CSC OnDemand

Collaborative Learning for Coordinated Specialty Care for people with first episode psychosis

Transition Planning Handout

Introduction

Coordinated Specialty Care (CSC) services for individuals with first-episode psychosis are intended to be time-limited. As such, all services are meant to be transitional in nature. Proper planning can help support the progress that participants have made in CSC programs.[1]

Participants should view transitioning from the team as being positive, meaningful, and something to work toward. Not all participants will want ongoing services after leaving the CSC program, even though they will benefit from ongoing care.[1] It is important to use shared decision-making (SDM) to help identify possible beneficial services.

Preparing for Transition

The length of time that clients stay in a program can vary significantly. The transition process may begin when a participant reaches clinical stability, a participant wants to receive care from other providers, a participant moves, the team determines that the participant does not have a primary non-affective psychotic disorder diagnosis, or the team decides that the participant needs more intensive services.[1] The timing and transition will be a result of SDM among all relevant participants.[2]

The transition planning process ideally begins six months before discharge. Helping participants and their families reassess their needs and preferences, and equipping them with knowledge about mental health services and the mental healthcare system, will help guide their selection of the most appropriate services from the options available.[3]

In its CSC transition planning guide,[1] the National Association of State Mental Health Program Directors recommends that the CSC team consider the following factors when planning for transition:

- Progress toward treatment goals
- Clinical stability
- Substance use
- Physical health
- Level of functioning
- Ability to manage symptoms
- Medication adherence
- Support system
- Stability of housing situation
- Ability to engage
- Developmental stage
- Response to decreased CSC services

The Transition Planning Process

Transition planning is not always linear.[1] During the last six months of treatment, the team must actively work toward planned transition, bolster effective support networks, and initiate plans for accessing needed services in the community. The team, with activities led and coordinated by the primary clinician, will collaborate with participants and family members using SDM to determine the best options for care in the future. The team will help the participant and family identify sources of care in the community and create a support network that covers all needed areas of continuing care.[4]

If a participant wishes to leave the program before the team thinks that they are ready, the team can use the SDM approach to make decisions. This process may provide an opportunity to re-engage the participant with the team, or to support the individual transitioning to alternative services. If these efforts prove unsuccessful, however, the team should emphasize safety. The team should work with the participant and family whenever possible to prevent relapse, recognize early warning

signs of psychosis, and know how to access services.[1] In this section, we briefly examine transition planning tasks for each team member.

Primary Clinician

The primary clinician plays a central role in the transition process by helping the participant and their family create a plan for obtaining care in the community and making that plan become a reality.[5] The primary clinician will be responsible for several transition planning activities:[4]

- Working with individuals and families to identify and address termination or transition needs and preferences
- Coordinating with other team members to ensure that the plan is comprehensive, incorporating medication, school or work, and recovery goals
- Assessing further needs and preferences
- Working with the participant to implement the transition plan
- Meeting with the participant—both alone and with their family—to mark the transition from the program

Supported Education and Employment Specialist (SEES)

Each SEES should be a part of the team's approach to working with participants and family members about what transition means and how to negotiate transition successfully. From the start, the SEES should be mindful about the need to assist participants in building natural supports and should start talking specifically about transition three to four months before the expected transition date.[5]

As the SEES and the program participant work toward transition, they will need to research various options in order to make informed decisions about what to include in the transition plan to help the participant remain successful.[5] For individuals who are employed, the SEES and the participant should talk about the supports that have been most effective and identify other agencies or resources that can provide this same level of support. They should also identify which natural supports have been valuable and create a plan to continue those supports.[4] The SEES should connect with family members to ensure that they contribute to the transition plan and provide them with community vocational/education resources, as well as education regarding special accommodations as they relate to work and school. The SEES should also make referrals to the state vocational rehabilitation agency when applicable.[4]

As the SEES begins to think about helping participants transition from the program, they should consider these key questions:[5]

1. Is the participant transitioning out of the program while currently working or in an education program?
2. What services have been helpful in supporting the vocational and/or educational activities?
3. What, if any, supports will participants need once there has been a full transition?
4. What natural supports are available or already in place, and how can those supports assist during the transition?

The SEES spends time learning from participants about what supports they feel have been most helpful in maintaining employment. Visiting participants on the job and meeting regularly with their supervisors may be just the right amunt of support for one person, but not enough, or too much, for the next individual. It is essential to customize the transition plan for each person. Furthermore, if the employer has received supports from the SEES, someone should talk to the employer about the transition plan.[5]

Family Education and Support Specialist

For many families, their experience of CSC will be very positive, with strong bonds forged among participants, their families, and the team. Families may be hesitant to move forward with community services, but they and their participant relatives will need to take steps to prepare for and feel confident about transitioning to new treatment providers.[3] The family clinician and other members of the CSC team will play a critical role in guiding families through the planning process.

During family meetings, the family clinician will describe the expected timeline of progress within the program. Generally, at least two sessions should be devoted to specific discussion of family needs and treatment transitions.[2] The goals of these sessions are to review progress made in the program, go over and refine the discharge plan, and make referrals to any additional resources needed by the family.[2] Both NAVIGATE and OnTrackNY provide resources for use with families in transition planning. (See the *NAVIGATE Family Manual* and *OnTrackNY Family Treatment and Resources Manual* for information on discharge planning with families.)

Typical discharge planning activities[2] include:

- Ensuring that the family understands the next treatment options
- Responding to any questions that the family has |about discharge
- Reinforcing strengths that the family has exhibited
- Obtaining feedback on the CSC program

Peer Specialist

From the very beginning of their relationship, a peer specialist can help prepare a CSC participant for moving on from the program.[6] Peer specialists can use tools—such as OnTrackNY's T-MAP document—to help participants identify and detail their needs, desires, personal goals, and community resources. Peer specialists can focus their attention on laying the groundwork for the program participant's future life as a connected member of the greater community. Modeling self-advocacy skills across life settings, the peer specialist can help by sharing experiences of being a responsible young person who struggles with serious mental illness.[5]

As participants' and families' time with the CSC team draws to a close, peer specialists can play a critical role in facilitating transitions from the team to other resources in the community.[5] Participants and families may be understandably quite anxious at the prospect of leaving the team and uncertain of their options. Peer specialists can relate their own experiences of transitioning between levels of care or from one provider to another. They can recount lessons learned and ways in which they managed both the feelings associated with moving on and the practicalities associated with establishing care elsewhere.[5]

The Transition Plan

All team members should work with the participant to create a transition plan. The transition plan should be a resource that the participant can use to guide their selection of future supports and services. The team can also use the plan to review tools and strategies to aid with ongoing illness and wellness management commonly associated with sustaining one's engagement in their own recovery.[4]

The transition plan should identify goals and personal and service-related needs, such as:[1]

- Mental health care
- Substance use treatment
- Medication management
- Physical health care
- Care management or care coordination
- Peer support
- Housing
- Vocational and educational opportunities

Together with the participant, the team should take stock of the ways the participant has benefitted from the program and use that information to drive transition planning.[1]

Treatment and Service Providers

For most program participants, transition planning will involve identifying another provider of mental health treatment. A few participants may elect to see a primary care physician for medication after leaving the program.[5] Others may not be interested in continuing mental health treatment but may be open to connecting with other community resources such as case management services, self-help groups, or peer-run support programs.

Types of service providers may include Community Mental Health Centers, Federally Qualified Health Centers, and Young Adult Services program.[1] Team-based care with case management may also be helpful. Other participants may prefer smaller, private practice settings. If the CSC program is part of a larger agency, consider referring participants to services within that agency.[1]

If a client leaves a program due to geographic moves, you should refer them to another CSC program. If there are no CSC programs in the area, your program may be able to offer support over long distances or refer the individual to another local provider.[1] Participants who are going to college should be connected to the university's 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.[1] Opportunities for accommodations under the Americans with Disabilities Act can also be explored.

Part of the transition involves helping participants and families explore options of potential providers. It is

important to make referrals to specific providers to best address each participant's needs.[1] Providers should be knowledgeable about psychosis, evidence-based practices for psychosis, transition-age youth and young adults, person-centered and recovery-oriented care, and the CSC model. They should also have experience working with people who are acutely ill. Take the participant's and family preferences into account when making referrals and consider potential barriers such as lack of transportation, hours when services are offered, scheduling constraints, insurance coverage, co-pays, administration of injections, and laboratory and monitoring services for clozapine.[1]

Once a participant has selected a potential provider, it is important for the CSC team to work with the provider to see that the transition goes smoothly. This involves educating the provider about CSC services as well as FEP and its treatment.[1] It is particularly helpful to address misperceptions providers may have about the abilities of individuals experiencing psychosis.[1] If the participant feels comfortable, their family may start to engage with the new provider. The team should give the provider the following information:[1]

- The initial clinical and functional presentation
- Current clinical and functional status
- Participant characteristics when stable
- Participant characteristics when most impaired
- History of safety concerns
- Diagnostic evaluation and conclusions
- Treatment approach and rationale
- Current and historical psychopharmacological interventions
- Side effects, dosing, and medication adherence
- Family involvement and dynamics
- Participant and family attitudes and feelings about the transition
- Psychiatric advance directives

CSC team members can offer to accompany the participant to the first meeting with the new provider.[1] The prescriber on the team may also communicate directly with the new prescriber or provide a written summary. It is also valuable to provide a summary of additional information from the participant's perspective.[1]

To make the transition process easier, it can be advantageous for teams to build referral networks. These networks can allow more providers to learn about CSC services. It may also be helpful for CSC teams to offer relevant providers with educational opportunities.[1]

Transition Challenges

Transition will involve many challenges. Many clients will have developed a strong attachment to their team and may be reluctant to discuss transfer of care issues and planning.[4] Some may not want to end the relationship and may wish that it could continue.[4] They will be familiar and comfortable with the ease with which they have been able to reach CSC staff, the flexibility of scheduling appointments, and the open communication with all team members.[3] For many participants and families, relinquishing that dependable support will be frightening. Establishing relationships with new mental healthcare providers may seem overwhelming and risky. Participants and families need to know that they will be ready to take the step to community care because they will be properly prepared to navigate a world that is unfamiliar to them.[3] It is critical that the team begins discussion of and work toward transition long before transfer must actually occur.[4] The main tasks for the team include ensuring that the support network is safely in place and that it covers all needed areas of continuing care. All team members can assist in this area by helping to determine the best community care for a participant within each specialty area. An SDM approach is especially important when planning ongoing care, as this is a time when the participant and their family need to drive planning and take ownership of decisions about the future.[4]

Post-Transition

The team should assess safety throughout the transition process. There are a lot of risks during this time as participants anticipate the loss of relationships with the CSC team. The participant and the new provider are not as familiar with one another and the participant will be spending less time with the new provider than with the CSC team.[1] CSC services might overlap with the new provider during this time (however, insurance may not pay for this).[1] CSC team members should check in with the participant regularly during this time and troubleshoot any issues that arise. CSC team members might also be in contact with the new provider during this time.[1]

CSC team members should remain in contact with the participant and, if permitted, the participant's family and new providers.[1] During this time, the CSC team can encourage the participant to address questions or concerns with the new provider or identify a different provider. The CSC team should continue to offer support to the new provider.[1]

Some CSC programs allow readmission if transition is unsuccessful or symptoms worsen. In addition, some CSC programs have opportunities for participants to remain involved after transition, including serving on peer advisory boards, mentoring, or visiting.[1]

References

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