Moving from islands of order to a sea of chaos: Transitions out of early intervention services for psychosis

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Following a long series of referrals, Robin finally enters what is increasingly recognized as best practice care: an early intervention service for psychosis (EIP). However, after two-years of receiving flexible and multidisciplinary care, Robin must graduate from the program and move on to other services – an uncertain next step in the path to recovery.

In the last two decades, EIP services have emerged across North America, Europe, the United Kingdom, and Australia, with dual objectives of providing phase-specific interventions and improving access to needed care to reduce treatment delays. To address the latter, initiatives such as outreach campaigns, open referral policies, and other interventions have been encouraged. This understandable focus on pathways to EIP care has eclipsed the arguably equally important, yet to-date under-researched, pathways out of EIP care. Similarly, although it is potentially critical to tracking continued recovery, studies and tools assessing fidelity to best practice often lack a component that evaluates transition onward following an EIP.

Recently, new research has increasingly recognized the challenges that may arise during pathways out of EIP care (e.g. [1]). In the current issue of *Psychiatric Services*, Jones et al offer a qualitative exploration of matters relating to transfers between EIP (also known as Coordinated Speciality Care [CSC] in the United States) and subsequent care, as well as their implementation [2]. Based on 144 interviews with diverse stakeholders, the authors carefully identified and described the logistics behind transfers, service fidelity to recommended guidelines, and the subjective experience of transfers from both clinician and client perspectives. Their work highlights several additional points that warrant further reflection.

First, based on the authors’ discussion, there is an obvious need for collaboration not only between services but also within services, and that this collaboration should include client perspectives and involvement. Although it is likely that many clients were previously informed
by the service about their discharge, some clients nonetheless reported that they had not discussed the prospect of discharge with their provider or were not always aware of their discharge plan, potentially setting the stage for future disengagement. As one can imagine, it can be distressing for clients if – unsure of what to expect after EIP– they are faced with the possibility of soon losing services they have benefited from or relied upon. This finding is particularly problematic given that client-oriented care and shared decision making are increasingly recognized as fundamental values of EIP [3]. However, as the authors comment, recognizing and evaluating this best practice regarding transitions is itself lacking in guidelines and recommendations, despite it being such a critical step during the client’s care journey. In other words, while EIP services are likely mindful of the need to signal their time-limited provision of services, ensuring that this is communicated in a structured and systematic manner is necessary so that clients and clinicians have shared expectations.

Availability of peer support is another factor that may facilitate post-EIP engagement and help bridge the gap between EIP and other services. Unfortunately, despite the field’s growing acknowledgement of peer support as a vital aspect to mental health care, its actual implementation remains meagre in some settings. Nonetheless, its potential utility in transitions was highlighted by the challenges clinicians described regarding maintaining engagement and adherence to post-EIP treatment. Peer support could ensure some continuity during the handoff between EIP and post-EIP services, thereby promoting ongoing engagement and ultimately supporting successful transitions. Over time, the integration of peers (and peer support) could also be facilitated by digital platforms that are already being designed to improve continuity of care following EIP [4].
Finally, the uncertainty regarding which strategies can be used to mitigate the problem of service discontinuity at the time of transitions (whenever they occur) is reflected in the unstandardized approaches and varying expectations related to EIP discharge described by Jones et al. While innovations such as extending EIP or “stepped-down” transitional approaches may help to facilitate smoother transfers between services, at the end of the day these strategies are far from being a solution to the larger healthcare problem: that post-EIP mental health care is often “the opposite of recovery”, expensive, inaccessible, agnostic to client needs, and thus a potential contributor to disengagement. Unfortunately, these issues coincide with the other treatment, financial, and structural barriers encountered by those who could benefit from receiving psychopharmacologic or supportive/therapeutic care – barriers that warrant further research to identify possible solutions to mitigate their negative effects and improve mental health care services in general.

Overall, the paper by Jones et al provides an in-depth examination of transitions after EIP/CSC care from both clinician and client perspectives. While the US healthcare setting in which the study was conducted poses unique structural barriers regarding transitions, these challenges and their potential solutions require additional research and action across EIP services worldwide. Without more structured transitions to ensure a seamless handoff between EIP services and the greater mental health care system, and the implementation of facilitators to improve post-EIP engagement, EIP services will remain islands of order in a sea of chaos – a sea that clients, like Robin, will be left to navigate.
References


