INFORMATION BRIEF

Outreach for First Episode Psychosis

EXAMPLES FROM THE FIELD FOR STATE AND AGENCY ROLES

2017

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Introduction: 'Recipes' for Outreach and Public Education Efforts

There are several distinctive features of programs that are designed to serve people experiencing their first episode of psychosis (FEP). Perhaps most distinctive among these is the systematic outreach to community partners in order to educate them about psychosis in order to facilitate timely linkage of persons with FEP to evidence based services. Education often includes information about the signs and symptoms of psychosis and dispels myths about severe mental illnesses. It is important that community partners understand that: evidence based interventions are available in their community; these programs have been demonstrated to effectively engage and treat individuals experiencing a first episode; and with effective treatment recovery from these conditions is the expectation. Delaying access to specialized care may increase the risk of suicide and potentially result in more intense symptoms, deteriorating functioning, and increased social isolation. It is therefore critical to reach individuals as early in their first episode as possible. Engaging a wide range of community partners to recognize the signs and symptoms of early psychosis and to link individuals to effective care is therefore an essential feature of FEP programming.

Some of the earliest signs and symptoms of psychosis can be best observed by individuals who are in regular contact with someone who is becoming ill. Since first episode programs typically focus on individuals in the age range of mid-teens to early adulthood, teachers, family members and co-workers are the most likely to detect early indicators of illness and can thus be critical outreach partners. Without education, they may misinterpret these signs and not take any action. Additionally, persons experiencing psychosis may come into contact with law enforcement, as well as the various components of the health care system where individuals may seek care (e.g., primary care, emergency or crisis services, as well as inpatient settings). The goal of outreach, then, is to devise a plan that maps out the various portals though which an individual may be identified and to systematically reach out to representatives of each of these portals in order to provide education about psychosis and the ways in which individuals seen in these settings can be effectively approached and linked with specialty care. Engaging these clients in care can require age and developmentally appropriate approaches including language and media. Since FEP programming seeks to shorten duration of untreated psychosis (DUP), and since multiple pathways to care may be used, it is critically important that an effective outreach and public education effort be designed and executed.

In order to document how effective outreach and engagement might occur, the authors conducted a series of interviews with both state officials who oversee the development of FEP programs, as well as local agency personnel who operate them, to understand the strategies and processes that are involved in their respective outreach efforts. The interviewees represent systems and settings that vary in several important dimensions. Some of the FEP programs are rural in areas, others in urban. Some of the outreach efforts discussed were part of larger marketing programs being conducted by the parent agency, while others were stand-alone efforts. Some built upon existing networks and relationships, while others were relatively new starts. From these interviews, the authors have extracted a series of 'recipes' that may be considered in designing and executing community outreach efforts.

1. Examples of outreach efforts at the state level.
2. Descriptions of strategies used by provider agencies.

It is intended as a companion piece for the *Guidance Manual: Educating Communities to Identify and Engage Youth in the Early Phases of an Initial Psychosis* which details lessons-learned from the PIER approach.

State Level Outreach for First Episode Psychosis

The role of the State Mental Health Agency (SMHA) in outreach for first episode psychosis (FEP) programs depends on a variety of factors that may be unique to each state.

Factors Can Include:

- Existing statewide public education efforts for mental health;
- The maturity of the statewide FEP programs and how broadly they are available throughout the state. The greater the number of program the more efficient a statewide effort can be;
- The state's relationship with the sites providing services
  - Including the degree of direct support and/or regulatory oversight; and
  - The purchasing and quality assurance processes;
- The state's relationship with other state agencies that may also provide services to (or come into contact with) the individuals who will receive the FEP services, such as the Department of Education; and
- How much staff time, funding, and other resources are available to devote to state-level outreach.

The elements of outreach may include the following:

- Building and maintaining a network of key relationships at the state level that create an accessible and effective system of identification and referral to first episode programs;
- Educating individuals in the network about the existence and effectiveness of the first episode programming and the importance of identifying individuals early and referring them to specialized services;
- Understanding the roles and responsibilities of other state entities (like vocational and educational services) and how state SMHA leadership can best facilitate the success of the program through interdepartmental collaboration;
- Educating the Medicaid authority and other payers about how outreach and engagement are key components of the FEP coordinated specialty care (CSC) treatment model; and
- Supporting and regulating provider agencies to assure that they are providing effective outreach and education activities which may involve training the agencies, developing educational materials, and/or establishing and monitoring outreach performance metrics.

What is the State's Role in Outreach?

There is no single way to approach outreach. Much depends on factors such as the SMHA's relationship with the FEP sites, the resources available to the state, and the SMHA's relationship with other relevant state agencies.

For a number of states, the set-aside funds are limited, and in many cases they comprise the entirety of the budget for FEP activities. However, set aside funds have been the driving force for expansion of these programs nationally, with Congress doubling the level of the set aside funds from 5% to 10% of the mental health block grant.

Devoting SMHA staff time to help FEP program sites develop their outreach efforts is a good investment. Since most states are contracting with programs that are part of their existing network of providers, SMHA staff familiar with them can best assist with program outreach development. It is likely that FEP related activities will be added to the SMHA staff's current responsibilities.

The greater the block grant resources, or the more state resources devoted to the program, the more SMHA leadership and oversight are likely to be devoted to outreach. Some states are able to devote staff whose sole responsibility is assisting the FEP sites in their outreach efforts. Many times the block grant coordinator is the point of contact for the set aside funds, as well as coordinating all other block grant activities.

Possible roles for the state include the following:

- Setting the overall FEP outreach strategy for the state;
- Contracting with vendors (e.g. OnTrackUSA http://practiceinnovations.org/OnTrackUSA and EASA http://www.easacommunity.org/) to train programs in outreach activities, and to develop outreach materials;
- Direct outreach by the state to the general public and to the wider healthcare and social services system(s);
- Creating statewide/common outreach materials for sites;
- Mandating outreach activities/staffing at the sites;
- Providing technical assistance to sites on outreach strategies;
- Acting as a liaison with other state agencies and state level organizations;
- Using state-wide data to identify potential service recipients and/or to predict the demand for FEP services statewide and by region; and
- Outreach to a state-level pediatric primary care/behavioral health integration organization or pediatric consultation helpline to share information about the FEP program to pediatric primary care. Thirty states have such an entity (e.g., http://www.mdbhipp.org/).

Strategies

State outreach methods vary from a strong, state-led approach to a much more decentralized model in which the service agencies have great latitude in developing their outreach strategies and activities. In states that are more directly involved, they often formulate an outreach strategy and may contract with national vendors to assist programs in developing their outreach efforts. Every state is different in terms of geography, population density and resources available to devote to FEP programs. The state's approach will depend on these and other factors. A few states, such as Oregon, are able to implement FEP programs statewide; others are able to implement programs in specific regions in the state; and some states with modest funds or very small populations may be limited to implementing only some components of FEP services rather than a full CSC program. The state's role in outreach may be adjusted to accommodate these differing program dimensions, which are strongly related to the resources available – either state or federal.

The public mental health system has traditionally focused on providing services to individuals with serious and persistent mental illnesses—often long term illnesses. While community mental health providers may be well known in their community as the safety net for individuals with serious mental illnesses, the development of new FEP services and the availability of these services for young people experiencing FEP are likely unknown to important parts of the community. New FEP programming designed to reduce the duration of untreated psychosis likely requires fresh outreach activities to venues that serve clients who may be new to the public mental health system, such as schools. State leadership in helping to conceptualize the agency strategy and support its work is particularly important.

Outreach in an urban setting can be far different from outreach in a rural or frontier setting, where transportation may be limited and/or time consuming. In some states, collaboration among departments of state government is a tradition, while in others it may only be a goal (and not everyone's goal). For example, Maryland's SMHA is part of an ongoing, statewide consortium with university based colleagues who have focused on children's mental health issues for several years (see http://www.mdbhipp.org/). The consortium provided an outstanding venue to introduce the FEP programming to a statewide audience with experience working together. To the degree to which this sort of consortium exists, it can provide an excellent venue to feature the FEP program and to integrate it into other efforts.

DIRECT OUTREACH BY THE STATE

Some states are directly reaching out to the possible referral entities that may be related to other agency activities.

Statewide outreach activities include:

- Statewide helpline to refer people to services;
- State website and online marketing program (see for example https://marylandeip.com/);
- State-level outreach to pediatric primary care and psychiatric providers;
- Explaining the importance to early FEP treatment to state agencies such as the Department of Rehabilitation, Child and Family Services, Justice-related agencies, and the State Board of Education;
- Organizing or presenting at state-level conferences;
- Creating a statewide advisory board and/or engaging with the sites' advisory board related to FEP; and
- Using state or large provider/insurer databases to determine the level of unmet need for FEP services.

OUTREACH MATERIALS

Sites typically use outreach materials, such as fliers, brochures, presentations, hospital cards, etc. that let the public know that the program exists, what it does, and how they can be contacted. If states are implementing programs in multiple locations, it can be advantageous to adopt a strategy that maximizes resources by using a common program model, developing common outreach materials, and even developing a statewide FEP program related presence, such as a website.

Materials that have been developed by states include:

- Brochures;
- Fact sheets;
- Materials specific to referral sources;
- Presentations; and
- Cards that provide hospital staff with ready information about their local FEP programs.

As the state, and perhaps the contracting agency, SMHAs are in a strong position to develop common materials that may be used statewide. The degree to which the materials are common can range from just the design (branding), to the use of a single contact presence, including website, email address and phone number. Having a common point of contact for FEP services may work best when FEP programs are broadly implemented in the state. If services are only available in limited areas, statewide outreach may create demand for which no service supply currently exists. Educating consumers and families about what should be available to them, however, may stimulate citizen advocacy for service expansion.

LIMITED IMPLEMENTATION

If the state only has resources to develop one FEP program, several FEP programs that do not cover all regions of the state, or just enough funding to expand the availability of the evidence-based subcomponents that make up dedicated CSC FEP programs, the state still can play an important role in supporting and encouraging outreach by the participating programs. This may include developing or obtaining outreach methods and materials.

MANDATING OUTREACH ACTIVITIES

Some states mandate that their FEP sites conduct outreach. For example, requiring that a certain number of contacts be made per month or per year. Others require sites to achieve outreach targets with funds tied to performance standards, including reporting on the types and number of outreach attempts. One state respondent noted that their SMHA encourages, but does not require, that the sites employ outreach coordinators, which they feel is especially important for their rural, low population density sites.

USE OF PEERS

Individuals with lived experience (e.g., persons who have experienced FEP, as well as others with experience navigating the service system, including family members) are likely to have a role in outreach at the site level, but they can also be useful at the state level. States have included peers on their advisory boards and central planning teams, and in some states they have been instrumental in improving the quality of the outreach materials that have been developed. Some states have mandated the hiring of peers, or at least encouraged their use by programs.

EVALUATION OF OUTREACH ACTIVITIES

There are two basic things to look at when evaluating the activities of sites and of the state agency (assuming that the agency is also directly participating in outreach): ***Process and Results***.

Evaluating *Process* can include the following:

- Number of contacts, currently and compared to prior periods;
- Referral sources contacted, currently and compared to prior periods;
- Types of contacts, currently and compared to prior periods;
- Caseload of sites, currently and compared to targets and to prior periods; and
- Duration of untreated psychosis for clients accepted into a site's program.

It can be helpful to track the sources of referrals, especially for new programs that do not already have a track-record. The sources of referrals may vary greatly depending on the characteristics specific to a site. Many of the referrals may be internal, meaning from within the other programs operated by the entity running the FEP program. Referral

data can include the source, the quantity of referrals, and the percentage of referrals that meet the inclusion criteria for the FEP program. Some sites believe that all referrals, whether or not they meet the inclusion criteria, reflect success because, while they may not be able to help the person through the FEP program, they facilitate further referrals to appropriate programming. The advantage of having an inclusive approach is that outreach need not be specific to the FEP program but can be a part of an overall outreach strategy for an agency highlighting their array of services. In this way, FEP outreach is like a product extension.

Evaluating *Results* can include the following:

- How productive each referral source is in generating a site's caseload, absolutely and relative to other referral sources;
- The factors related to the successes or challenges of a site's outreach efforts;
- Changes over time in the duration of untreated psychosis for clients accepted into a site's program;
- Whether or not a site's age range target or other inclusion criteria needs to be modified; and
- Whether or not a site's service area is too small or too large.

USE OF DATABASES AS AN OUTREACH TOOL

One state has begun to explore the use of state level databases to determine the level of unmet need for FEP services by developing algorithms to identify individuals who appear to be experiencing psychosis and therefore may be appropriate for FEP services. There is also some discussion of using data from large integrated health systems to identify individuals who are experiencing their first episode of psychosis and who might be targets for outreach activities. While many issues will need to be addressed before these approaches may be operationalized (privacy not least among them), the access to more comprehensive data systems is potentially a valuable tool for understanding the effectiveness of population based outreach strategies.

Summary

In summary, the degree of state involvement in the outreach activities was generally proportional to the level of program dissemination throughout the state. States with relatively larger block grants−or that supplemented block grant resources with state general funds− usually were more actively involved with supporting programmatic outreach efforts. States with fewer resources may have served a brokering role in which they linked programs to national resources (e.g. EASA, OnTrack) but often were less directly involved.

With some exceptions, state SMHA staff did not outreach to other state agencies regarding FEP programming. State vocational, housing and income support services, for example, typically were not recruited into the efforts in a manner that might parallel outreach efforts that were occurring at the community level. This is an area, then, for potential growth/ expansion of outreach efforts.

The one exception was a state that already had an established multi agency/university workgroup that preexisted the FEP programming and addressed youth issues in general. In this instance, the FEP programming was added to the list of youth oriented programs throughout the state. This group also included links to a pediatric primary care group. It is our understanding that these pediatric groups exist in many other states and could be an outreach target for states and could help programs reach out to primary care.

One state has been considering the use of existing state data resources that could be used to identify individuals who are experiencing a first episode of psychosis. To the degree to which comprehensive data systems are available to the state and issues of confidentiality/consent can be addressed, these data sources might provide a valuable tool in identifying persons who could subsequently be informed about the availability of help through specialized programs.

As is often the case, we observed substantial variability among the states; but all of the respondents clearly understood the importance of early identification and referral and the critical role of outreach and public education to achieve these ends.

Program Level Outreach for First Episode Psychosis

The authors talked to eight agencies operating FEP programs in urban, rural, suburban and frontier areas. These programs operate in many organizational settings, including Community Mental Health Centers, a large multi-component health system, Community Service Boards, and stand-alone programs. The programs possess a range of experience, with the oldest program having been in operation for well over ten years, and the newest program still in the process of installation. The average length of operation among the programs interviewed is 19 months, excluding the one program in operation for over 10 years.

Outreach via Relationships

As mentioned in the introduction, outreach efforts are often organized around a map of the potential portals where individuals with FEP can be identified and referred to specialized programs. Building a relationship with each of these portals requires developing and implementing a systematic outreach strategy. Establishing and nurturing strong relationships across many of these portals is key to reaching clients early in their experience of a first episode of psychosis. One program we talked to follows each outreach visit with a thank you card to express gratitude for the outreach recipient's time.

Although some programs in areas with high population densities may be able to reach capacity through internal referrals (if they are part of a larger agency which operates clinics, crisis services, etc.), meeting the overall needs of the population may still require outreach to other community portals where individuals are likely to be seen. Public education and targeted outreach can increase overall community awareness of FEP and develop a commitment to identifying and serving individuals promptly and effectively. Expanding outreach beyond the FEP program's agency can help to demonstrate unmet need for FEP services in the community, which can then be used to argue for the expansion of the program or the establishment of additional FEP program(s). Testimonials from individuals and families who are identified through contacts outside of the host agency can be powerful in legislative settings and support program expansion. For programs that are not closely associated with a larger agency and that may serve lower population density areas, close relationships with community stakeholders is even more crucial.

Over time, as outreach efforts and the relationships they nurture take root, FEP programs may find that they are receiving numerous referrals without doing as many active outreach efforts. One program, which has been in operation for over ten years, indicated that they do not need to do much active outreach to maintain their client population. They are well known within their community, by the police department, among the hospitals, and by schools and colleges. Even so, they still do frequent presentations and participate in trainings for the police department to accommodate turnover and the addition of new service agencies, physician practices, or specialty services in their area.

General Strategies:

DEMAND SIDE AND SUPPLY SIDE[1]

Researchers in Norway studied the sources of delay for individuals experiencing FEP and conceptualized them as involving both "demand side" and "supply side" elements.

On the demand side, individuals experiencing FEP and their families perhaps don't know about treatment options or don't seek treatment. The TIPS FEP treatment program in Norway used a mass and social media campaign to target this source of delay.

On the supply side, health professionals, especially Primary Care Physicians (PCPs) and other first points of contact in the health system, may not be referring clients to appropriate FEP treatment. Addressing this gap requires outreach to the professional community to make sure that they are aware of FEP treatment, its efficacy, and how its efficacy is inversely related to the length of the delay in receiving treatment.

When TIPS addressed these two sources of delay in targeted outreach campaigns, they reduced DUP by half. [2]

BEING EMBEDDED WITHIN COMMUNITY SYSTEMS

There are several contextual factors that strongly impact how outreach is conceptualized and delivered. One is the placement of the CSC program within the larger service community.

As noted earlier, programs that are part of a larger service agency can take advantage of their placement by leveraging existing organizational ties to gain easier access to health and behavioral health colleagues within the agency.

Most of the programs we talked to receive a significant percentage of their referrals from within the CMHC, behavioral health agency, or managed care organization in which they are housed. If an FEP program is part of a larger entity, outreach within the parent agency is critical (i.e., ensure that all internal stakeholders are aware of the specialty program, educated about FEP, and know how to refer).

Also, when discussing the FEP program with representatives from other parts of the broader agency, it can be fruitful to ask for aid in making connections with outside stakeholders that could facilitate the process of raising awareness and increasing referrals.

One program indicated that their team's psychiatrist also worked in the psychiatric unit of the local hospital, and that psychiatrist's hospital colleagues (being aware of his role in the CSC program) would usually refer suspected cases of first episode psychosis to him. Another CSC program is part of an agency that has a mental health team in the local jail, allowing them to easily identify individuals in that setting and link them to the CSC program.

[1] Thank you to Dr. Vinod Srihari of Yale's STEP program for introducing us to this concept.

[2] http://www.tips-info.com/wp-content/uploads/2009/11/the_TIPS-study_with_5_year_LME_analysis.Molde_april_09pdf.pdf

WHO CONDUCTS THE OUTREACH?

In several programs we interviewed, the entire team participated in outreach efforts. This was especially true during the startup phase of the program, but also characterized some respondents' plans to keep the whole team focused on relationship development, maintenance and public education. In many teams, even if all team members would occasionally assist in outreach efforts, one person was primarily responsible. Usually this was the team leader; but in two programs, the supported education/employment specialist was responsible for most outreach efforts. One respondent−an agency director with many connections in the community and who is very passionate about the program−has assumed a key role in outreach for the FEP program. A respondent in a large agency noted that they have a dedicated marketing budget. This greatly facilitated outreach both within and outside of the agency since the CSC program could be embedded in current marketing materials and programs.

One program makes extensive use of peers and family members in their outreach efforts and has found them to be particularly powerful, especially with family audiences. Several other programs indicated that peers participate in outreach, but have a greater role in client engagement.

Programs that made use of multiple team members for outreach efforts indicated that the staff member used was determined by the target audience. For example, a supported education/ employment specialist might do outreach to schools, and a psychiatrist might do outreach to other psychiatrists or to primary care physicians.

Programs may also hire full-time outreach coordinators. One program indicated that they are planning to hire such a coordinator; and one state indicated that one of its FEP sites has hired an outreach coordinator, which has greatly improved their outreach efforts. This SMHA has encouraged other programs in the state to do the same and will allow them to build in the cost of an outreach coordinator into their contracts with the state (which is critical since outreach and public education are an essential function that is usually not billable).

USE OF PROMOTIONAL MATERIAL

Programs varied in the use of promotional material, with several programs not using any, some programs providing pens and stickers, and one program providing pens, hand sanitizer, USB sticks, chap stick, flashlights, mugs, glasses, stress balls, chip clips, t-shirts, and power banks (to charge phones and electronics while on the go). Another program gives away branded cozies and finds them to be popular. Funding availability in leanly resourced teams was often the determining factor. Those that used 'swag' thought that it helped in outreach efforts.

Use of promotional material is part of relationship building. If a program is able to purchase (or acquire) it, it is important to keep in mind the target audience and to choose the most appropriate items. Over time program representatives may be meeting with stakeholders more than once. For the program that makes wide use of this practice, the better the relationship, the better the promo.

Also, remember that promo items should be given out with informative materials that explain the program. Ensure that materials are branded similarly (matching colors and/or logo) to the website and program brochures. This allows all of the items that are distributed to reinforce the brand position of the program, linking educational and promotional material.

OUTREACH TO RACIAL, ETHNIC AND LINGUISTIC MINORITIES

Several programs indicated that they have Spanish-speaking staff members who greatly facilitated outreach to individuals of Hispanic heritage. According to these programs, for Spanish as well as other languages, the language barrier is generally more of an issue for the consumer's family, rather than the consumer.

In diverse areas, having a diverse treatment team was seen by two interviewed programs as an asset for outreach to minorities, whether racial or linguistic. One program in an area with many refugees indicated that working with ethnic community leaders (often most accessible through churches, synagogues, and mosques) was also useful in helping overcome stigma about seeking help for mental illness that may be especially acute in some cultures.

ARE INAPPROPRIATE REFERRALS A PROBLEM?

Since the ultimate goal of outreach is to stimulate early identification and referral to FEP/CSC programs, it may be accompanied by inappropriate referrals – especially in the early stages of outreach. Some respondents saw this as a problem, especially when the referral was from another specialty provider. Clear, quick and responsive feedback to other specialty providers was used to educate them regarding the target population for the CSC program. When the referral came from outside of the specialty sector, programs generally did not view inappropriate referrals as an issue and felt it was important to accept all referrals and redirect them to appropriate services. One respondent noted that it is not the non-specialty community partner's role to make diagnostic distinctions, and so they take it upon themselves to appropriately link clients ineligible for FEP services to other services. Feedback to the referring individual or agency was seen as important to both clarify the target population for FEP services and to be seen by the referral source as responsive. Some FEP programs we interviewed are part of larger behavioral health agencies and thus could redirect clients easily internally.

Both approaches can make sense. While ideally there is no "wrong door," it is also important that a program reaches those it can best serve. Several programs who were receiving many inappropriate referrals for FEP services indicated that most of these inappropriate referrals were coming from one or two community partners. After providing a further educational presentation to these partners about the signs of FEP, inappropriate referrals fell substantially.

Portals:

Below we discuss the various places where individuals may be identified and referred, including self-identification and referral. Mapping these various portals for your community can be among the first tasks of developing an outreach program.

ONLINE

An online presence can be an important part of one's outreach effort. Optimizing a program's website and social media presence can make it easier for consumers, families, and other stakeholders to find out about available services and to refer people to them.

Dedicated FEP Provider Website

Several programs indicated that consumers and their families discovered their program through an internet search. In order to increase the chance that an internet search by area consumers and families will lead to a program's website, it is important that the website be optimized for search engines. This means the text on the website should contain the keywords that consumers and families are using to search. The area that the program serves should also be clearly stated. Remember, search engines use programs (bots) to read a website, and when someone searches the internet it will attempt to match their search terms to keywords found on that website. Also, the more other websites that contain links to a program's site, the higher it will rank in search results. An FEP program can encourage partners and state agencies to include a link to its website on their websites. One program indicated that they hired someone for a few hours a week to ensure that their program would appear high in a Google search of common FEP-related keywords for their region.

Programs should make it easy for consumers, families, and other stakeholders that find their websites to take next steps. When a family locates an FEP provider on the web, they may be desperate for help. One program includes their referral form on their website and allows anyone to submit referrals. This allows the program to direct all community partners to the referral form and allows them to share it among their network, but it also empowers consumers and families to refer themselves or loved ones. Regardless of the presence of a form, programs should be sure to include ordinary contact information (phone number, email address) to make access as easy as possible.

Social Media

Social media outlets (e.g., Facebook, Twitter) are also important components of an online presence. They can provide a powerful gateway to reach consumers, families, and other stakeholders and to make connections that can lead to the program website and/or to more formal connections. One program filmed several clips about their supported employment services for local television and then put them on YouTube. Another respondent noted that for their program's social media presence, they rely on YouTube because people spend more time on it when they want to learn; and they post videos that explain what treatment is like.

For a social media presence to be successful it needs to be active, with regular and frequent posts. However, as one interviewee pointed out, it is important to keep in mind that the popularity metrics that social media platforms employ are ultimately designed for the platforms themselves to boost sales. This program monitors how often their materials are shared, as that is an explicit measure of community members finding their outreach materials to be useful or compelling.

CRIMINAL JUSTICE SYSTEM:

Since the police are often first responders to individuals in psychiatric crisis, the criminal justice system contains many possible portals to target outreach. Several programs indicated their concern regarding association with involuntary care that may often accompany police or court involvement. In a well-resourced state, one respondent worked closely with the social worker who was attached to a Crisis Intervention Team to facilitate linkage and minimize coercion. Outreach within the criminal justice system ranged from extensive to none at all and likely will depend upon the nature and type of crisis services that may be available following police involvement. Similarly, relationships with crisis response teams are critically important.

Jails

One program was part of an agency that operates behavioral health services in the local jail. This allowed them to work with their colleagues to do outreach within the jail. Another program does outreach to the jails as part of a larger outreach initiative with the public defender's office. Although most programs are not so well placed for outreach into jails, jail administrators can be very grateful for information about FEP. Most jails in larger communities are likely to have mental health treatment provided in the jail. These specialty services could prove to be an important source of identification and referral.

Specialty courts

Mental health courts: Several programs indicated that they have done outreach to mental health courts and received clients from them. Depending upon the characteristics of the court, concerns with coercion, as discussed earlier, may also be relevant here.

Veteran's Courts: None of our respondents indicated outreach to Veteran's courts which may be a reflection of assumptions about the role of the Veteran's Administration in serving these individuals.

Public defender's office

One program has developed a strong rapport with their local public defender's office. They reported that the public defender was excited to learn about FEP services that could be a valuable benefit to their clientele. This program meets monthly with the public defender's office.

Prosecutors

None of the respondents specifically mentioned outreach to prosecutors' offices. Given their work with the public defender's office, no outreach may be needed for indigent clients served by public defenders. However, for persons who might have private counsel, making the prosecutor's office aware of the specialized services might help to identify persons who are criminally involved as a result of a first episode of psychosis.

Police department

One program participates in an annual training event for police officers in addition to participation in Crisis Intervention Training, as detailed below.

Crisis intervention teams

Three programs indicated that they are part of the crisis intervention training in their communities. These trainings reach police officers, EMS staff and paramedics, and firefighters, among others. They provide information about the signs of psychosis and what the psychotic experience is. Providing this type of education is both a valuable service to the police department and useful outreach for a program. Programs should ensure that all crisis intervention team members are aware of their services, as well as the places to which CIT teams may bring persons in crisis (e.g., emergency rooms, crisis hostels, etc.). As mentioned earlier, for CIT teams with a mental health professional on staff, it is likely to be particularly important to work with that person.

HIGH SCHOOLS

All respondents indicated that outreach to educational settings is critical, but that the responsiveness of these settings – especially high schools – was quite variable. One program indicated that the high schools in their service area all contract with a single agency to provide health counseling services. Outreach to this agency was positively received. The CSC program provided information through this contractor so that guidance counselors, school therapists, and teachers will know how to complete a referral if they feel that a student may need FEP services. One program has a school-to-work transition coordinator who provides outreach to both schools and the foster care system.

One respondent indicated that their site does outreach to a high school when a student from that school is part of their program.

High School Students

One program indicated that they hosted a table at a high school fair and received an enthusiastic response, since the high schoolers were very interested in the candy that they were handing out. Another program makes use of program graduates to perform outreach to high schools.

Counselors/Social Workers

Three respondents indicated that they reach out to high school guidance counselors in their initial outreach to high schools.

Teachers

One program indicated that it sends a school-to-work transition coordinator to schools who can speak to teachers or other transition workers about their program. This is an example of using established relationships with the schools that could include these vocationally-focused individuals and/or school health clinics rather than attempting to develop relationships with the schools *de novo*. Outreach through these channels can greatly reduce the necessity to get permission from each school and the district individually.

COLLEGES AND UNIVERSITIES

The experiences of programs engaging in outreach with higher education varied. Some programs found universities and community colleges to be very receptive to their outreach efforts, while others found them to be less so. Often, community colleges were seen as more responsive than four year colleges and universities. One program indicated that attempts to set up a meeting with leaders of the university's counseling center were rebuffed, and they were just allowed to leave brochures. However, another program indicated that the local university counseling center was very receptive.

Informal outreach with universities may be done through accepting interns from the university at one's program site. For example, a respondent indicated that their program accepts interns from the local university's college of social work. Another program accepts doctoral externs from the psychology department of a local university. This process allows students to learn about first episode programming, while also informing faculty supervisors about the program. This strategy both alerts the faculty to the program and introduces concepts of CSC/FEP into the curriculum informally.

Outreach to social work departments can also potentially provide additional benefits when graduating social workers take positions in the community. This is the impetus behind one program's outreach to their local university's social work department.

Some programs were very creative with these outreach strategies. One program put stickers with their contact information onto packages of ramen noodles (donated by a local grocery store) and handed them out at a tabling event during freshman orientation at the local college. In exchange for the noodles, the student heard about psychosis, its signs and symptoms, the existence of a treatment program and how to contact it. The program also distributed t-shirts with their name and logo to students. Respondents indicated that for each event at a college, they receive several referrals.

Community colleges

One program indicated that a local community college was stand-offish until the program was able to help them with a student experiencing psychosis. That event (in which the FEP team demonstrated their understanding of psychosis and the ability to effectively aid the school) established a strong relationship between the program and the college, which allowed the student to remain in school.

CHURCHES AND OTHER RELIGIOUS ORGANIZATIONS

Churches are central to the lives of many in the community; and clergy are often familiar with, and trusted by, congregation members. They are thus well positioned to both notice the changes in behavior that can signal the onset of psychosis and be a trusted confidant to their congregants. One program will periodically meet as a team, then go to a town in their service area and canvas the churches, talking to pastors when they are available and leaving a folder containing materials about the program. They will follow this up with a phone call and further visits, if the pastor expresses interest. They also make themselves available to address the congregation, if the pastor is willing.

HOSPITALS AND EMERGENCY DEPARTMENTS

Hospitals are always one of the key points for the identification of individuals with first episode psychosis. Inpatient wards and emergency departments are particularly important with key staff – like discharge planners and nurses, and are useful points of contact.

Hospitals are very hectic environments. Facilitating easy and timely referrals will help in outreach to hospitals. One program has a special email address that they give to their contacts in hospitals to highlight their referrals and to ensure an effective response from the program.

Psychiatric units

One respondent's program is part of an agency that staffs behavioral health staff within local hospitals, which allowed them to easily do outreach within the hospital system.

Discharge planners

Two programs with whom we spoke specifically target hospital discharge planners in their outreach efforts. One program created magnets that list the signs of psychosis and has their contact information, which they leave in discharge planners' offices (when they visit, they just stick it on the discharge planner's filing cabinet). Another program sends letters and brochures to hospital discharge planners, as well as trying to do outreach with them over the phone.

Social workers

One site indicated that they usually perform outreach to hospitals by contacting hospital social workers and scheduling a meeting at which they present information about psychosis and explain how high risk patients may be aided via referral to the program.

HEALTH PROFESSIONALS OUTSIDE OF HOSPITAL ENVIRONMENTS

Primary care physicians

Although all respondents felt that outreach to primary care physicians is important for their programs, several interviewees noted that it can be difficult. One indicated that, while it was difficult to reach physicians individually, they have met with more success doing presentations to organized practice groups. Another program reaches out to practitioners through a physicians' group run by their local coordinated care organization.

Small/individual practices

Two programs indicated that they walk in to physicians' offices and discuss FEP with nurses and the physician, if he/she is available. They often leave brochures. One program that we talked to said that they have a small brochure stand: they ask if they can leave it in physician's offices, and then they periodically restock the informational materials.

Physicians within hospitals or large practices

Programs often work with other members of the treatment team, such as hospital discharge planners or social workers (mentioned above) to reach physicians within hospitals or large practices and ensure that they are aware about FEP treatment options.

INDIVIDUAL MENTAL HEALTH PRACTITIONERS (THERAPISTS, PSYCHIATRISTS, AND PSYCHOLOGISTS)

One provider was in the process of setting up a program to cover several rural counties. They indicated that their initial outreach within the community was met with some hostility among local individual practitioners, who had theretofore been some of the only behavioral health providers in those counties. These individual practitioners worried that the program would take clients and endanger the practice economically. After meeting with several of the practitioners, the provider reached a more amicable arrangement through which (for those individuals already seeing a local practitioner when they enter the program) the community clinician is incorporated onto the FEP treatment team if they wish, thereby capitalizing on the clinician's existing relationship with the client. This may be particularly beneficial in rural or less well served areas since the therapists can assist in ongoing support and crisis availability contingent on their willingness to work within the team's fidelity parameters. It also will introduce community clinicians to this evidence based practice.

MANAGED CARE ORGANIZATIONS

One program is part of the network of a managed care organization (MCO) in a large metropolitan area. For six months when the program started, the program and MCO staff took an active role in engaging in outreach among its network of providers. They reported that this was important for raising awareness among their network partners, and that it was a successful effort. Broader community outreach was expanded as the FEP program matured.

Other Strategies

BOARDS OF DIRECTORS

As one respondent noted, the board of directors can be an invaluable aid to outreach efforts. Many board members for that program were well-connected professionally within the community in their capacity as current or former judges and doctors, as well as their participation on the boards of other organizations such as hospitals.

HEARING VOICES SIMULATION

One program mentioned that they have had a positive response at outreach events when they have done a hearing voices simulation. For this event, they ask participants to perform a relatively simple task (e.g., arithmetic or sorting playing cards), and after they have begun that task, a recording is played of the types of voices commonly heard by people experiencing psychosis. This can also be done while at an information booth, where headphones can make the simulation more realistic and powerful. This program also recommends the Hearing Voices app, produced by the University of Chester and the University of Manchester, which provides a simulation of this type of auditory hallucination. [It is available for Apple iOS and Google Android.]

Summary

Clearly, a wide variety of strategies are used in these eight programs that respond to their local circumstances and resources. The overarching theme, however, is the importance of systematic and thoughtful outreach to the portals where persons with FEP are likely to be seen. Mapping and diligently pursuing individuals in these settings requires persistence and creativity. It was clear from the interviews that FEP programs that persisted were well integrated into their communities and effective in broadening the net to more quickly identify persons in need.

Links:

Early Assessment and Support Alliance (EASA): http://www.easacommunity.org/

Early Psychosis Intervention (EPI): A Role for Everyone Early Identification: http://www.earlypsychosis.ca/pages/everyone/early-identification

Maryland Early Intervention Program (EIP): https://marylandeip.com/

Mind Map (a local marketing campaign in Connecticut that combines professional outreach with public education using social and mass media to shorten pathways to care): http://mindmapct.org/

NAVIGATE: http://navigateconsultants.org/

OnTrackUSA: http://practiceinnovations.org/OnTrackUSA

RA1SE: https://raiseetp.org/studymanuals/index.cfm

Specialized Treatment Early in Psychosis (STEPS): https://medicine.yale.edu/psychiatry/step/

Selected Resources on the NASMHPD Early Intervention in Psychosis Website:

- Fact Sheet: Implementation of Coordinated Specialty Services for First Episode Psychosis in Rural and Frontier Communities: https://www.nasmhpd.org/sites/default/files/Rural-Fact%20Sheet-_1.pdf
- Guidance Manual: Peer Involvement and Leadership in Early Intervention in Psychosis Services: From Planning to Peer Support and Evaluation: https://www.nasmhpd.org/sites/default/files/Peer-Involvement-Guidance_Manual_Final.pdf
- Information Guide: Steps and Decision Points in Starting an Early Psychosis Program: https://www.nasmhpd.org/sites/default/files/KeyDecisionPointsGuide.pdf
- Information for policy makers: https://www.nasmhpd.org/content/information-policymakers

- Manual: Educating Communities to Identify and Engage Youth in the Early Phases of an Initial Psychosis: https://www.nasmhpd.org/content/information-policymakers
- Recognizing and Helping Young People At Risk for Psychosis: https://www.nasmhpd.org/sites/default/files/EDIPP_Booklet_2014.pdf
- A Toolkit for Educating About Psychosis: https://www.nasmhpd.org/sites/default/files/EDIPP_Toolkit_2014.pdf
- Webinar: Community Outreach and Prevention as an Element of Early Intervention in Psychosis: https://www.nasmhpd.org/content/tacs-webinar-8-community-outreach-and-prevention-element-early-intervention-psychosis-july
- Webinar: Methodological and Practical Issues in Population Based Programming: Incidence, Engagement, Penetration & Outreach Effectiveness https://www.nasmhpd.org/sites/default/files/Sept%208%20PPT%20-%20OH%20Presenters%20slides%20handout.pdf