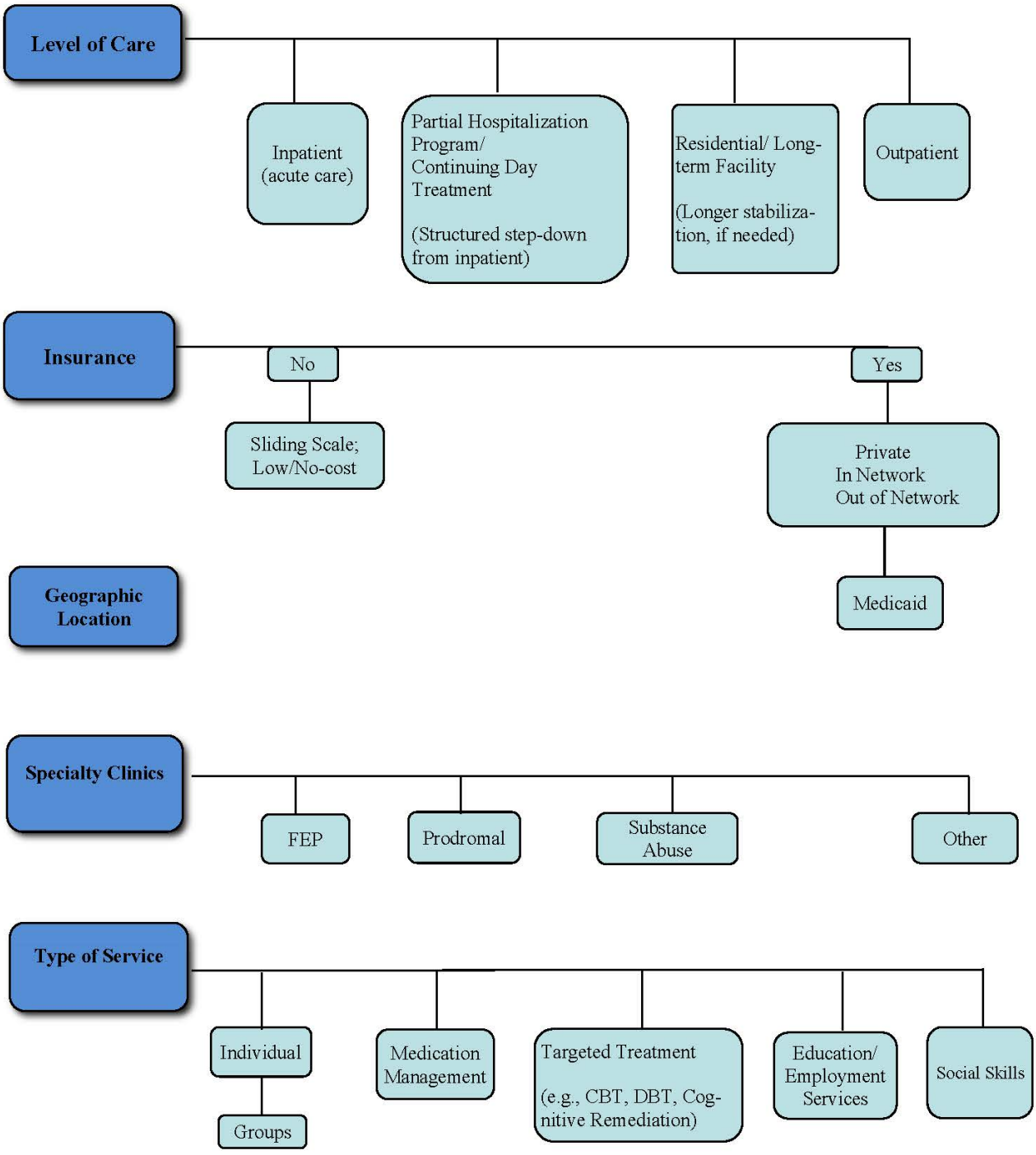
## SUBSTANCE USE ASSESSMENT (sample)

| Type of Substance | Pattern of use (dates and age): Start/stop dates, periods of sobriety, periods of intoxication | Pattern of use: Amount, administration | Additional notes |
|---|---|---|---|
| Alcohol | Began drinking age 16; 3 blackouts from intoxication (heaviest ages 19-22, most weekends); stopped drinking 2 months before date of onset—no Tx | 4-6 drinks in one setting, mostly mixed drinks and liquor | |
| LSD | Used twice, 1st: age 19, 2nd: age 21 | Between 200-400ug taken orally | experienced “trips” for up to 12 hours |
| Cannabis | Tried once age 16; 19-21 increased use (every other day); stopped 1 month before date of onset | Smoked 1-2 joints 3-4 times p/week | Possibility that cannabis was sometimes laced with PCP (in college) |

Sample Timeline



**Redirecting Referrals Diagram**

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A program funded by the NY state Office of Mental Health designed to provide early intervention services for young people who have recently started:

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

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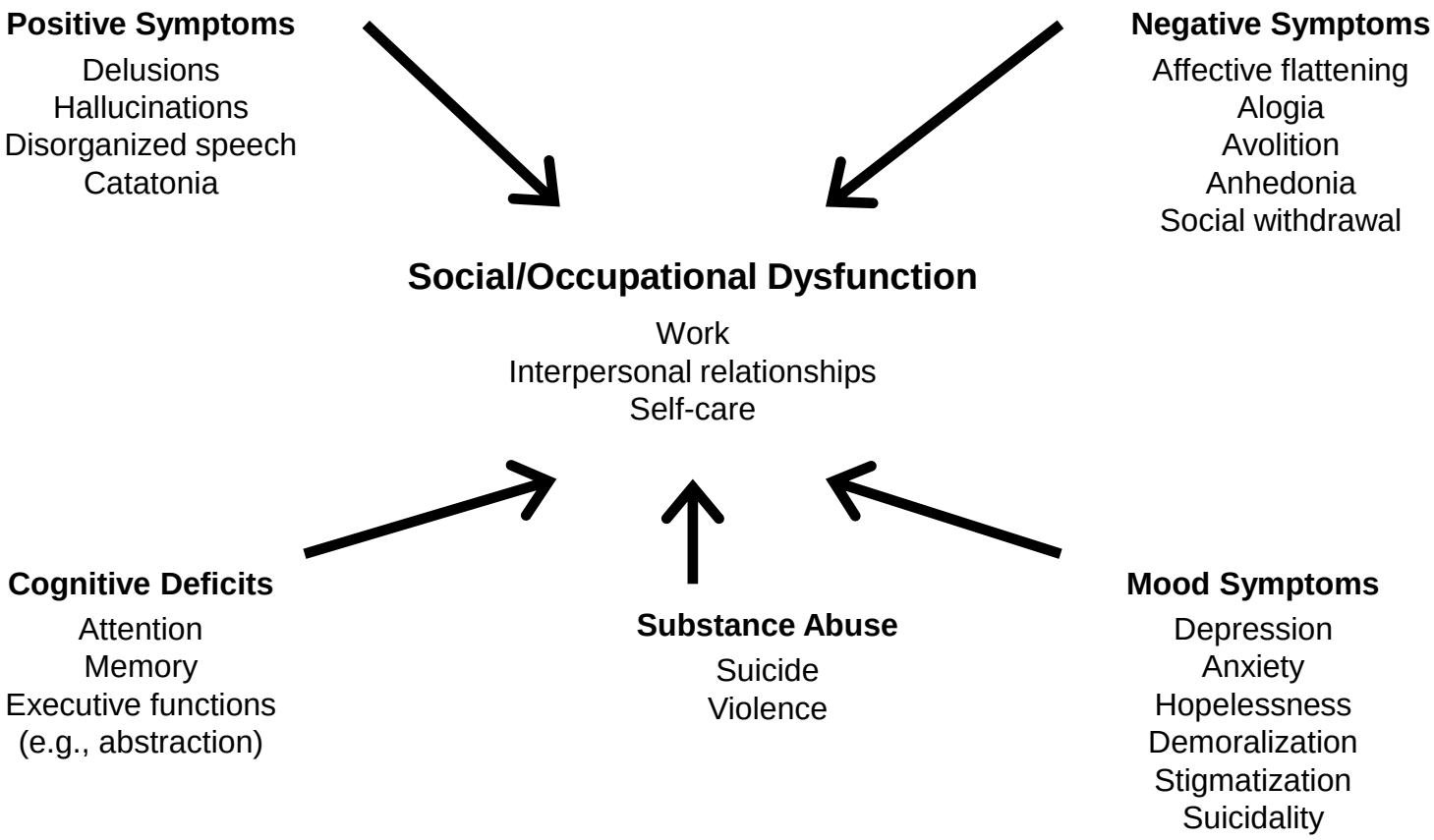
# What is Psychosis?

Symptoms may include:

- Unusual thoughts or beliefs that appear strange to the young person or to others
- Feeling fearful or suspicious of others
- Seeing, hearing, smelling, tasting or feeling things that others do not
- Disorganized, “odd” thinking or behavior
- Strange bodily movements or positions

# These experiences may affect your life



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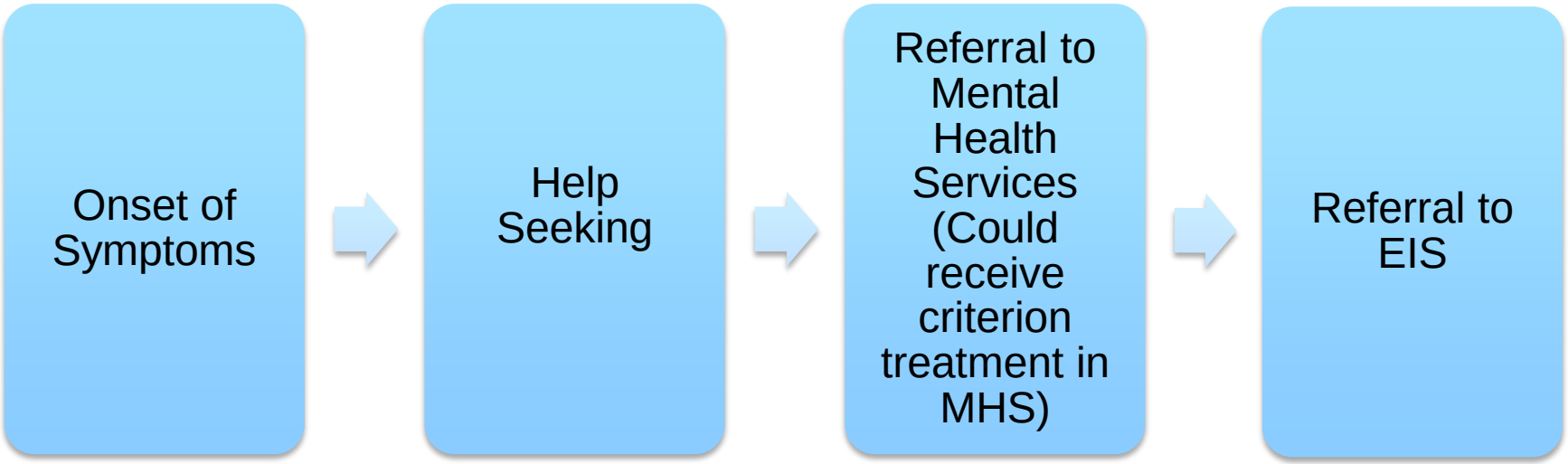
# Prevalence and Impact

- Onset in late adolescence, early adulthood
- Psychotic symptoms, cognitive deficits, and social impairments contribute to disability
- Lifetime risk for suicide is 5%
- 2.5 million adults in U.S. are affected
- Economic cost of $62.7 billion in 2002

# The Big Picture: Rationale

- Under-treatment of mental disorders in youth
- Under-treatment or non-treatment of psychotic illness operationalized as “duration of untreated psychosis (DUP)”– onset of psychotic symptoms to delivery of criterion treatment
- Shorter DUP or more rapid “pathway to care” associated with better short-term outcomes
- Specialized early intervention services* (EIS) superior to usual care for individuals with “first episode psychosis (FEP)” while care is being delivered
- Goal is to reduce DUP and provide EIS to promote long term recovery and reduce disability

# Roadmap for Pathway to Care

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# Current System

Stigma
Lack of Knowledge
Distrust
Lack of recognition
Insidious Onset

Help seeking

Referral from GP
Lack of Access
Unaffordability and
Inefficiency of health
care

Dropout from care or long-term dependence on the MH system

Mental Health Clinic

Police

ER/IP



**Compton M, Broussard B: Current Psych Reviews 2011, 7, 1-11**

# Vision 1.0

Help seeking

Special EIS

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# Vision 2.0

Help seeking

Special EIS

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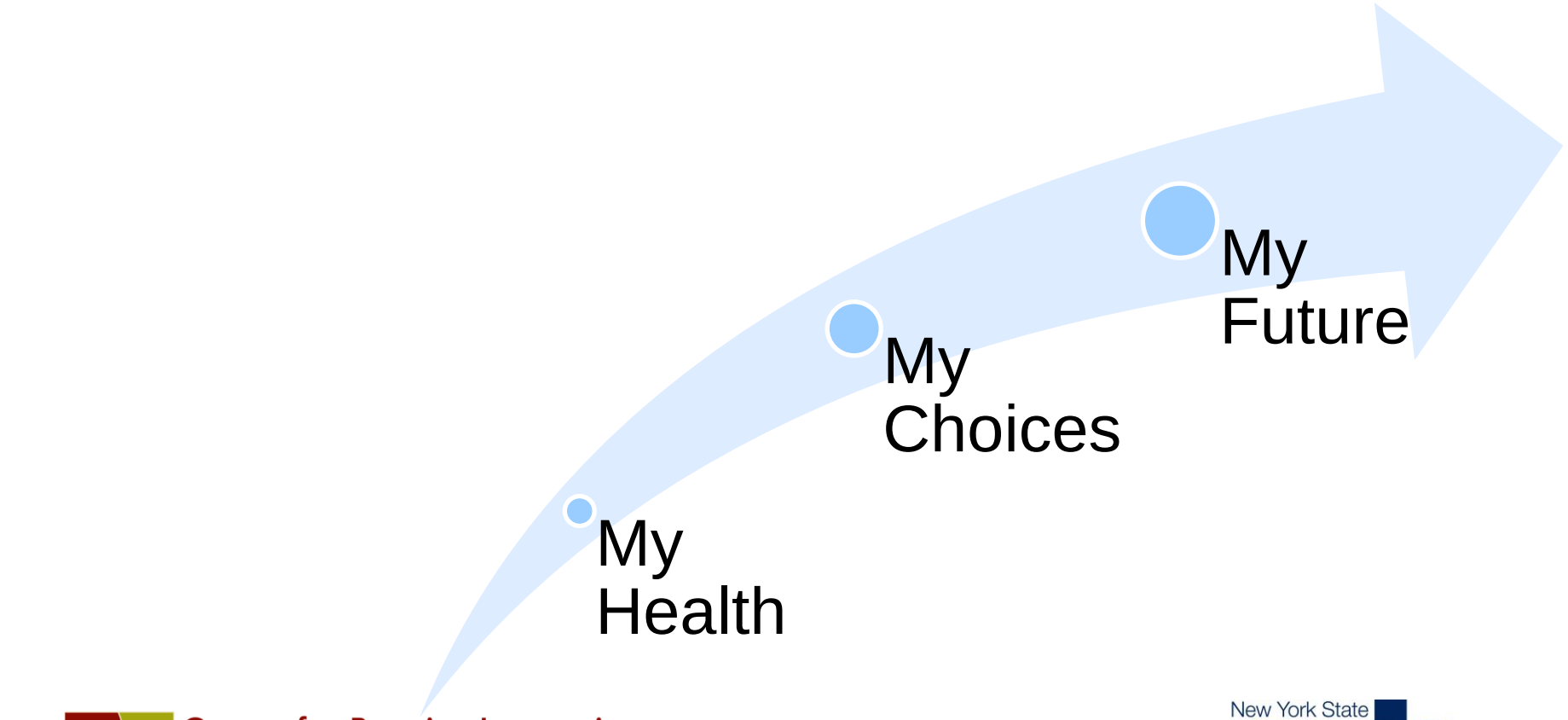
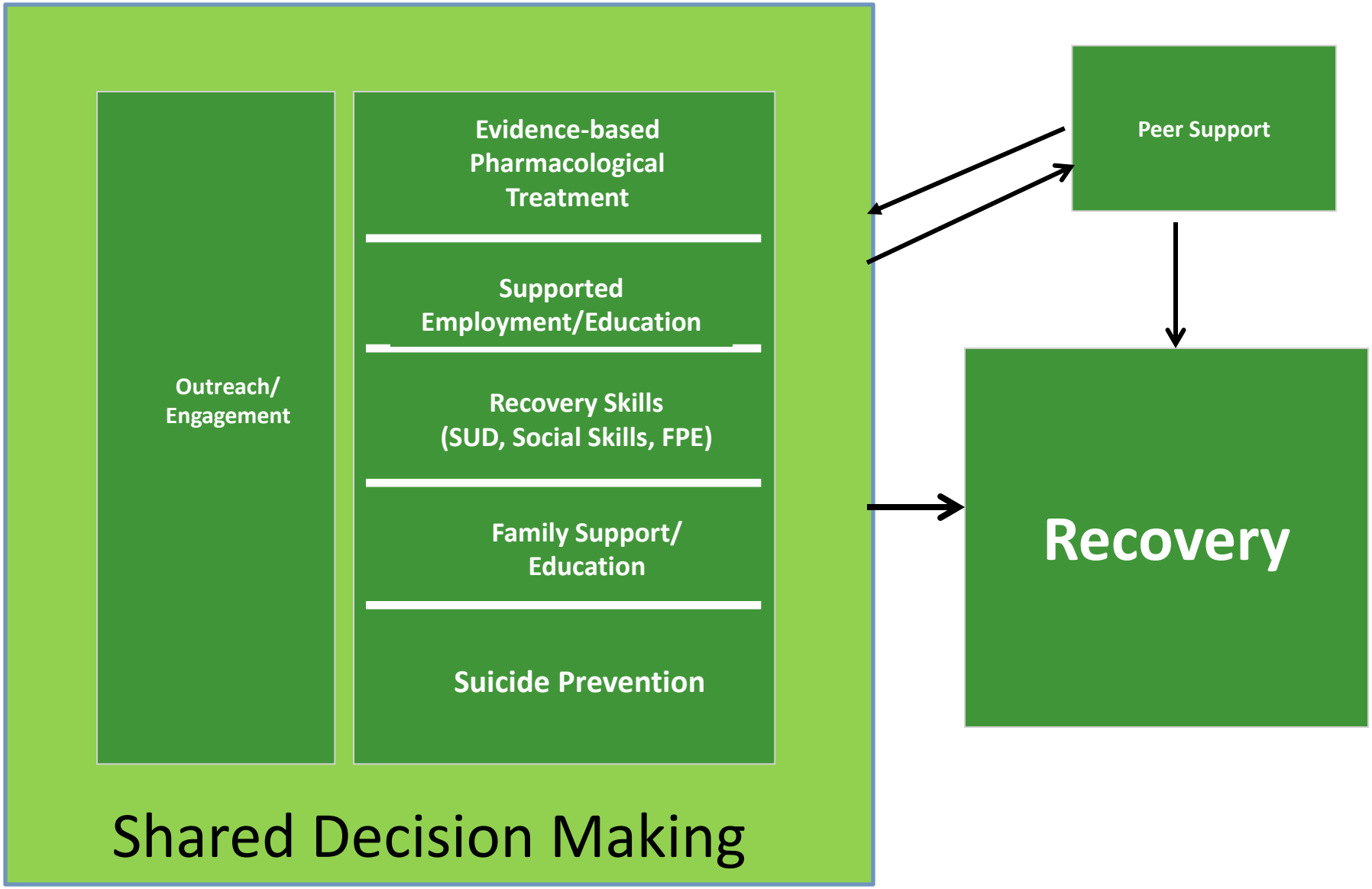
# The OnTrackNY FEP Initiative




Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
*Building best practices with you.*

New York State
Office of Mental Health

# Overall Framework



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# Governing Principles

- **Disability**:
  Limiting disability is the central focus of OnTrackNY; disability is determined and influenced by treatment and environment

- **Recovery**:
  The evolving concept of recovery has multiple definitions, central to each is the core value of empowerment and a personal journey in which the individual acquires the skills and personalized supports necessary to optimize recovery

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# Governing Principles *(continued)*

- **Shared decision-making**:

  Shared decision-making facilitates recovery and provides a framework within which the preferences of consumers can be integrated with provider recommendations for available treatments

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# OnTrackNY Team

- Team Leader (may also be a primary clinician)
- Supported employment/supported education specialist
- Outreach and Recruitment Coordinator (may also be a primary clinician)
- Recovery Coach (may also be a primary clinician)
- Psychiatrist
- Nurse

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# Evidence-based Interventions

**Services provided for up to 2 years; focus will be based on individual need**

- FEP-relevant illness management coping strategies
- Medication treatment
- Education/Employment
- Substance abuse
- Family support
- Suicide prevention
- Social skills training (individual and group)
- Physical health
- Trauma
- Income
- Housing

# Stages of OnTrackNY Intervention: Primary Clinician Activities

| Phase | 1. Engage & Assess | 2. Test, Titrate & Monitor | 3. Re-Evaluate |
|---|---|---|---|
| Timing | Months 1-2 | Months 3-22 | Months 23-24 |
| Duration | Varies with Individual Illness Trajectories and Developmental and Functional Milestones Achieved | | |
| Purpose | Develop trusting relationship with client and family<br>Introduce client and family to all members of Team<br>Conduct needs assessment<br>Provide support<br>Minimize stigma, limit stress<br>Establish goals | Provide OnTrackNY interventions as appropriate<br>Review and revise goals<br>Explore risk factors for relapse<br>Strengthen support network<br>Support positive self regard and assist in managing stress<br>Maintain continuity of contact | Prepare for termination<br>Meet with consumer and family to discuss and plan termination<br>Meet with consumer alone to mark end |
| Activities | Make home visits<br>Obtain history<br>Meet with caregivers<br>Engage in safety planning<br>Engage family members and provide support<br>Ensure adequate housing & financial resources<br>Link with members of Team | Mediate conflicts<br>Help client & family with coping & relapse prevention strategies<br>Identify gaps and modify network as necessary<br>Review and revise needs assessment and safety plan<br>Monitor contact w/ rest of Team<br>Link with community resources | Coordinate assessment of further needs<br>Prepare for termination<br>Ensure support network and connection to service providers safely in place<br>Plan for long-term goals<br>Hold transfer-of-care meetings as needed |

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## Locations

- Kings County Medical Center (Brooklyn, NY)
- Mental Health Association of Westchester (Yonkers, NY)
- Washington Heights Community Services at New York State Psychiatric Center (Washington Heights, NY)
- Zucker Hillside at North Shore Long Island Jewish Hospital (Queens, NY)

**Inquire within about additional locations throughout New York State**

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# Initial Screening and Eligibility

- **Age:** 16-30
- **Diagnosis:** Schizophrenia, schizoaffective disorder, schizophreniform disorder, psychosis not otherwise specified, or delusional disorder
- **Psychopathology:** Psychotic symptoms lasting at least one week
- **Duration of Illness:** ≤ 2 years since the first onset of psychotic symptoms
- **New York State Resident**

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# Eligibility Rule Outs

- Developmental Disabilities (evidenced by IQ < 70)
- Primary diagnosis of substance induced psychosis, psychotic mood disorder,
  or psychosis secondary to a general medical condition
- Serious or chronic medical illness significantly impairing function independent of psychosis

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# Screening and Referral Process

- **Initial call from consumer, family member, and/or provider (goal is to connect within 24 hours)**
- **Pre-screening activities: Goal is to promote engagement by meeting with consumers and families in person; collaborate with current providers**
- **Evaluation: comprehensive evaluation with consumer (goal is to make a determination within 24 hours)**
- **Timeframe: time to enrollment (goal is within 7 days)**

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**Referrals can be addressed to:**

Kings County Medical Center (Brooklyn, NY)

- Kings County: 718-245-5242
- MHA Westchester: 914-345-5900 ext.7727
- Washington Heights Community Services at New York State Psychiatric Center: 646-774-8459
- North Shore LIJ: 718-470-8888

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**Other inquiries about the program**

**and/or training can be addressed to:**

Liza Watkins, LMSW

Associate Director

ontrack@nyspi.columbia.edu

# RESOURCES LIST (template)

## Area Emergency Rooms (including CPEPs)

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

_____

## Mobile Crisis teams and Lifenet phone numbers

**Lifenet: 1-800-Lifenet**

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 numbers: _____

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:

_____

## SUPPLEMENTAL READINGS

- The following article provides a description of attenuated and sub-threshold symptoms. This information is helpful in determining the date of onset.

  **Yung and McGorry (1996). The prodromal phase of first-episode psychosis: past and current conceptualizations. Schizophrenia Bulletin.**

  **Link:** http://www.ncbi.nlm.nih.gov/pubmed/8782291

  **ABSTRACT**
  The initial prodrome in psychosis is potentially important for early intervention, identification of biological markers, and understanding the process of becoming psychotic. This article reviews the previous literature on prodrome, including descriptions of symptoms and signs, and patterns and durations of prodrome in both schizophrenic and affective psychoses. Early detailed descriptions, achieved through mainly anecdotal reports, are compared with current conceptualizations, such as the DSM-III-R checklist of mainly behavioral items, which seeks to enhance reliability of measurement but at the expense of adequately describing the full range of phenomena. Current confusion about the nature of prodromal features and concerns regarding the reliability of their measurement are highlighted. This article proposes an alternative model for conceptualizing prodromal changes (the hybrid/interactive model) and discusses the different ways to view this phase. The need for a more systematic evaluation of the prodromal phase in first-episode psychosis is emphasized.

- The following article discusses substance use in the context of a psychotic episode, and outlines specific features that can guide the assessment of a substance induced psychotic episode.

  **Caton, C. L., Drake, R. E., Hasin, D. S., Dominguez, B., Shrout, P. E., Samet, S., & Schanzer, W. B. (2005). Differences between early-phase primary psychotic disorders with concurrent substance use and substance-induced psychoses. *Archives of general psychiatry*, *62*(2), 137-145.**

  **Link**: http://archpsyc.jamanetwork.com/article.aspx?articleid=208288

  **ABSTRACT**
  The distinction between a substance-induced psychosis and a primary psychotic disorder that co-occurs with the use of alcohol or other drugs is critical for understanding illness course and planning appropriate treatment, yet there has been little study and evaluation of the differences between these 2 diagnostic groups. To identify key demographic, family, and clinical differences in substance-induced psychosis and primary psychotic disorders diagnosed according to DSM-IV criteria using a research diagnostic instrument for psychiatric and substance use comorbidity. Data on demographic, family, and clinical factors were gathered at baseline as part of a 3-year longitudinal study of early-phase psychosis and substance use comorbidity in New York, NY. The study is based on a referred sample of 400 subjects interviewed at baseline. Participants had at least 1 psychotic symptom assessed during administration of the research protocol, had used alcohol and/or other drugs within the past 30 days, and had no psychiatric inpatient history before the past 6 months. Subject race included 43.5% black, 42.0% Hispanic, and 14.5% white or other. Overall, 169 (44%) were diagnosed as having substance-induced psychosis and 217 (56%), as having primary psychosis. Significant differences were observed in all 3 domains. Multivariate analysis using logistic regression

identified the following 3 key predictors as being greater in the substance-induced group: parental substance abuse (odds ratio [OR], 1.69; 95% confidence interval [CI], 1.00-2.85), a diagnosis of dependence on any drug (OR, 9.41; 95% CI, 5.26-16.85), and visual hallucinations (OR, 2.13; 95% CI, 1.10-4.13). The key predictor of total positive and negative symptom score was greater in the primary psychosis group (OR, 0.96; 95% CI, 0.94-0.97). Differences in demographic, family, and clinical domains confirm substance-induced and primary psychotic disorders as distinct entities. Key predictors could help emergency clinicians to correctly classify early-phase psychotic disorders that co-occur with substance use.

- The following article describes the process of getting connected to specialty services. This information can help guide your outreach and recruitment strategies.

**Norman, R. M. G., Malla, A. K., Verdi, M. B., Hassall, L. D., & Fazekas, C. (2004). Understanding delay in treatment for first-episode psychosis.Psychological Medicine, 34(02), 255-266.**

**Link:**
*http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=196845&fileId=S0033291703001119*

**ABSTRACT**
A lengthy delay often occurs between the onset of symptoms of psychotic disorders and initiation of adequate treatment. In this paper we examine the extent to which this represents a delay in individuals contacting health professionals or a delay in receiving treatment once such contact is made. Pathways to care were examined in 110 patients of the Prevention and Early Intervention Program for Psychosis in London, Canada. Data were collected using structured interviews with patients, family members, consultation with clinicians and review of case records. Family physicians and hospital emergency rooms were prominent components of pathways to care. Both delay to contact with a helping professional and delay from such contact to initiation of adequate treatment appear to be about equally important for the sample as a whole, but some individuals appear to be at risk for particularly lengthy delay in the second component. Individuals with younger age of onset, or who had initial contact with professional helpers before the onset of psychosis and were being seen on an ongoing basis at the time of onset of psychosis, had longer delays from first service contact after onset to initiation of adequate treatment. The greater delay to treatment for those being seen at the onset of psychosis does not appear to reflect differences in age, gender, symptoms, drug use or willingness to take medication. Interventions to reduce treatment delay should increase the public's awareness of the symptoms of psychotic illness and the need to seek treatment, but of equal importance is the education of service providers to recognize such illness and the potential benefits of earlier intervention.

- The following article describes family members' perspectives about the prodromal phase, onset of psychotic symptoms and help-seeking behavior. Observations by family members described here may provide some guidance for clinicians when obtaining corroborative information to determine eligibility.

**Corcoran, C. et al (2007). Trajectory to a first episode of psychosis: a qualitative research study with families. Early Intervention Psychiatry, 1(4)**

**Link:** http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2614330/

**ABSTRACT**

The trajectory in psychotic disorders which leads from a relatively normal premorbid state in young people to a first episode of psychosis is only partly understood. Qualitative research methods can be used to begin to elucidate the temporal unfolding of symptoms leading to a first episode of psychosis, and its impact on families. We conducted open-ended interviews with family members of 13 patients with recent onset non-affective psychotic disorders, which focused on changes observed, effects on the family, explanatory models, help-seeking patterns and future expectations. Standard data analytic methods employed for qualitative research were used. Narratives by family members were remarkably similar. First, social withdrawal and mood symptoms developed in previously normal children; these changes were typically ascribed to drugs or stress, or to the 'storminess' of adolescence. Coping strategies by family members included prayer and reasoning/persuasion with the young person, and family initially sought help from friends and religious leaders. Entry into the mental health system was then catalysed by the emergence of overt symptoms, such as 'hearing voices', or violent or bizarre behaviour. Family members perceived inpatient hospitalization as traumatic or difficult, and had diminished expectations for the future. Understanding families' explanatory models for symptoms and behavioural changes, and their related patterns of help-seeking, may be useful for understanding evolution of psychosis and for the design of early intervention programmes. Dissatisfaction with hospitalization supports the mandate to improve systems of care for recent-onset psychosis patients, including destigmatization and a focus on recovery.

- The following article describes how insight about symptoms can vary amongst people experiencing a first episode and multiple episodes of psychosis. Such observations may provide additional guidance for clinicians assessing for insight and awareness.

**Thompson, K. N., McGorry, P. D., & Harrigan, S. M. (2001). Reduced awareness of illness in first-episode psychosis.** ***Comprehensive psychiatry*****,*****42*****(6), 498-503.**

**Link:** http://www.sciencedirect.com/science/article/pii/S0010440X01262452#

**ABSTRACT**

We sought to investigate whether first-episode and multiple-episode patients differ in their awareness of their illness. A total of 312 multiple-episode and 144 first-episode patients participated, the majority of whom had a schizophrenia spectrum disorder (schizophrenia or schizophreniform disorder). Insight was measured using the Scale for the Assessment of Unawareness of Mental Disorder (SUMD). First-episode patients with a schizophrenia spectrum disorder were less aware of having a mental illness than multiple-episode patients. Our findings suggest that in the time following the first episode of psychosis, patients may become less defensive, and possibly more skilled in using medical terms to describe their illness. We suggest a need for skilled psychoeducation that addresses awareness in patients with psychosis, particularly those who are unaware of their illness.