



GUIDANCE DOCUMENT

# Transitioning Clients from Coordinated Specialty Care: A Guide for Clinicians

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# INTRODUCTION

## ABOUT THIS GUIDANCE DOCUMENT

Coordinated Specialty Care (CSC) is a model of early intervention for individuals in the first few years of psychosis onset. It is generally structured as an intensive, time-limited intervention. This means that most clients will ultimately graduate from the program. Depending upon their preferences and needs, they may transition to other forms of treatment, typically within 2 to 5 years of admission.

This *Guidance Document* provides recommendations to CSC staff who help facilitate these transitions. It provides practical strategies for assessing readiness for transition, identifying post-CSC goals and needs, finding appropriate community resources to meet these needs, making referrals to formal services, managing the actual transition, and conducting follow-up. In addition to discussing the steps involved in making a single referral, this guide offers suggestions for building a referral network. It is primarily directed toward CSC clinicians, since they most often have responsibility for organizing the transition of their clients. However, it may also prove helpful to any CSC team member who leads or plays a supporting role in the transition process, including team leaders, case managers, supported education and employment specialists, peer specialists, and psychiatrists.

The recommendations contained in this guide are based upon what the authors learned from semi-structured interviews conducted with experts from CSC programs and with providers who routinely receive CSC clients for continuing care. While conducting these interviews, the authors found significant variability among programs in their policies and practices regarding when and how to transition clients. This guide identifies practices for which there was general support among a majority of interviewees. It also identifies best practices that, in the judgment of the authors, represent an ideal approach to transitioning clients.

The primary goal of this Guidance Document is to promote best practices in client transitions among CSC clinicians. Obviously, CSC staff must adhere to the transition policies and procedures of their program and to the guidance they receive from their supervisors and program leaders. However, CSC program leaders may find the recommendations in this document useful in refining their team policies and practices.

It is important to recognize that not all clients will need or want ongoing mental health services following their graduation from CSC services. An assessment of their clinical and functional status, as well as sensitivity to their self-identified goals and needs, are essential components of the transition process. Shared decision-making that involves a collaborative review of options and their likely outcomes will help foster a successful transition. While continuing mental health services are not always needed or desired, many of the recommendations that follow address the likely benefit of such services for the many clients who want, and who may benefit from, continuing care.



A note about language is in order. Early Intervention and First Episode Psychosis Services are also used to refer to CSC services, but we use the latter term in this Guidance Document. We use “client” to refer to the individual receiving CSC services, although we realize that other terms may be used or preferred. We refer to the professionals who will provide continuing care after the transitions as “receiving providers.”

A set of short webinars, designed to educate receiving providers, is available as a companion piece to this Guidance Document. Its content focuses on psychosis, CSC services, and strategies for transitioning and providing effective care to CSC clients. These webinars are available online at [www.nasmhpd.org](http://www.nasmhpd.org) and may be helpful in informing receiving providers about successful transition strategies.

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to keep them on their life course and ensure timely  
access to CSC for other individuals in need.**

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## **WHY FOCUS ON TRANSITIONS FROM CSC?**

The number of CSC programs in the United States has grown rapidly, from a handful of programs that existed in the year 2000, to more than 200 programs that were either operating or under development in 46 states in 2016 (NASMHPD, 2016). Thus, there are now many more clients receiving CSC who, in most cases, will be transitioned to continuing care in the community. After all the care and attention clients receive during a course of treatment within CSC programs, it is crucial to support their transitions from these programs with the objective of sustaining the gains they have made. In light of research showing that many clients struggle to maintain superior outcomes after CSC (Jones, 2016), connecting them to the best possible ongoing treatment and support services, whether formal or informal, is particularly important.

There is compelling evidence that the time from onset of illness to connection with appropriate care is a strong predictor of a variety of outcomes (e.g. Penttilä, et al., 2014; Kane, et al., 2016). Evidence also shows that shortening the duration of untreated psychosis can have a positive impact on long-term outcomes (e.g. Hegelstad, et al., 2012). Since most programs can serve only a limited number of clients at any given point in time, transitioning clients who have had a course of CSC is essential to ensure timely access to CSC for other individuals experiencing a first episode of psychosis.

## **WHAT PROMPTS A TRANSITION?**

Multiple decisions and events may trigger a client’s departure from CSC. For example, a client may have completed a full course of treatment within the CSC program or reached a time limit prescribed by the program—usually two to five years. This planned transition will be the primary focus of this guide.

Other departure triggers include: clinical stability, with all CSC treatment goals accomplished by the client before reaching the end of a typical length of stay; a client requesting to receive care elsewhere or choosing to terminate CSC treatment; a client moving to another geographic location, such as going off to college; or a determination by the CSC team that the client's primary issue is likely not psychosis, prompting referral to more diagnostically appropriate treatment. Less commonly, it can become clear over time that a client needs a higher level of care than CSC provides, such as Assertive Community Treatment (ACT). Some of these alternative treatment scenarios will be briefly discussed at the end of this guide.

## RECOMMENDATIONS

### CONSIDER ALL CSC SERVICES TRANSITIONAL

For many CSC clients, this is their first experience with mental health treatment. In addition, for most clients, their CSC treatment is a time-limited episode of specialty care, after which many will move into continuing care with other providers. It is helpful to think about the entire episode of CSC as transitional in nature, rather than viewing transition as a “task” to be completed at the end of the course of treatment.

At the beginning of treatment, convey to clients and their family members that CSC is a transitional set of services and supports to keep the client on his or her desired life course. Explain that such services are designed to be time

limited, both to maximize the benefits of CSC programming and to assure appropriate access to others who need the service. They will often appreciate hearing that CSC is “not forever,” since such language conveys optimism about getting better and moving on with life. This message may help build initial engagement and client comfort in the program, and minimize disruption when the transition occurs. It also helps the entire CSC team to recognize that transition is a natural part of the care process and that the goal is to support the client's movement to less intensive services.

At the same time, be aware that some clients may be reluctant to engage in a service that they fear may end before their needs are fully met. It is essential that services be viewed as a welcoming and stable place for support. You can foster this relationship by being proactive in helping the client and family build and connect with an array of services and natural supports over the course of treatment, rather than waiting to search for resources and make referrals near the end of the episode of care. Consider a formal or informal step-down in CSC services over the course of treatment in order to ease the impact of an abrupt decrease in services and to assess how the client responds to the less intensive care. Step-down can include less frequent visits or a reduction in the types of services being provided.

## BE AWARE OF YOUR OWN EMOTIONS

Like all mental health professionals, CSC clinicians may feel a range of emotions about discharging their clients. It can create feelings of excitement and pride, but also feelings of disappointment, loss, anxiety about the client's future; frustration at program or institutional policies that limit the client's length of stay; or even critical feelings toward receiving providers

who will deliver the continuing care. Be mindful of these emotions, which will likely be mixed; manage their impact on you, clients, and family members; revel in the successes the client has achieved; maintain hope for the future; and, when needed, turn to your supervisor, program leaders, or peers for support and guidance.



## EDUCATE AND ENGAGE CLIENTS AND FAMILIES

Within the guidelines of your program's policies and procedures, engage clients and family members in shared decision-making about transition goals, timing, and continuing care services. They, too, will likely be filled with mixed emotions about progress that has been made, leaving the CSC team, and the continuing care plan. Allow room

for the expression of those emotions, while helping clients and family members grapple with the constraints imposed by policies that limit a continuing CSC stay, eligibility for continuing care services, availability of those services, and insurance coverage. If your program has peer or family peer staff members, include them in these discussions as appropriate, since sharing their lived experience and support can help clients and families express their own feelings and develop personal goals for the transition.

Anticipate and address client ambivalence about continuing treatment. Encourage her or him to take pride in the accomplishment of completing the CSC program. Be optimistic about the client's future. Acknowledge that services will inevitably be somewhat different after the transition. Emphasize that there likely will be less frequent contact, less outreach, and perhaps less flexibility than in the CSC program.

## ASSESS READINESS FOR TRANSITION TO CONTINUING CARE

Many CSC programs have policies or funding requirements that specify a maximum length of stay, typically with some flexibility to accommodate variations in client readiness to transition. These limitations may guide and constrain decision-making about the timing of the transition. Your program might also use formalized assessments, rubrics, or other tools to inform transition decisions.

Quite often, however, the transition criteria, client assessment, and decision-making process will be less formal and will involve not only you, as the clinician, but other members of the team as well. In assessing the client's readiness to transition to continuing care, it is important to balance the desire to be flexible about the length of stay with the need to open up treatment slots for other individuals. Be prepared to repeatedly revisit assessments of a client's readiness for transition, as clients continue to improve or experience setbacks, and then recover.



### CONSIDER THE FOLLOWING FACTORS IN DETERMINING THE APPROPRIATE TIME FOR A TRANSITION:

- **Progress toward treatment goals:** Which goals have been achieved? Can the goals that remain be accomplished in a lower level of care?
- **Clinical stability:** Is the client symptom free or are symptoms stable? Has there been a recent relapse such that continuing CSC services is still required? Has there been a recent medication change that requires ongoing monitoring by the prescriber?
- **Substance use:** Are substances being used, and do these jeopardize the client's stability?
- **Physical health:** Is the client's physical health stable and is health care in place to address existing health concerns?
- **Level of functioning:** Is the client capable of instrumental activities of daily living? Is he or she steadily engaged in work, school or some other activity?
- **Ability to manage symptoms:** Can the client recognize changes in symptom levels and early warning signs of relapse, and use self-management skills to cope with exacerbations? Is he or she aware of when and where to ask for help?
- **Medication adherence:** Does the client adhere to prescribed medications and work with the prescriber regarding medication concerns? If the client is no longer on medication, does the client know how to work with a prescriber to restart medications if needed?
- **Support system:** Does the client have a range of supports in place?
- **Stability of the housing situation:** Is the client's housing situation stable and does he or she have sufficient skills and supports in place to live in that housing?
- **Ability to engage:** Has the client been able to engage in CSC and is he or she likely to be able to engage with a new provider?
- **Developmental stage:** Is the client aging out of the system of care for children and adolescents and becoming eligible for services that may not be offered by the CSC, such as supported housing? How will this new eligibility affect the client's services and supports?
- **Response to decreased CSC services:** Has there been a natural decrease in CSC services as the client has improved? Was there a planned decrease in CSC services as part of a formal step-down phase or a trial of less frequent or fewer services? If so, how did the client respond to these changes?

## CLARIFY POST-CSC GOALS AND NEEDS

Like assessing a client's readiness for transition, planning a transition also tends to be a somewhat informal process in most CSC programs. However, some have developed checklists and other transition tools to organize the work. (You will find examples in Appendix A and in the Additional Resources section below).



Begin with input from the CSC team and your supervisor, and then engage the client and family in a shared decision-making process to identify goals and needs in the post-CSC continuing care phase. Ideally, these discussions should begin at least six months before the anticipated time of transition. Frequency of visits, if previously reduced, might need to be increased to plan for and manage the transition. Consider goals and needs that are both personal and service-related. Think broadly about areas of need, including: mental health care, substance use treatment, medication management, physical health care, care management or care coordination, peer support, housing, and vocational and educational opportunities. As mentioned above, attention to these areas has ideally been a focus throughout participation in CSC and simply becomes more intensified as an anticipated transition grows near.

In thinking about future needs, take stock of what clients have benefited from while in CSC, and use this information to help shape transition decisions.

## IDENTIFY THE BEST TYPES OF SERVICE PROVIDERS

Start by identifying the types of providers or programs that might meet the client's needs. Outpatient clinics in Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) are the types of programs to which CSC clients are commonly referred. Young Adult Services programs may be particularly suited to receive many CSC clients due to their focus on the transition age developmental stage. Team-based care that includes case management may be most appropriate for clients who need a high degree of support. In situations where less support is deemed necessary, clients may desire private practice settings that are, by nature, smaller, less institutional in character, and may be less overwhelming.

If your CSC program is embedded within a larger agency, the natural transition may be to continuing care providers in the agency. Such transitions have advantages, including building upon existing relationships between CSC and continuing care staff, ease of communication and “warm handoffs,” client familiarity with the agency, and not having to change the location in which care is received.

However, some clients may have travelled significant distances for CSC services and may desire a continuing care location that is closer to home or in a more youth-oriented environment. CSC services may have been funded through a grant, which made treatment free to the client, but your agency might not accept the client's insurance for continuing care.

Desired services also might not be available within the agency. Another quite sensitive issue is that clinicians on continuing care teams may be most familiar with treating individuals who have been disabled by their experiences with serious mental illness, and these clinicians may be less familiar and skilled at working with clients with psychosis who have made major gains in functioning and recovery.

Culturally specific behavioral health programs may be appropriate for some clients, while others may feel that they would lack privacy in these typically small, community-based programs. A primary care provider (PCP) or primary care clinic, with or without a simultaneous referral to a therapist, may be appropriate for clients who are clinically stable, need medication management, and may have special needs for physical health services. If the PCP is comfortable prescribing antipsychotic medications, this may be an attractive option in cases where the client is strongly connected to the PCP.

### SELECT SPECIFIC PROVIDERS FOR REFERRAL

After identifying the type of services that will be needed by the transitioning client, search for specific providers who offer the desired services and who you believe could best address the client's needs. Some clients may prefer to obtain services close to home, while others may prefer obtaining them at some distance from home to ensure their privacy. Among the providers in the desired geographic area, determine which are most knowledgeable about and comfortable with: psychosis; evidence-based practices (EBPs) for psychosis; transition age youth and young adults; person-centered and recovery-oriented care; and the CSC model. Providers who are used to working with acutely ill, high-need clients may be particularly well suited, especially if they have a recovery-oriented focus rather than solely a chronic disease management approach.

As you sort through available providers, prioritize client and family preferences based, perhaps, on their prior experience. Discuss with them the pros and cons of each option. Consider potential barriers to accessing those providers, including: transportation needs; the hours during which services are offered; client schedule constraints; insurance coverage; the cost of co-pays; administration of injections; and laboratory and monitoring services for clozapine. Engage the client and family in a discussion of potential barriers and possible strategies for overcoming them, so that the services targeted for a referral are realistic.

### MAKE REFERRALS

Your agency may prohibit clinicians from “endorsing” a specific provider or require that a number of options be provided to clients if multiple options are, in fact, available. In most cases, providing options and encouraging clients and family members to explore them is considered a best practice. Suggest, for example, that they meet with and interview potential providers to determine if there is a good fit.





The steps in the transition process are not always linear, as you search for information about available services and clarify what specific providers have to offer. Once a potential or likely receiving provider(s) has been identified, obtain a release of information and discuss the potential referral with the provider. Learn more about the services offered and the treatment philosophy, assessing whether these might meet the client's goals and needs. Ask about and understand the referral procedures and practices of the receiving provider. Determine if the provider views the client as a reasonable match for the services offered, and whether he or she has any hesitation or concerns that can be addressed. Determine if there are admission criteria that the client must meet, if there are current openings to actually serve the client, or, if the services are not immediately available, approximately how long the client might have to wait to obtain them.

A critical step in this process is to educate receiving providers about the nature of CSC services. They may not be familiar with this treatment modality, and how the continuing care needs of clients transitioning from CSC may differ from those with chronic psychotic disorders who have not had the benefit of early intervention. Provide succinct information about the evidence base for positive outcomes with early intervention. Also offer information about early psychosis and its treatment if the receiving clinician lacks sufficient familiarity with this topic. The challenge is to informally assess the provider's level of knowledge, and educate her or him about these topics, without being perceived as condescending. This can be accomplished tactfully by providing information in the context of the individual client being referred, rather than adopting a "teaching" stance. For example, use language such as "Like many clients coming from a CSC program . . ." Anticipate and address misconceptions that may need to be clarified. A receiving provider might not expect that the client could work or go to school, rather than being placed on disability; have relatively intact social functioning and activities of daily living; and have active and constructive family involvement. If it seems appropriate, provide a list of educational resources, such as those listed in Appendix B of this document, as part of the referral and handoff documentation.

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When discussing the referral, review the diagnostic formulation, history of symptoms, and differential diagnoses that were considered and ruled out. Some providers may believe incorrectly that clients who are functioning well or whose symptoms are currently in remission have not had a psychotic disorder. It can be upsetting to clients and disruptive to their treatment if the receiving provider dismisses psychosis and the diagnosis that was arrived at after careful longitudinal assessment. Clarify the CSC team's perspective on related issues, such as whether a client's flat affect is a symptom of depression or a negative symptom of his or her psychotic disorder, and whether the client's cognitive symptoms are related to psychosis rather than attention deficit disorder or some other cognitive impairment.

Describe the family’s connection to the client and its role in her or his CSC treatment. With the client’s permission, encourage the receiving provider to meet with family members, to foster their supportive role, and to utilize their input as a “worry barometer,” detecting changes in the client’s clinical status and level of functioning. Encouraging a connection with the family is particularly important if the provider usually serves adults and does not routinely involve family members.

With respect to the current referral, seek the opportunity for a more in-depth discussion with the receiving provider about the client and family. Build on the information listed above by sharing the “full” clinical story, including, but not limited to, the following elements:

### ELEMENTS OF THE CLINICAL STORY

- The initial clinical and functional presentation
- Current clinical and functional status
- Client characteristics when the client is stable and functioning at his or her best
- Client characteristics when most symptomatic or functionally impaired
- History of safety concerns
- The diagnostic evaluation and conclusions
- The treatment approach used by the CSC team and the rationale for that approach
- Current and historical psychopharmacological interventions, side effects, dosing, and medication adherence
- Family involvement and dynamics
- Client and family attitudes and feelings about the transition
- Psychiatric Advanced Directives (where available)

Offer to accompany the client to a joint, first meeting with the receiving provider to make a “warm handoff.” Also, offer reassurance that the CSC team will support the transition and is willing to provide consultation regarding the client and his or her care during or after the transition. If possible, arrange for the client’s CSC prescriber to communicate directly with the receiving prescriber to review information on the diagnostic considerations, medication trials, responses, side effects, and current medication regimen. If this is not possible, consider asking the referring physician to write a brief (e.g., 1-page) summary of these items for the receiving prescriber to review.

In addition to completing any referral documents required by the receiving provider and providing him or her with a copy of the CSC treatment plan, collaborate with the client to provide a succinct summary of additional information from *his or her perspective*. This can be useful to the receiving provider and helpful to the client as he or she strives to put the CSC

experience in perspective. Work together to answer such questions as: What were the presenting problems? How did these problems change during the client's CSC stay? What did the client learn about herself or himself? What skills did he or she develop? What is the client's relapse prevention plan? What treatments did the client respond well to and what treatments were not effective? (See Appendices A and C for examples of talking points with clients and a handoff document template.)

If a client has opted for referral to low-intensity services, such as care by a PCP, review early warning signs of psychosis with the client and his or her family, and discuss signs that may indicate the need for additional services. Provide guidance about how to access those services and clarify whether the CSC team would be available to help the client make additional connections to services. Provide a copy of the relapse plan to the client and her or his family, so they will have it on hand and can share it with future providers.

### MANAGE THE ACTUAL TRANSITION

As mentioned above, a gradual decrease or a step-down in CSC services can make the actual transition less abrupt and create an opportunity to develop strategies for dealing with problems that arise as services are reduced. As the transition nears, service frequency may need to be increased in order to prepare and plan for the transition, as well as to monitor for the impact of the increased risk associated with transitions.

As the formal transition approaches, consider celebrating the "graduation" with the client, family and CSC team. This acknowledges the gains made by the client and conveys a sense of optimism about the future. Providing a simple certificate of completion can be meaningful to the client.

Increase overall vigilance and assessments of safety through the transition process, without undermining the client's efforts to forge a connection with the receiving provider. Transitions are high-risk periods, as clients and families first anticipate and then experience the loss of valued relationships with the CSC team. Risk is also heightened because connections to the receiving provider are not yet fully developed, that provider is less familiar with the client, and the provider will have less time than the CSC team to spend with the client.

An agreement among the client, receiving provider, and CSC team to overlap services can decrease anxiety and increase safety during the transition. Consider transitioning the client to the receiving clinician first, followed by a slightly later transition to the receiving prescriber. If neither a CSC team member nor a trusted support person will be accompanying the client to his or her first visit to a new agency, review the transportation arrangement. Schedule a cab, Lyft or Uber, or medical transportation service, if necessary, or review the public transportation route with the client.

Periodic in-person or phone check-ins between the client and the CSC team can provide reassurance, enable safety assessments, and facilitate problem-solving around transitional issues.



Such contacts will allow the client to talk about stressors related to the new treatment setting or receiving provider, and to discuss practical strategies for managing the stress. With the client's permission, a follow-up call between the CSC team and the client's family can also be helpful. Be mindful that insurance policies may prohibit payment for delivery of similar services to a client by the referring and receiving providers at the same time. Moreover, agency policies may prohibit the delivery of non-reimbursable care to a client being seen by the receiving provider. In addition, formal discharge from CSC may be necessary before the receiving provider can bill for services.

Periodic contacts between the CSC clinician and the receiving provider also can be beneficial. Such contacts offer both parties an opportunity to “compare notes” about the transition and the client's response. They also allow the CSC clinician to give the receiving provider additional information, reassurance, and support, and to jointly problem-solve if the transition is not unfolding as planned.

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## **PROVIDE POST-TRANSITION FOLLOW-UP**

Engage in enough contact with the client and, if permitted, the family and receiving provider, to ensure that the transition is successful and a connection to the receiving provider is established. Encourage the client to work through challenges in developing a working relationship with the receiving provider. If the client fails to make that connection or states an intention to discontinue the treatment, work with the client to determine his or her thinking about the provider and the need for continuing services. If the issue appears to be difficulty engaging in the new treatment environment, explore with the client problem-solving strategies or other steps that may best suit the client's preferences and needs. In some situations, a consultation with the receiving provider about the engagement challenges and strategies may be helpful. If it becomes clear that the client and receiving provider are not a good match, or that the client intends to discontinue treatment, then work with the client to find an acceptable alternative.

Continue to be a resource to the receiving provider so long as he or she is interested in such contact, and your CSC's policies and practices, and your professional time, allow. Your consultations with the receiving provider may be particularly important and impactful if and when the client experiences an acute exacerbation of illness or a decline in functioning.

Your CSC program might offer the client opportunities for ongoing connection to the program after the transition, such as serving on peer advisory boards, providing mentoring or peer support to current clients, or visiting the CSC team just to say hello. Encourage your client to take advantage of these options, which may lessen the sense of loss, ease the transition, and offer additional support, so long as such activities do not undermine the connection the client is developing with the receiving provider.

## CONSIDER READMISSION IF NECESSARY

Your program may or may not permit readmission when a transition is unsuccessful or the client subsequently experiences a significant increase in symptoms or decline in functioning. Consider the following factors when weighing the possibility of a readmission: Is it allowable under your program's policies? Does the client still meet program eligibility criteria? Was the transition unsuccessful and, if so, why? What factors contributed to the increase in symptoms or the decline in functioning? What would be the goals of a readmission and the anticipated length of stay? What would be the likely transition plan after an additional course of CSC treatment?

## OTHER TRANSITION SCENARIOS

It is not uncommon for clients to move geographically before they have completed a course of CSC treatment. In an ideal scenario, refer the client to a CSC program in the area to which the client is moving. This is becoming increasingly possible as the number of programs around the country continues to expand. Check the Additional Resources section at the end of this document for a link to CSC directories. If local supports are scarce, consider providing distant support to the client during his or her transition, if your CSC program's policies permit.

A client going off to college or returning to college to finish his or her studies is a common precipitant for a geographic move. In this situation, encourage and foster the client's connection with the college counseling center, the office for students with disabilities, the campus chapter of *Active Minds*, the organization *Students with Schizophrenia*, or other mental health support groups and campus recovery communities. Assist the client in connecting with a supported education program in the area, if one exists. With the client's consent, it may be helpful to discuss the client's situation with college officials who provide various forms of student support. Become knowledgeable about the resources on campus in order to discuss options with the client. Discuss with clients the pros and cons of declaring a disability for purposes of accommodation on campus under the Americans with Disabilities Act (ADA).

Among the clients who are not moving away, some will achieve clinical stability or symptom remission, have strong social supports, and accomplish their CSC treatment goals, such that continued CSC services seem no longer warranted. A sustained period (e.g., 1 year) of doing well without medication also indicates a potential opportunity to move the client to a lower intensity level of care, such as a primary care provider. During such transitions, focus heavily on relapse prevention strategies, crisis plans, and steps for seeking a higher level of care if necessary. Ensure that peer support is in place if the client is open to this.



Use similar strategies for a client who, from a professional perspective, needs CSC services but refuses continued treatment and insists on discharge against medical advice. Use motivational interviewing to try to re-engage the client. Attempt to maintain the client's connection to the CSC team to see if the desire for discharge will pass, or connect the client to a lower level of care if he or she finds that option more acceptable. If these options are refused, it is particularly important to emphasize to the client ways to prevent relapse, how to recognize early warning signs of psychosis, and how to access additional services, if needed. Also review relapse prevention strategies, a crisis plan, and early warning signs of the need for treatment with family members or other client supporters.

When ongoing assessment during CSC reveals that the diagnosis is something other than a psychotic disorder, such as substance-induced psychosis or borderline personality disorder, and your CSC does not treat individuals with these diagnoses, consider referring the client to a program more relevant to his or her condition.

For a small percentage of clients, participating in a CSC program may not bring about functional improvement or a decrease in clinical acuity. After consultation with the team, it may be necessary to transition this type of client to a more intensive level of care such as Assertive Community Treatment (ACT), partial hospitalization combined with residential programming, or long-term inpatient treatment.

## **BUILD A REFERRAL NETWORK**

The focus in this Guidance Document has been on facilitating the transition of a client and making client-related referrals. However, CSC teams can also work to build a referral network to facilitate the referral of individuals experiencing a first episode to the team, and the transition of CSC clients to continuing community care. While network development typically is led by team leaders, program managers, or outreach staff, as a member of the team you can contribute to this effort.

Each referral you make will further educate a receiving provider about CSC and its clients. It also will give you the opportunity to strengthen your working relationship with that specific provider. The more contacts you make, the larger your referral network will grow over time.

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**CSC teams should build a referral network to facilitate the referral of individuals experiencing a first episode of psychosis to continuing community care.**

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You also may have the option, as part of your team, to participate in a form of outreach called “professional detailing.” This involves maintaining regular contacts with referring and receiving providers. It might involve making monthly in-person visits or phone calls and providing them with additional informational materials. Recurring contact with agencies that accept CSC referrals is particularly important due to staff turnover. Seize every opportunity to make a connection with professionals and agencies in your system of services.

Your CSC program also may offer, and you may be able to participate in, a variety of educational events that are designed to increase the knowledge and skills of community providers and to build community relationships. These activities often help allay concerns or misperceptions among community providers about the population served by CSCs. They also can further those providers' understanding of CSC eligibility criteria. The content of such educational events often covers the basics about psychosis, including: symptoms, psychological and psychopharmacological interventions, the impact of stress, relapse prevention, integrating families into care, shared decision-making, and recovery approaches. When CSC clinicians participate in these educational activities, they can strengthen relationships between CSC referring clinicians and receiving providers.

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## CONCLUSION

As a CSC clinician, you are providing care to individuals at perhaps the most critical time in their lives. You are often supporting their recovery by helping to manage their entry into the mental health system of care, guiding their movement through an array of intensive CSC services, and then facilitating their transition from the program.

Understanding the needs and preferences of the clients and their families is essential. Developing knowledge of the community-based system of care is also critical. In the end, your primary task is to develop strong working relationships with clients, family members, other members of your CSC team, and providers within the community. These relationships will enable you to provide effective care and to achieve appropriate transitions.

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[https://www.nasmhpd.org/sites/default/files/Information Guide-Snapshot of State Plans Revision.pdf](https://www.nasmhpd.org/sites/default/files/Information%20Guide-Snapshot%20of%20State%20Plans%20Revision.pdf).

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## ADDITIONAL RESOURCES

### **Active Minds**

<https://www.activeminds.org>

### **EASA Center for Excellence Program Directory of Early Psychosis Intervention Programs**

<https://www.nasmhpd.org/sites/default/files/2015%20Program%20Directory.pdf>

### **National Association of State and Mental Health Program Directors (NASMHPD). Outreach for First Episode Psychosis: Examples from the Field for State and Agency Roles.**

[https://www.nasmhpd.org/sites/default/files/DH-Information\\_Brief\\_on\\_Outreachactivities\\_gleaned\\_from\\_states\\_and\\_agencies%20%282%29\\_0.pdf](https://www.nasmhpd.org/sites/default/files/DH-Information_Brief_on_Outreachactivities_gleaned_from_states_and_agencies%20%282%29_0.pdf)

### **OnTrackNY Primary Clinician Manual (includes transition planning tools)**

[http://www.ontrackny.org/portals/1/Files/Resources/PrimaryClinicianManual\\_2015.03.25\\_Final.pdf](http://www.ontrackny.org/portals/1/Files/Resources/PrimaryClinicianManual_2015.03.25_Final.pdf)

### **Prodrome and Early Psychosis Program Network (PEPPNET) Directory**

[https://med.stanford.edu/content/dam/sm/peppnet/documents/PEPPNET\\_directory-earlypsychosis.html](https://med.stanford.edu/content/dam/sm/peppnet/documents/PEPPNET_directory-earlypsychosis.html)

### **PhenX Toolkit Early Psychosis Clinical Services Specialty Collection**

<https://www.phenxtoolkit.org/index.php?pageLink=browse.nimh.epsc>

### **Providing Continuing Care After Early Intervention for Psychosis Webinar Series**

[www.nasmhpd.org](http://www.nasmhpd.org)

**Students with Schizophrenia**

<https://www.facebook.com/studentswithschizophrenia/>

**Substance Abuse and Mental Health Services Administration (SAMHSA)  
Environmental Scan of Evidence-Based Practices for Treating Persons in  
Early Stages of Serious Mental Disorders**

<https://www.nasmhpd.org/sites/default/files/Environmental%20Scan%20%202.10.2015.pdf>

**World Health Organization Disability Assessment Schedule, Version 2.0**

<http://www.who.int/classifications/icf/whodasii/en/>

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## RECOMMENDED CITATION

**Pollard, J.M., Hoge, M.A.** (2018). *Transitioning Clients from Coordinated Specialty Care: A Guide for Clinicians*. Alexandria, VA: National Association of State Mental Health Program Directors.

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## APPENDICES

**Appendix A:** Examples of Transition Checklists and Planning Tools

**Appendix B:** Resource List to Give to Receiving Providers

**Appendix C:** Example Transfer Document Template

## APPENDIX A

### Example Transition Checklists and Planning Tools

Included with permission from EASA and FIRST



(EASA logo only belongs with first half of Appendix A, 2nd half correctly headed with logo for FIRST's affiliation)

#### EASA Transition Checklist – Revised 11/27/2011

(Begin this process 6 months prior to graduation from EASA)

1. Individual has a written transition plan that reviews strengths and accomplishments to date, long-term and short-term goals, and a plan for achieving them.
  - a. Career goals: school and work
  - b. Family and relationships
  - c. Housing and independent living
  - d. Economic stability and insurance
  - e. Transportation
2. The individual has connected with the ongoing supports and resources needed to accomplish their ongoing goals.
3. Individual has written relapse plan/advanced directive.
  - a. Plan early, intermediate and late warning signs
  - b. Plan specifies actions to be taken by the individual and others when these signs occur
  - c. Plan includes history of effective and ineffective interventions, and preferences about medications/strategies
  - d. The individual has identified one or more key individuals to advocate in case of relapse
    - i. Advocate has a copy of plan
4. Appropriately qualified ongoing prescriber is identified (if necessary and/or desired).
  - a. The individual has met and accepted the medical individual
  - b. It is clear how the individual is going to pay for the medical care
  - c. A copy of the individual's most recent assessment, medication history and relapse plan has been sent to prescriber

- 5.** Ongoing counselor is identified (if necessary).
  - a.** A determination has been made of whether the individual needs/ wants an ongoing counselor
  - b.** Counselor is identified and individual has met, accepted counselor
  - c.** Counselor has treatment and medication history, assessments, relapse plan
  - d.** It is clear how the individual is going to pay for services
- 6.** The family/immediate support system is engaged with ongoing professional and self-help resources.
- 7.** Access to medications has been established (if necessary).
  - a.** Individual has access to medications through insurance or other means
  - b.** Medications have been established through pharmaceutical assistance or other means for the next 3 months
  - c.** Individual knows how to secure future medications
- 8.** Individual has completed treatment goals or has a clear path for completing them.
  - a.** Goals have been reviewed and mutual agreement has been established that they have been met adequately
  - b.** Specially focus on current and future career and educational goals
  - c.** Provide resources for all goals not yet met or intended future goals
- 9.** The individual has copies of key supportive documents (electronic or hard).
  - a.** Medication history
  - b.** Treatment summary
  - c.** Resume
  - d.** Relapse plan
  - e.** Ongoing goals and service plan
- 10.** Family members and/or other key support system members have been consulted regarding transition planning at the individual's level of consent.
  - a.** Meeting has occurred & transition plan in place that all have agreed to
  - b.** Family members and other key supporters have a copy of the relapse plan
  - c.** Provide list of resources that may be necessary in the future (i.e. SSI, VRD)
- 11.** Individual has completed discharge survey and permission to follow up established.



Best Practices in Schizophrenia Treatment  
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*Promoting Innovation. Restoring Lives.*

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### Transition from *FIRST* Talking Points

If a FIRST client expresses a desire to transition from FIRST to a lower level of care, utilize this document for transition talking points to determine if client is adequately prepared to dis-enroll from FIRST.

1. Has the client been enrolled and active in the FIRST program for a minimum of three years?
2. Does the client consistently demonstrate beneficial and healthy life choices, including utilizing effective coping strategies?
3. What progress has the client made in the following areas:
  - i. Psychiatric symptoms/medical adherence;
  - ii. Vocational/Educational achievements;
  - iii. Family relationships and social support system;
  - iv. Independent living;
  - v. Knowledge and use of community resources;
  - vi. Alcohol and other drug use; and
  - vii. Physical health issues?
4. Is the client able to identify areas, which require additional interventions, strategies, or resources to maintain wellness and support at a lower level of care (e.g., does the client want to continue to meet with at least one FIRST team provider)?
5. Can the client identify individuals who will provide support once the client dis-enrolls from the FIRST program?
6. Does the FIRST team agree with the client's assessment of readiness and decision?
7. Are there any other considerations?

## APPENDIX B

### Resource List for Continuing Care Providers

Thank you for agreeing to the care of our former client! We hope that you will find these articles, websites, webinars, and training resources useful in learning more about psychosis, recovery with early intervention, and recommended evidence-based practices.

### Webinars on Providing Continuing Care After Early Intervention for Psychosis

[\[insert web address once uploaded to NASMHPD site\]](#)

### The National Association of State Mental Health Program Directors' (NASMHPD) *Early Intervention in Psychosis* virtual resource center

<https://www.nasmhpd.org/content/early-intervention-psychosis-eip>

### The National Institute of Mental Health information on Schizophrenia and treatment

<https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>

### Signs & symptoms of psychosis:

<http://www.schizophrenia.com/earlysigns.htm#>

### Recovery Story Videos

<https://vimeo.com/user23094934/voices-of-recovery>

### Practice Guidelines and Manuals

<https://iepa.org.au/resources/>

### Training & webinar resources:

<https://med.stanford.edu/peppnet/resources/TreatmentWorkGroupVideos.html>

<https://www.nasmhpd.org/content/information-providers>

### Shared Decision Making & Prescribing for Psychosis

<http://www.psychiatrictimes.com/schizophrenia/shared-decision-making-treatment-psychosis>

<http://brss-tacs-decision-tool.samhsa.gov>

### Improving Physical Health of Young People with Psychosis

<https://www.iphys.org.au>

### To learn more about EBPs for Schizophrenia

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC377570s/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3792827/>

### SAMHSA webcast on First Episode Psychosis Intervention

<https://youtu.be/nxCy-88hRXE>

## APPENDIX C: Example Transfer Document Template

Included with permission from STEP

### STEP Handoff Transfer Letter Template

Our goal is to create a useful summary of what we would want to know if we were receiving this patient in a narrative, reading friendly format. Most, if not all, of these elements should be included, but feel free to condense or re-order the sections and modify as appropriate (e.g. if you're referring to another CSC, no need to explain what CSC is; may not be prior treatment history if STEP first entry into care; some sections may overlap, no need to be redundant). It should be brief (no more than 1-3 pages) in order to give the receiving provider a good snapshot of the most pertinent information about the patient.

- Brief description of STEP and the benefits of CSC and early intervention
  - “Thank you for agreeing to work with \_\_\_\_\_ (DOB XX/XX/XXXX). We have had the pleasure of working with \_\_\_\_\_ in the Specialized Treatment for Early Psychosis (STEP) Clinic since XX/XX/XXXX. STEP is an early intervention program for 16-35 year olds in the first few years of a primary psychotic disorder; this kind of program is known as Coordinated Specialty Care (CSC). Our research, as well as that of other programs, has shown that CSC can greatly reduce the impact of psychotic disorders on symptoms and functioning; and keep young people closer to their premorbid trajectory.”
- Reason for referral (e.g. moving; upon further assessment doesn't meet criteria/primary issue not psychosis and needs more appropriate treatment; graduated STEP)
- Clinical formulation & history
  - Diagnosis/diagnoses and rule outs if applicable
  - Current phase of treatment
  - Estimated date of psychosis onset
  - History of symptoms
  - Contributing factors
  - Premorbid functioning
- Current Goals & Recommendations
  - Monitor for these early warning signs of psychosis ...
- Treatment History
  - Course in STEP
  - Prior to STEP
  - Medication trials (e.g. side effects/adverse reactions, preferences, positive responses, doses and durations)
  - Psychiatric hospitalizations? How many? Last one?

- What works well for this patient (e.g. engagement strategies, modalities, styles/ approaches)? What to avoid?
- Risk history and any ongoing concerns
- Potential barriers/causes of disruption to look out for, including pragmatic barriers like transportation
- Patient Strengths & Interests
- Stressors
- Reverse Workup (include labs and other test results if applicable)
- Physical Health
- Substance Use
- Vocational/Educational
- Family & social support
- Cultural factors
- Other factors? (e.g. trauma history, comorbid conditions)
- Resources to learn more about early stages of psychosis and treatment:
  - <https://www.nasmhpd.org/content/early-intervention-psychosis-eip>
  - or more targeted resources as appropriate
- Encouragement to contact STEP treaters and provide contact info

Enclose contact and insurance information if not already provided on receiving providers' form(s).