CONNECTICUT EARLY PSYCHOSIS LEARNING HEALTH NETWORK

Transforming Access, Care Quality, and Outcomes

STEP-CT

# Early Detection: Screening, Assessment, and Engagement

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# Early Intervention Service Care Pathway www.step.yale.edu

## Early Detection (Module A)

- Community education
- Academic detailing of referral sources
- Rapid eligibility determination and assertive enrollment into care

**Deliverable**

*Equitable, non-coercive and rapid (low DUP) access to care across target region*

## Evaluation & Initiation of Treatment (Module B)

***3 months***

- Comprehensive case formulation including working diagnosis and treatment plan
- Initiation of initial phase of treatment, including family education
- Risk mitigation for suicide, violence, and criminal justice liaison

**Deliverable**

*Case formulation and preliminary treatment*

## Continuing Treatment in Coordinated Specialty Care (Module C)

***2-3 years***

- Ongoing longitudinal diagnostic evaluation
- Individual psychotherapy
- Pharmacological treatment
- Family education: individual and group based
- Rehabilitation: support for education, employment, vocational counseling
- Primary care coordination
- Case Management: e.g. housing, transportation, entitlements

**Deliverable**

*Value: i.e. Population health outcomes benchmarked to international standards/ low cost of care*

## Care Transition (Module D)

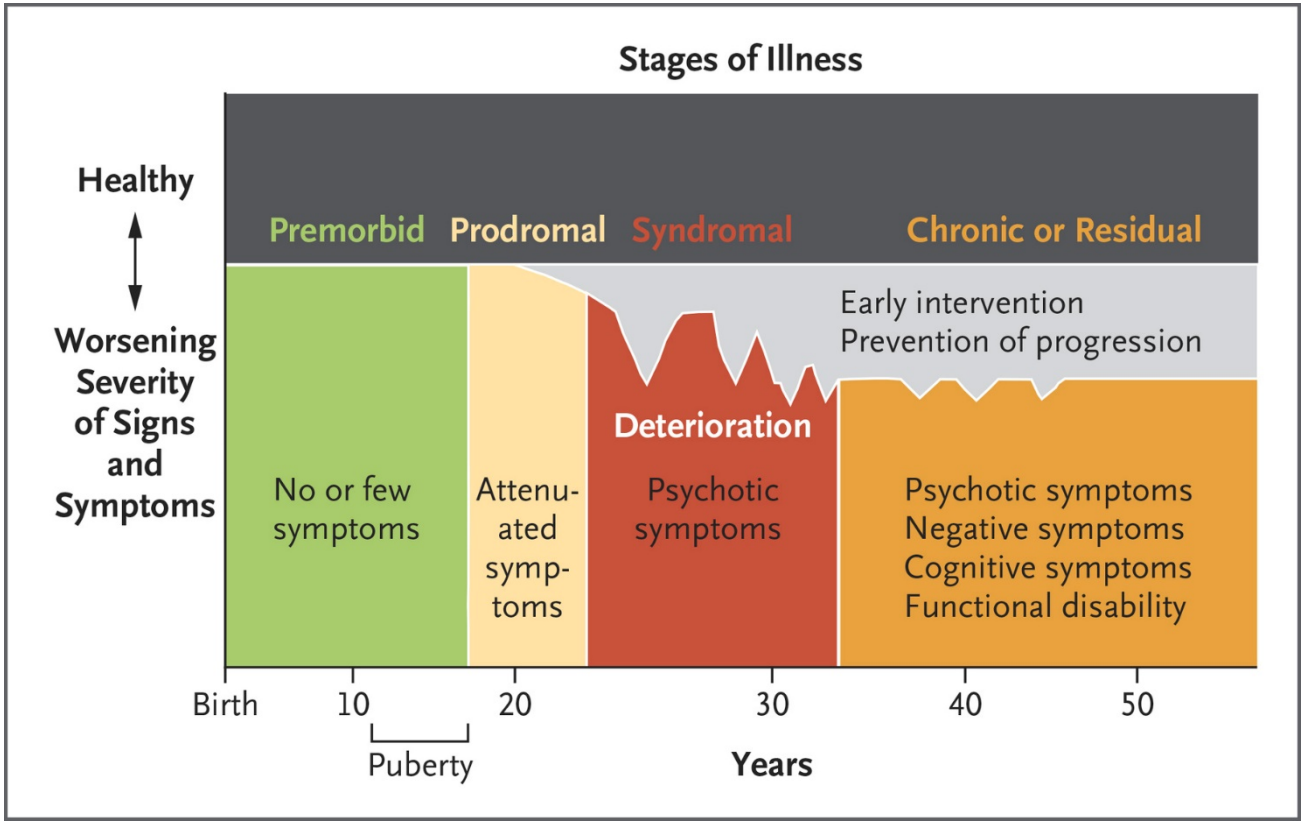
***3 months***

- Individualized selection and referral to local outpatient provider (e.g. primary care, behavioral health, LMHA)
- Ongoing liaison and maintenance of good bi-directional referral and consultative network
- Regular audit of post-transfer engagement rates with continuous performance improvement.

**Deliverable**

*High engagement rates in mainstream services; Tele-consultation to build clinical capacity and regular audit of population health outcomes to drive performance improvement across local network of care.*

# Why is early detection important?




Jeffrey A. Lieberman, and Michael B. First. Psychotic Disorders. *N Engl J Med* 2018; 379:270-280

# DUP is associated with worse outcomes

- worse positive symptom severity
- worse negative symptom severity
- poorer rates of remission
- poorer social cognition
- cognitive impairment

(Perkins DO, et al. Am J Psychiatry. 2005;162:1785–1804.)

# Reducing DUP is associated with better outcomes

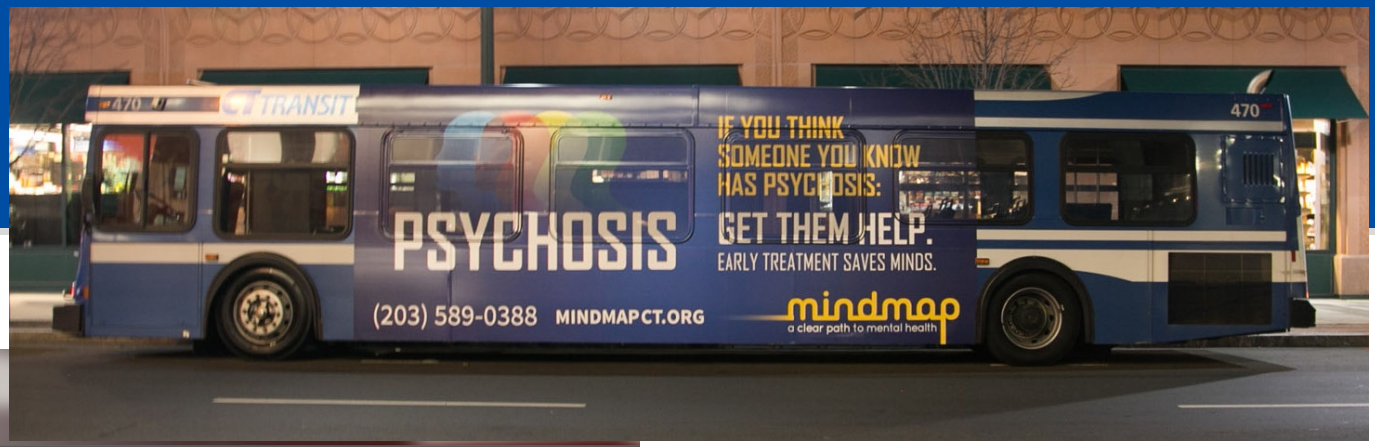
- Clinical, functional, and cognitive benefits
- reducing the social consequences of psychosis onset
  - social isolation
  - unemployment
  - homelessness
  - deliberate self harm
  - violence toward others

# Mindmap: 3-pronged Population Based Early Detection

1. **Media Campaign** (targets *Demand > Supply)*

2. **Professional Outreach & Detailing** (targets *Supply side DUP)*

3. **Rapid Access to STEP** (targets *Supply >> Demand)*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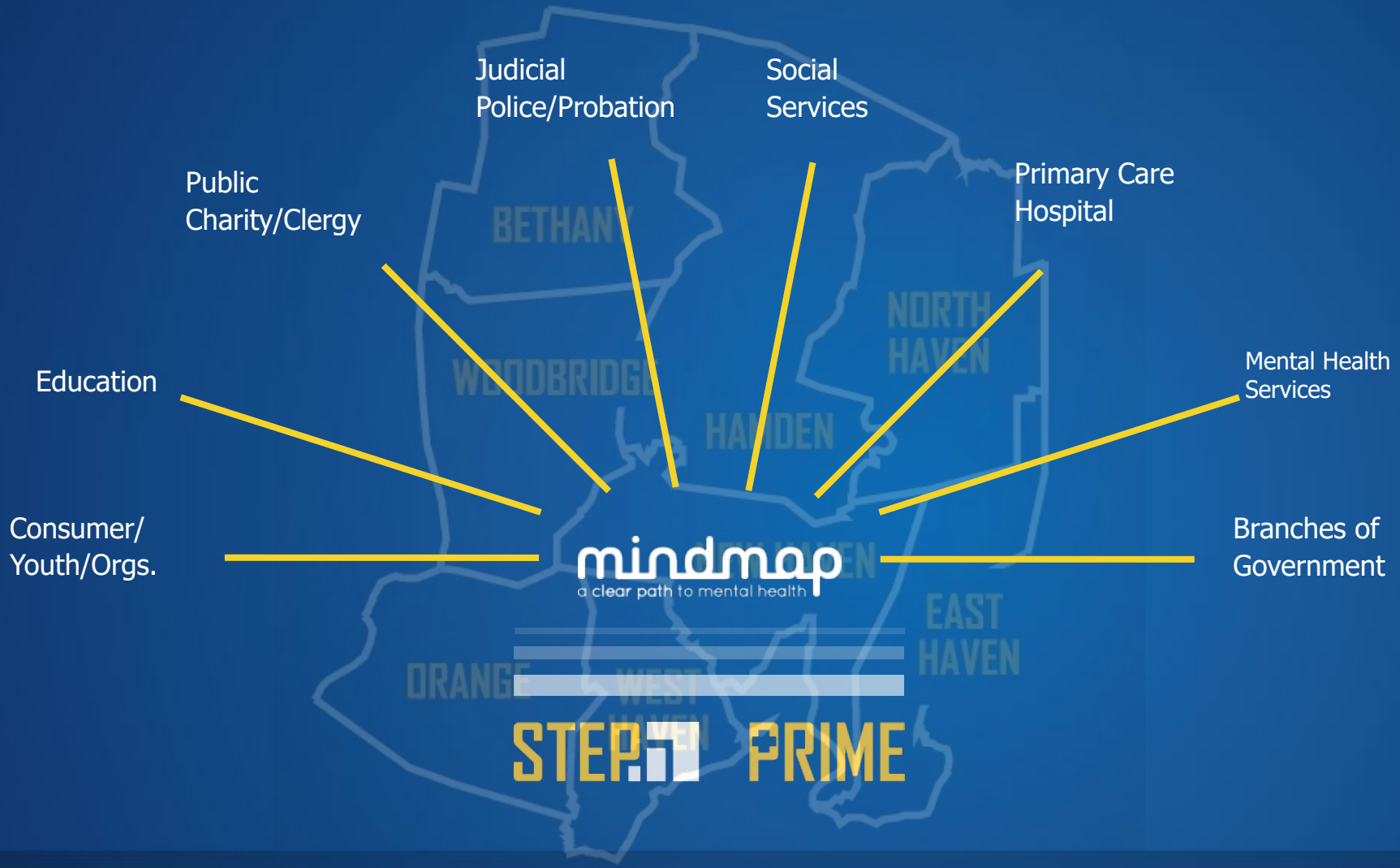
# Innovative treatment for young people with psychosis at no cost for two years

By Jocelyn Maminta Medical/Health Reporter
Published: January 4, 2016, 6:49 pm


# 2. Professional Outreach & Detailing (POD) (*Supply > Demand)*



# Screening: What are the main questions?

- Do they meet age and catchment criteria?

- Is there presence of full psychosis? Examples of it?

- Is the psychosis clearly better explained by something else? (medical, substances, other psychiatric dx)

- How long has someone been experiencing psychosis? Is it still FEP?
  - Calculating DUP– formally through the SIPS
  - OR attempt to assess for onset of full psychotic sx and likely associated change/drop in functioning
    - When did they lose insight?
    - If/when did they start acting in a dangerous or disorganized manner?
    - If/when were they hospitalized? Or treated?
    - How did they respond to previous pharm treatment (if any)

# Assessment: Differential diagnosis in first-episode psychosis

- (Non-affective) Primary Psychotic Disorders
  - Brief psychotic disorder/schizophreniform
  - Schizophrenia
  - Delusional disorder
  - Schizoaffective disorder
- Affective/Mood psychosis
  - Bipolar disorder w/psychotic features
  - MDD w/psychotic features
- Personality disorders:
  - Schizoid/schizotypal
  - Borderline
- Other
  - Attenuated psychotic symptoms
  - Substance-induced
  - Psychosis secondary to a medical condition
  - Psychosis in complex trauma/PTSD/DOC

# Assessment: What can guide us?

- Personal history and medical history
- Family history
- Timing of sx
- Prominent mood sx?
- Mainly non bizarre delusions?
- Illness duration

# Assessment tools and strategies

**Assessments:**

- Structured Interview for Psychosis Risk (SIPS)
  - Can request trainings from Barbara Walsh at PRIME (Yale)
- MINI-SIPS (training online)
- SCID (for differential)
- PANSS (for monitoring the severity of sx)

## risk assessment

- Self harm and violence towards others
- Risk of neglect and victimization

**Strategies:**

- Ask open questions, be patient, normalize, be curious
- Use collateral supports for info
- Consult (with team, case discussion)

# (Assertive) Engagement Strategies

- Be flexible, responsive, *(timing, duration, rescheduling, location)…* persistent, and young-adult oriented (texting)

- Orient around shared goals and give support right away
  - Give practical assistance (Dixon et al., 2016)
  - "getting back on track" with school, work, or relationships
  - getting relief from distressing symptoms (meds, coping), and minimize meds side effects

- Slow, gradual approach – pace of meeting, safety of topics, use "befriending" (Bendall et al, 2003)
  - Be clear, be aware of internal distractors

- Aim to be normalizing and curious

- Avoid confrontation, don't debate 'reality,' yet avoid collusion
  - *"That must be (stressful, scary, overwhelming, etc.), I imagine it might feel really unsettling to feel like you don't know who you can trust"*

# Case example

- 20 y/o black, straight, cis male (Josh*), sophomore in college, living in the dorm
- Grades began dropping, skipping class, isolating from his friends, poor hygiene (fx decline, negative sx?)
- Believes classmates & professors are all in on a plan with the government to hurt him; convinced he is being monitored (Paranoia/Persecutory delusions)
- Noticing signs just for him in school assignments and on YouTube (Ideas of Reference)
- Hears voices saying *"they're out to get you" "they are in on" "you need to stop them or they will ruin you"* (auditory hallucinations)
- Smoking cannabis regularly for several years, recently increased his use to "help deal with the stress"
- Hospitalized after causing a disturbance during an exam; yelling in a verbally aggressive and disorganized way, that he knows they are all in on it; appeared disheveled, hadn't showered in some time, lost a lot of weight
- After inpatient hospitalization, prescribed antipsychotic, discharged home to family, and referred to STEP…

# Case Discussion

- What should you consider in the following areas?
  - Initial screening/assessment
    - Any differentials to consider?
  - Engagement strategies
    - Potential barriers?
  - Initial treatment considerations
    - Therapeutically?
    - Medication?