Introduction to Early Identification and Classification Across the Psychosis Spectrum

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Learning Objectives

• Describe the mental health disorders in which a person can experience psychosis spectrum symptoms

• Recognize and be able to screen for early signs and symptoms of psychosis

• Consider the impact of substance use and social determinants of health on the identification, referral, and care-seeking behaviors of individuals experiencing early psychosis
Early Identification and Intervention

• Many individuals experience distressing psychosis symptoms before they present for clinical care (or while they are in care for other conditions)

• Early symptoms are distressing and can interfere with a young person’s life goals
  • The longer these symptoms go untreated, the harder it may be to recover

• Early identification can help us better understand and treat the earliest stages of psychosis
What is Psychosis?
The diagram illustrates the stages of illness with a focus on worsening severity of signs and symptoms over time. The stages are divided into premorbid, prodromal, syndromal, and chronic or residual phases.

- **Premorbid**: No or few symptoms.
- **Prodromal**: Attenuated symptoms.
- **Syndromal**: Psychotic symptoms.
- **Chronic or Residual**: Psychotic symptoms, negative symptoms, cognitive symptoms, functional disability.

The timeline includes birth, puberty, and years 30 to 50, with early intervention and prevention of progression emphasized.

Key terms highlighted include:
- Etiology
- Plasticity
- Treatment

Slide courtesy Bob Heinssen, NIH
Psychosis Symptoms – First Episode Psychosis Stage

Positive
- Delusions
- Hallucinations

Negative
- Affective flattening
- Anhedonia
- Avolition
- Alogia

Disorganized
- Speech
- Behavior
Psychosis Symptoms

• Conceptually - gross impairment in reality testing and lack of insight
  • Gross impairment in reality testing:
    • delusions and hallucinations
  • Lack of insight:
    • inability to recognize or understand problem
Delusion

• Fixed belief
• Based on incorrect inference about reality
• Held strongly DESPITE
  • obvious evidence to the contrary
  • what almost everyone else believes
Some Types of Delusions

• Delusions of Reference – belief that events occur in reference to person - e.g., people talking in public refer to him/her

• Persecutory Delusions – belief that others are "out to get them"; being tormented, followed, tricked, spied on, or subjected to ridicule

• Grandiose Delusions – belief that one possesses exaggerated power, abilities, importance
Some Types of Delusions

- **Somatic Delusions** – belief that something is wrong or changed about one's body

- **Delusions of Guilt** – belief that one has done something terrible, sinful, unforgivable

- **Delusion of Control** – belief that actions, impulses or thoughts are controlled by outside agency (e.g., arms forced to move) (thought insertion, thought withdrawal)

- **Thought Broadcasting** – belief that one’s thoughts are audible to others
Hallucinations

• Sensory perceptions that occur without any actual external stimulus, but have compelling sense of reality.
  • Auditory
    • Can be any sound, but voices common in schizophrenia
  • Visual
    • clearly formed images (e.g., people) or unformed images (flashes of light)
  • Tactile – bodily sensation
  • Olfactory – perception of odor
  • Gustatory – perception of taste
• Contrast to illusion
Exercise: Hallucinations

• Jot down your observations of your auditory perceptions. What do you hear?

What is it like to hear voices?
Other Schizophrenia Spectrum Symptoms

• Disorganized speech
• Grossly Disorganized Behavior
• Catatonic Behavior
• Negative Symptoms
DSM-5 Mutually Exclusive Disorders* With Psychosis Symptoms

- **Schizophrenia Spectrum and Other Psychotic Disorders**
  - Schizophrenia
  - Schizophréniform
  - Schizoaffective
  - Delusional Disorder
  - Brief Psychotic Disorder
  - Psychotic Disorder due to Another Medical Condition (AMC)
  - Substance/Medication Induced Psychotic Disorder
  - Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
  - Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

- **Major Mood Disorders**
  - MDD with psychotic features
  - Bipolar Disorder with psychotic features

*at a given point in time
Schizophrenia

- psychosis symptoms
- major depressive episode
- manic episode

> 6 months
Schizophreniform

- Black: Psychosis Symptoms
- Blue: Major Depressive Episode
- Red: Manic Episode

>1 month but < 6 months
Schizoaffective Disorder

- **Psychosis Symptoms**
- **Major Depressive Episode**
- **Manic Episode**
Delusional Disorder

Delusions ONLY

>1 month
MDD with Psychotic Features

- Psychosis Symptoms
- Major Depressive Episode
- Manic Episode

The diagram indicates a major depressive episode with psychotic features, excluding a manic episode.
Bipolar Disorder with Psychotic Features

- Psychosis Symptoms
- Major Depressive Episode
- Manic Episode
“Other Specified” or “Other Unspecified” Schizophrenia Spectrum and Other Psychotic Disorder

• Anything psychotic that does not meet full criteria for other disorders, causes significant distress/impairment
• Other Specified: Clinician chooses to specify the reason
  • Example: Persistent auditory hallucinations but no other symptoms
• Other Unspecified: used when clinician chooses not to specify the reason the criteria are not met
  • Examples: not enough information or contradictory information
Other *Non-Mutually* Exclusive Disorders

- Autism Spectrum Disorders
- Post-traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Borderline Personality Disorder
- Schizotypal Personality Disorder (or Schizoid, Paranoid)
- Substance Related Disorders
Psychosis as a Continuum in the General Population

Fig. 4. Psychosis: variation along a continuum.

J. van Os et al.
Traditional Strategy for Identifying, Studying and Treating Psychotic Disorders

Adapted from Knowles, 2004
Clinical/Ultra High Risk Strategy for Identifying, Studying and Treating Psychotic Disorders

Adapted from Knowles, 2004
Clinical High Risk Stage - Subthreshold (attenuated) Psychosis Symptoms

- **Attenuated Positive**
  - Unusual thought content or referential thinking
  - Suspiciousness or persecutory ideas
  - Grandiose ideas
  - Perceptual abnormalities

- **Attenuated Negative**
  - Reduced emotional expression
  - Decreased social interest
  - Low motivation
  - Trouble thinking abstractly
  - Trouble with occupational/school functioning

- **Attenuated Disorganized**
  - Odd speech
  - Odd or unusual behavior or appearance
  - Trouble with focus and attention
  - Impairment in personal hygiene
Features that Distinguish Subthreshold (attenuated) from Threshold Positive Symptoms

- Degree of conviction/meaning
- Degree of distress/bother
- Degree of interference with life (acting on, talking about, impairment from)
- Frequency, Duration, (“Amount” of) Preoccupation
Threshold v. Subthreshold: Troy

Troy is a 22-year-old, white male. Troy indicated that he experiences a “tugging” in his brain, which he described as a “force” that controls his thoughts. He had difficulty describing what the tugging sensation felt like but reported, “You know when magnets repel, it feels like that, that same kind of thing where they are slipping around. Convert that into my head.” He said he is not sure what or who “the force” is, or where it came from, but he reported full conviction in the force, and that it really bothers him when it forces him to behave inappropriately. He gave an example of an incident when his mother was being nice to him but then “I felt [the tugging]...and I got overwhelmed, its such a struggle to speak. It creates a tension, and I needed to get out and I screamed at my mom and had to run upstairs.” He rated his impairment for this sensation as a 9/10 because “I had to quit my job because of it”.

Jennifer is a 16-year old black female reporting that she hears her name being called about four times/month. She said this experience began in the past year, and can happen anywhere. She said she is unsure why it is happening, saying she “doesn’t know what to make of it.” She denied that it bothers her, but that it is “weird” – when she hears her name being called she often turns to look or asks someone if they heard it too (which they did not). She denied hearing any other words or sounds.

Adapted from McGlashan et al. (2010)
Signs of Possible Psychosis

- Often family and friends are the first to notice when the young person exhibits:
  - behavioral change
  - decline in school or work
  - social withdrawal or isolation
  - neglect of appearance or hygiene
  - odd behavior or appearance
  - reduced activity level
  - confusion or puzzlement
  - odd or disorganized speech
Probability of Transition to Psychosis in Individuals at Clinical High Risk
An Updated Meta-analysis

Gonzalo Salazar de Pablo, MD; Joaquim Radua, MD, PhD; Joana Pereira, MD; Ilaria Bonoldi, MD, PhD; Vincenzo Arioni, MD; Filippo Besana, MD; Livia Soardo, MD; Anna Cabras, MD; Lydia Fornea, MSc; Ana Catalan, MD, PhD; Julio Vaquerizo-Serrano, MD; Francesco Coronelli, MD; Simri Kaur, MSc; Joseette Da Silva, MSc; Jae Il Shin, MD, PhD; Marco Solmi, MD, PhD; Natasia Brondino, MD, PhD; Pierluigi Politi, MD, PhD; Philip McGuire, MB ChB, MD, PhD; Paolo Fusari-Poli, MD, PhD

*JAMA Psychiatry.* 2021;78(9):970-978.

\( k=130 \) \( (n=9,222) \)

Figure 2. Meta-analytic Cumulative Risk of Transition to Psychosis in Individuals at Clinical High Risk for Psychosis

Error bars indicate 95% CIs.
Psychosis Spectrum Symptoms in Adolescents

• Population based studies of children and adolescents
  • Rates of psychotic-like experiences (Kelleher et al. 2012 meta-analysis)
    • 17% of children age 9-12 years
    • 7.5% of adolescents age 13-18
  • Symptoms may be transient in most children
  • Evolution into persistent or worsening symptoms appear influenced or moderated by:
    • Severity of symptoms
    • Comorbid depression, anxiety, substance use
    • Traumatic or stressful experiences
    • Socio-economic disadvantages
    • Race
    • Genetic family history of psychotic disorders

• Emphasizes importance of early screening and intervention
The neurodevelopmental path of early psychosis leads to barriers in achieving a typical developmental trajectory. Interventions must facilitate an improved trajectory.
### Common Challenges Associated With Early Psychosis For Students

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Academic, Interpersonal and/or Environmental Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorganized thinking</td>
<td>Difficulty following lectures, tracking conversations, completing reading assignments</td>
</tr>
<tr>
<td>Perceptual experiences (e.g., hearing voices, seeing images)</td>
<td>Distraction while trying to concentrate during tests, exams, presentations</td>
</tr>
<tr>
<td>Suspicious or unusual thoughts</td>
<td>Anxiety or fear of others; challenges or withdrawal from relationships with friends, classmates, family, instructors</td>
</tr>
<tr>
<td>Cognitive problems</td>
<td>Trouble with memory, attention, planning</td>
</tr>
<tr>
<td>Depression and/or negative symptoms</td>
<td>Low motivation for self-care, exercise, low self-esteem, demoralization, internalized stigma, fatigue or trouble sleeping, feeling overwhelmed or low stress tolerance, suicide or self-harm thoughts</td>
</tr>
</tbody>
</table>

*Adapted from: Jones, Bower, & Furuzawa [www.nashmpd.org](http://www.nashmpd.org)*

*Back to School: Toolkits to Support the Full Inclusion of Students with Early Psychosis in Higher Education*
THC in cannabis can cause brief psychosis

Individuals exposed to cannabis in adolescence are 2-4 X more likely to develop PS disorder than non-exposed
  – OFC not everyone exposed develops psychosis and not everyone with psychosis was exposed

RECOMMENDATION – consider avoiding or delaying cannabis use until after age of typical psychosis expression/onset (at least 25 y.o.)

Greater frequency and duration, earlier first use, higher potency THC = increased psychosis risk

Risk for scz spectrum disorders greatest with cannabis, though other substances (amphetamines, hallucinogens, opioids, sedatives) also increase risk
Pennsylvania Early Psychosis Experiences with Substance Use - Current
World Health Organization (WHO) Guidelines

- Recommend DUP less than 3 months
- Currently DUP in the United States averages between 1 and 3 years
Coordinated Specialty Care Components

- Case Management
- Evidence-based psychotherapy
- Family Therapy/Family Psycho-education
- Supported Employment/Education
- Evidence-Based Psychopharmacology
- Care coordination
- Community Outreach and Engagement
- Peer support
PA FEP CSC Programs: 17 total

www.headsup-pa.org/find-a-center/

coordinated specialty care
No two stories are exactly the same. Treatment is a collaboration between you and the team of professionals ready to help. Each individual at our centers has access to a variety of services and options.

Psychotherapy
learning to focus on resiliency, managing the condition, promoting wellness and developing coping skills

Medication Management
finding the best medication at the lowest possible dose

Supported Employment and Education
providing support to continue or return to school or work

Peer Support
connecting the person with others who have been through similar experiences

Case Management
working with the individual to develop problem-solving skills, manage medication and coordinate services

Family Support & Education
giving families information and skills to support their loved one’s treatment and recovery

CAPSTONE-PPY/WYCA/CMU
HARRISBURG

CHOP FEP-Children’s Hospital of Philadelphia
PHILADELPHIA

CSG EPIC-Community Service Group
WILLIAMSPORT

Connect to Empower-OMSU Behavioral Health Services
DANVILLE

ENGAGE-Wesley Family Services
NEW KENSINGTON

ENGAGE-Wesley Family Services
WHIENSBURG

HOPE-Children’s Services Center
HOMESTATLE

HOPE-Children’s Services Center
STROUDSBURG

HOPE-Children’s Services Center
WILKES-BARRE

InSight
STATE COLLEGE

On My Way-Child and Family Focus, Inc.
ALLENTOWN

On My Way-Child and Family Focus, Inc.
BROOMALL

On My Way-Child and Family Focus, Inc.
PHOENIXVILLE

On My Way-Child and Family Focus, Inc.
SOUTHAMPTON

PEACE-Horizon House
PHILADELPHIA

PERC-University of Pennsylvania
PHILADELPHIA

Safe Harbor-UPMC Western Behavioral Health
ERIE

Services for the Treatment of Early Psychosis (STEP) Clinic
PITTSBURGH

*We are always growing! For the most up-to-date list of centers, visit us online.
Coordinated Specialty Care (CSC) Services for First-Episode Psychosis in Pennsylvania

https://www.youtube.com/watch?v=VIAKDD_VyJc

"A Look Inside Early Psychosis Care in Pennsylvania"
HeadsUp is a **collaborating** organization whose mission is to help **end the stigma** around psychosis through **education, advocacy, and support**

We promote **early intervention** centered around personalized, accessible, and effective care for all people in Pennsylvania

Visit and follow us online! headsup-pa.org

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Our deliverables include:

**Program Evaluation, Data Collection, and Research**

**Education, Training, and Clinical Care**

**Outreach and Cross-Systems Engagement**
<table>
<thead>
<tr>
<th>MYTH</th>
<th>FACT</th>
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<tbody>
<tr>
<td><strong>Individuals Who Have SMI Cannot Reach and Maintain Recovery</strong></td>
<td>Historically, recovery from SMI was not considered likely or even possible. However, a range of evidence over the last two decades indicates that around 65% of people with SMI experience partial to full recovery over time.³</td>
</tr>
<tr>
<td>Recovery does not necessarily mean the absence of symptoms. Recovery from SMI is defined in both objective and subjective ways.⁴,³,⁵ This incorporates concepts that go beyond just having stable symptoms. It includes well-being, quality of life, functioning, and a sense of hope and optimism.⁶,⁷,⁸,⁹</td>
<td></td>
</tr>
<tr>
<td>Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The four major dimensions that support recovery are health, home, purpose, and community.⁵⁰,⁵¹</td>
<td></td>
</tr>
<tr>
<td>✓ Health – overcome or manage one’s disease(s) or symptoms, and make informed, healthy choices that support physical and emotional well-being</td>
<td></td>
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<tr>
<td>✓ Home – have a stable and safe place to live</td>
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</tr>
<tr>
<td>✓ Purpose – conduct meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society</td>
<td></td>
</tr>
<tr>
<td>✓ Community – have relationships and social networks that provide support, friendship, love, and hope</td>
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<tr>
<td>Individuals should identify their recovery goals and receive support for them in their treatment plans.</td>
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<td>MYTH</td>
<td>FACT</td>
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<tr>
<td><strong>People Who Have SMI Cannot Obtain Competitive Employment or Complete Education</strong></td>
<td>Employment and education provide a sense of purpose that is a critical aspect of life in recovery. In fact, most people who have SMI do want to work and see work as an essential part of their recovery. Between 40% and 60% of people who enroll in supported employment obtain competitive employment. There is ample evidence that employment is not “too stressful” for individuals who have SMI. The benefits of employment and education for people with SMI are well documented. They include improved economic status, increased self-esteem, and symptom reduction. In fact, the detrimental effect of unemployment creates clinical risks for people who have SMI. These are often overlooked.</td>
</tr>
<tr>
<td>Supported employment programs can improve outcomes for individuals who have SMI. This includes a higher likelihood that they obtain competitive employment, work more hours per week, maintain employment for a longer period, and have a higher income. In turn, supported education programs can reduce burdens for people who have SMI and want to finish or go back to school. It offers specialized, one-on-one support to help navigate academic settings and link to mental health services.</td>
<td>Individuals should receive encouragement if their recovery goals include employment or education. There are supportive and effective programs to reach these goals and they have considerable benefits.</td>
</tr>
</tbody>
</table>
What are some barriers young people experience in seeking mental health care for early psychosis?
Some Barriers to Help Seeking

• Access to accurate information - about psychosis symptoms and treatment
• Stigma and cultural factors => Fear/shame
  • Parents/Family
  • Peers
• Financial factors
• Lack of universal screening…

NOTE: Significant differences relative to whites are indicated by ** * p < 0.01; **** p < 0.0001.
Figure 3. Percentage of children aged 5–17 years who had received any mental health treatment, taken medication for their mental health, or received counseling or therapy from a mental health professional in the past 12 months, by race and Hispanic origin: United States, 2019

Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: a systematic review

P. C. Gronholm1,2, G. Thormicroft1,2,3, K. R. Laurens4,5,6,7 and S. Evans-Lacko1,2,8

doi:10.1017/S0033291717000344

Sense of difference
- Something is wrong, not normal (17)
- Mental illness (18)
- Diagnosis, psychosis, psychotic symptoms (15)

Characterising difference negatively
- Mad, crazy, mental (19) [1]
- Dangerous, violent, unpredictable (4)
- Stupid, incapable, lazy (7)
- Adhering to stigmatised attitudes [1]

Negative reactions (anticipated and experienced)
- Others’ negative and judgemental reactions (18)
- Others’ social distancing (8)
- Others’ sense of stigma, shame and embarrassment (8)
- Personal feelings of shame and embarrassment (13) [1]
- Personal feelings of guilt (2)
- Personal fear that experiences will worry or upset others (7)
- Perceived public stigma [4]

Processes along PATHWAYS TO CARE:
Reluctance to consider symptoms/illness as mental-health related; delayed help-seeking (from both informal and formal sources of support); delays, reluctance and fear in relation to mental health service contact and treatment (e.g. medication)

Lack of knowledge and understanding
- Lack of knowledge due to stigma (3)
  - Not understanding what is happening at onset of difficulties (17)
  - Not knowing where or how to seek help, or how to provide support (13)

Service-related factors
Deterring:
- Feeling labelled, judged and treated differently by service providers (10) [1]
- Prejudiced attitudes towards (and fear of) mental health services (13) [1]
- Belief that mental health services break families apart (4)

Facilitative:
- Normalising, destigmatising peer environment (7)
- Normalising impact of treatment (7)
- Treatment reduces internalised stigma [1]

Strategies
- Non-disclosure (21) [1]
- Concealment efforts (9)
- Denying, ignoring, not accepting or admitting situation (14)
- Normalising and rationalising experiences (6)
- Social withdrawal (7)
- Using personal resources to cope with stress of stigma [2]
Systematic review of pathways to care in the U.S. for Black individuals with early psychosis

Oladurni Olusoye, Beshan Davis, Franchesca S. Kuheny and Deidre M. Anglin

npj Schizophrenia (2021) 7:58; https://doi.org/10.1038/s41537-021-00185-w

Fig. 1  Synthesis of pathways to care for Black individuals with early psychosis. Dashed boxes represent an individual or entity; light orange boxes represent the pre-prodromal phase; orange boxes represent the prodromal phase; red boxes represent experiences during the period of untreated psychosis; green boxes represent contact with services.
Challenges of Psychosis Spectrum (PS) Screening

- Mental health professionals perceive barriers in screening/identifying PS symptoms in adolescents/young adults:
  - Little normative/base rate data – Is this just a “normal” experience? Is this just an “adaptive” response to circumstances?
  - Comorbidities - Is this just “due to/manifestation” of [other thing]? (esp. substances)
  - Limited collateral informant (parent) knowledge of subthreshold positive symptoms
  - Stigma and fear
- More than 65% of youth experiencing persistent PS symptoms report previously talking to a medical professional or some other professional about their thoughts, feelings or behaviors…. But not necessarily about these symptoms.
- Mental health professionals have access to a critical window of opportunity to screen for psychosis spectrum symptoms and connect a young person with appropriate clinical care
  - Especially important for individuals who have historically been underserved in traditional community care for psychosis: Black and indigenous people of color, Asian and Latinx populations, LGBTQ+
Pennsylvania Early Psychosis Admission
Social Determinants of Health - Current

Participant Characteristics at Admission

Sex
- Male: 64.54%
- Female: 34.42%
- Transgender Male (female at birth): 0.78%
- Transgender Female (male at birth): 0.26%

Sexual Orientation
- Bisexual: 4.00%
- Lesbian, gay, or heterosexual: 67.24%
- Other: 0.90%
- Unknown: 29.00%

Race
- White: 67.30%
- Black or African American: 45.75%
- Asian includes Indian: 6.35%
- Multi racial: 1.55%

Admit Hispanic: 7.40%

Insurance Status at Admission
- Medicaid: 876 (60.41%)
- Private health insurance: 472 (32.69%)
- No insurance: 100 (6.99%)

Primary Qualifying Diagnosis at Admission
- Schizophrenia: 335
- Other specific psychotic disorder: 240
- Bipolar Disorder: 23
- Major Depressive Disorder: 17
- Alcohol or Other Subst use: 12
- Delusional Disorder: 9
- Other Non-schizophrenic: 1
- Not Specified psychosis: 1

Diagnosis: 712
Pennsylvania Early Psychosis Admission Social Determinants of Health – Current, cont.
Pennsylvania Early Psychosis Admission Social Determinants of Health – Current, cont.

Participation Reporting Fiscal Support

<table>
<thead>
<tr>
<th>Type of Monetary Entitlement</th>
<th>Participations</th>
</tr>
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<tbody>
<tr>
<td>Family</td>
<td>58.63%</td>
</tr>
<tr>
<td>SNAP</td>
<td>17.66%</td>
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<tr>
<td>Unemployment</td>
<td>14.49%</td>
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<tr>
<td>TANF</td>
<td>11.89%</td>
</tr>
<tr>
<td>SSDI/SSDI</td>
<td>5.21%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>0.45%</td>
</tr>
<tr>
<td>Other disability benefits</td>
<td>0.57%</td>
</tr>
<tr>
<td>No fiscal support</td>
<td>1.75%</td>
</tr>
</tbody>
</table>

Familial Support and Involvement

Preference of Family Involvement

<table>
<thead>
<tr>
<th>Frequency of Family Contact</th>
<th>Prefers no family involvement</th>
<th>Prefers family involved with some restrictions</th>
<th>Prefers family involved with no restrictions</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>About daily</td>
<td>44</td>
<td>160</td>
<td>290</td>
<td>502</td>
</tr>
<tr>
<td>About monthly</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>About weekly</td>
<td>13</td>
<td>27</td>
<td>13</td>
<td>53</td>
</tr>
<tr>
<td>Less than monthly</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Never</td>
<td>6</td>
<td>7</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Grand Total</td>
<td>69</td>
<td>199</td>
<td>314</td>
<td>582</td>
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Pennsylvania Early Psychosis Admission
Social Determinants of Health – Current, cont.
Pennsylvania Early Psychosis Admission Social Determinants of Health – Current, cont.
FLOWCHART FOR EARLY PSYCHOSIS SCREENING FOR COMMUNITY MENTAL HEALTH PROVIDERS

**AGES 11-35+**

**AGE CONSIDERATION:** Early psychosis screening is recommended for 11-35 year olds; outside this range new-onset primary psychotic disorders are rare and different assessment approaches and referrals may be needed.

**FUNCTIONING:** Marked decline in performance at school/work and/or typical activities, withdrawal, changes in sleep patterns.

**ATYPICAL:** Seeing things not there: e.g., shadows, flashes, figures, people, or animals. Hearing things others do not: e.g., clicking, banging, wind, mumbling, or voices. Seeing or hearing everyday experiences as unfamiliar, distorted, or exaggerated.

**COGNITION:** Memory, attention, organization, processing speed. Understanding abstract concepts, social cues, complex ideas.

**THOUGHTS:** Unwarranted suspiciousness about friends, family or strangers. Unfounded concern something is wrong with their bodies. Thinking that their body or mind has been altered by an external force. Believing others can read their mind or control their thoughts.

**SPEECH:** Trouble putting thoughts into words. Speaking in jumbled or hard to follow sentences. Dressing inappropriately for the weather or behaving oddly.

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*Telephonic Psychiatric Consultation Service Program (TIPS): www.dhs.pa.gov/Providers/Providers/Pages/TIPS.aspx

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Did the patient or collateral disclose (on the Prime 5 or otherwise), or do you observe***:

- **COGNITION:** Cognitive difficulties
- **THOUGHTS:** Thought disturbance or unusual beliefs
- **FUNCTIONING:** Functional decline
- **ATYPICAL:** Atypical perceptual experiences

- **What is the EXPERIENCE like?**
  - Is it odd and not explained by the patient's cultural, medical, or developmental context?

- **Are any of the following true?**
  - The experience is IMPACTING their emotions, behavior, or functioning
  - The experience is RECURRING
  - The experience is PROGRESSING

- **Is there a safety concern?**
  - **YES**
  - **NO**

- **REASSURE & REDIRECT**
  - Reassure the patient that they will be helped
  - Connect them to resources
  - Refer them to the appropriate mental health treatment

- **SAME-DAY ASSESSMENT**
  - Screen, assess, and triage
  - Screen regularly for additional psychotic-like experiences
  - Educate the patient and family on general mental health resources and direct them to call 911 or to the Crisis Center

- **MONITOR & EDUCATE**
  - Screen regularly for additional psychotic-like experiences
  - Educate the patient and family on general mental health resources and direct them to call 911 or to the Crisis Center

- **SPECIALTY MENTAL HEALTH ASSESSMENT & TREATMENT**
  - Refer the patient to specialized mental health assessment and treatment

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Screening for Psychosis

There are two ways to score the PRIME-5. Either way suggests a fuller evaluation for subthreshold or threshold psychosis symptoms should be considered:

1) **Sum of the 5 items.** To score, sum items 1-5 to obtain a total. Find the individual’s age, then look at their PRIME-5 Score. A person scoring at or above the PRIME-5 score has endorsed a level of symptoms that is 2 standard deviations higher than the mean of others his/her age.

<table>
<thead>
<tr>
<th>Age</th>
<th>PRIME-5 Score</th>
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<tbody>
<tr>
<td>11</td>
<td>19</td>
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<td>12</td>
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<td>21+</td>
<td>12</td>
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</tbody>
</table>

2) **Traditional Criteria.** <=One item rated 6 (Definitely Agree) OR >=three items rated 5 (Somewhat Agree) is considered significant (i.e., warranting consideration of fuller evaluation).

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Conclusions

• Because schizophrenia spectrum disorders are relatively common, affecting approximately 4% of young people, nearly all mental health care providers will encounter individuals experiencing psychosis or its early warning signs.

• The sooner individuals are identified and receive care following the first onset of psychosis spectrum symptoms, the better their functional and personal outcomes are likely to be.

• This webinar provided an introductory overview of early psychosis symptoms across the spectrum from risk symptoms to threshold psychosis disorders.

• Collective strategies for recognizing, assessing and responding to psychosis spectrum symptoms are critically important, especially in the context of social determinants of health that may impact the recognition and referral pathway.
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Q & A

Open Discussion