Transitions of Care

ED/Hospitals

- **Transitions of Care.**
  - Develop a clear discharge plan with patient and involved support system.
  - When referring to outpatient specialty services (e.g., coordinated specialty care) allow opportunity for providers to meet patient in person in the hospital as able.
  - Review and reconcile medications with the patient and family before discharge.
  - Create a relapse prevention plan with patient and their support system, including when and who to contact for help before discharge.
  - Send aftercare summaries to outpatient care providers within 3 days of discharge.

Behavioral Health Agencies

- **Transitions of Care**. Offer step-down services that focus on:
  - *Individualized clear transition planning*: develop a clear collaborative plan with patient and their support system.
    - Begin discussing transitions early (at entry to services and regularly thereafter), and communicate clearly about treatment timeline
    - Assess readiness to transition using standardized tools to evaluate symptom severity, readiness and patient/family voice.
    - Identify nonmedical barriers to transition and mitigate as able (e.g., transportation barriers, insurance coverage, social support)
    - Review and reconcile medications with the patient and their support systems prior to transition
    - Co-create a relapse prevention plan with the patient and their support system, including early warning signs, specific action steps, and contacts.
  - *Continuity of relationships:* continue to provide needed services to patients with providers whom they have developed relationships with. (e.g., psychotherapy, medication management) as able.
  - *Gradual reduction of intensity*: allow flexibility to increase intensity again if needed.
    - Establish a minimum standard for follow-up contact (e.g., within 1-2 weeks post-transition); increase intensity for patients at higher risk of recurring symptoms.
  - *Emphasis on recovery and empowerment*: promote self-efficacy in managing health and social goals. Provide psychoeducation about self-management strategies, recovery, resilience and episodic nature of psychosis.

    - *Integrated care:* coordination with primary care, social services, housing and education and employment supports outside of the coordinated specialty care program
        - Facilitate direct introductions to receiving providers, especially primary care, through warm handoffs before transition.
        - Provide clear guidance to receiving teams regarding necessary ongoing monitoring for recurrence of symptoms, medication side effects, and behavioral health supports (e.g., psychotherapy, peer support, family therapy, etc.)
        - Arrange for periodic psychiatric consultation as needed post-transition
    - For individuals with persistent symptoms of multiple complex needs, coordinate direct handoff to assertive community treatment, intensive case management and/or residential programs.

Primary Care

- **Transitions of Care**
    - Seek out educational opportunities as needed on co-managing patients with psychosis with behavioral health providers
    - Co-manage patients with psychosis with behavioral health providers.
    - Do not unnecessarily discontinue antipsychotic medications
    - Monitor for side effects of antipsychotic medication
        - Offer monitoring through telehealth/virtual contact if unable to meet in person
        - Teach patient's support system how to monitor for side effects, and instructions for how to support seeking help as needed.
    - Identify contacts for recurrence of symptoms after transition if necessary.

Health Plans

- **Transitions of Care:**
    - Provide increased case management services to patients with identified psychosis. Support scheduling follow up appointments with providers
    - Support patient and family in identifying and scheduling with a primary care provider before and during transition to less intensive care.
    - Offer incentives to behavioral health agencies that provide coordinated specialty care
    - Consider declining to contract with providers (e.g., primary care, behavioral health agencies, hospitals) that do not have a referral pathway to coordinated specialty care programs in their region.

    - Do not require prior authorization for second-generation antipsychotics
    - Track relevant outcomes in claims data (e.g., ER visits, hospitalizations) to identify and intervene on disparities in care.
    - Support access to specialty consultations as needed after transition

Employers

- **Transitions of Care**
    - Require behavioral health vendors to have a standardized protocol for referral to specialty services for people with suspected psychosis.
    - Ensure benefit provider provides case management support for people identified with diagnosis of psychosis

Washington State Agencies

- **Transitions of Care:**
    - Advocate for further development of services to provide full continuum of care for people with intensive behavioral health needs. (e.g., partial hospitalization programs, residential treatment programs, etc.)
    - Support culturally-specific and trauma-informed behavioral health services through grants/contracts
    - Disseminate directory of coordinated specialty care programs to medical providers in regions where service is available

Literature Review

Citation	**Abstract**	**Findings**
Systematic Reviews		
Puntis S, Minichino A, De Crescenzo F, Cipriani A, Lennox B, Harrison R**.** **Specialised early intervention teams (extended time) for recent-onset psychosi**s. Cochrane Database Syst Rev. 2020 Nov 2;11(11):CD013287. doi: 10.1002/14651858.CD013287.pub2. PMID: 33135812; PMCID: PMC8094422.	Background Psychosis is an illness characterised by the presence of hallucinations and delusions that can cause distress or a marked change in an individual's behaviour (e.g. social withdrawal, flat or blunted affect). A first episode of psychosis (FEP) is the first time someone experiences these symptoms that can occur at any age, but the condition is most common in late adolescence and early adulthood. This review is concerned with FEP and the early stages of a psychosis, referred to throughout this review as 'recent-onset psychosis.' Specialised early intervention (SEI) teams are community mental health teams that specifically treat people who are experiencing, or have experienced, a recent-onset psychosis. SEI teams provide a range of treatments including medication, psychotherapy, psychoeducation, educational and employment support, augmented by assertive contact with the service user and small caseloads. Treatment is time limited, usually offered for two to three years, after which service users are either discharged to primary care or transferred to a standard adult community mental health team. Evidence suggests that once SEI treatment ends, improvements may not be sustained, bringing uncertainty about the optimal duration of SEI to ensure the best long-term outcomes. Extending SEI has been proposed as a way of providing continued intensive treatment and continuity of care, of usually up to five years, in order to a) sustain the positive initial outcomes of SEI; and b) improve the long-term trajectory of the illness. Objectives To compare extended SEI teams with treatment as usual (TAU) for people with recent-onset psychosis. To compare extended SEI teams with standard SEI teams followed by TAU (standard SEI + TAU) for people with recent-onset psychosis.	Systematic review to compare specialized early intervention teams that are extended with treatment as usual, and standard early intervention + treatment as usual for people with recent onset psychosis – found 3 RCTs with 780 participants, comparing extended SEI with standard SEI Outcomes were assessed at 36 months for two trials and 41 months for one trial Preliminary evidence says extending SEI team prevents disengagement, but certainty was low; not many ongoing trials, so not likely to be any definitive evidence for several years.

Search methods
On 3 October 2018 and 22 October 2019, we searched Cochrane Schizophrenia's study-based register of trials, including registries of clinical trials.

Selection criteria
We selected all randomised controlled trials (RCTs) comparing extended SEI with TAU for people with recent-onset psychosis and all RCTs comparing extended SEI with standard SEI + TAU for people with recent-onset psychosis. We entered trials meeting these criteria and reporting usable data as included studies.

Data collection and analysis
We independently inspected citations, selected studies, extracted data and appraised study quality. For binary outcomes we calculated the risk ratios (RRs) and their 95% confidence intervals (CIs). For continuous outcomes we calculated the mean difference (MD) and their 95% CIs, or if assessment measures differed for the same construct, we calculated the standardised mean difference (SMD) with 95% CIs. We assessed risk of bias for included studies and created a 'Summary of findings' table using the GRADE approach.

Main results
We included three RCTs, with a total 780 participants, aged 16 to 35 years. All participants met the criteria for schizophrenia spectrum disorders or affective psychoses. No trials compared extended SEI with TAU. All three trials randomly allocated people approximately two years into standard SEI to either extended SEI or standard SEI + TAU.

The certainty of evidence for outcomes varied from low to very low. Our primary outcomes were recovery and disengagement from mental health services. No trials reported on recovery, and we used remission as a proxy.

Three trials reported on remission, with the point estimate suggesting a 13% increase in remission in favour of extended SEI,

	but this included wide confidence intervals (CIs) and a very uncertain estimate of no benefit (RR 1.13, 95% CI 0.97 to 1.31; 3 trials, 780 participants; very low-certainty evidence). Two trials provided data on disengagement from services with evidence that extended SEI care may result in fewer disengagements from mental health treatment (15%) in comparison to standard SEI + TAU (34%) (RR 0.45, 95% CI 0.27 to 0.75; 2 trials, 380 participants; low-certainty evidence). There may be no evidence of a difference in rates of psychiatric hospital admission (RR 1.55, 95% CI 0.68 to 3.52; 1 trial, 160 participants; low-certainty evidence), or the number of days spent in a psychiatric hospital (MD -2.70, 95% CI -8.30 to 2.90; 1 trial, 400 participants; low-certainty evidence). One trial found uncertain evidence regarding lower global psychotic symptoms in extended SEI in comparison to standard SEI + TAU (MD -1.90, 95% CI -3.28 to -0.52; 1 trial, 156 participants; very low-certainty evidence). It was uncertain whether the use of extended SEI over standard SEI + TAU resulted in fewer deaths due to all-cause mortality, as so few deaths were recorded in trials (RR 0.38, 95% CI 0.09 to 1.64; 3 trials, 780 participants; low-certainty evidence). Very uncertain evidence suggests that using extended SEI instead of standard SEI + TAU may not improve global functioning (SMD 0.23, 95% CI -0.29 to 0.76; 2 trials, 560 participants; very low-certainty evidence). There was low risk of bias in all three trials for random sequence generation, allocation concealment and other biases. All three trials had high risk of bias for blinding of participants and personnel due to the nature of the intervention. For the risk of bias for blinding of outcome assessments and incomplete outcome data there was at least one trial with high or unclear risk of bias.	

	Authors' conclusions There may be preliminary evidence of benefit from extending SEI team care for treating people experiencing psychosis, with fewer people disengaging from mental health services. Evidence regarding other outcomes was uncertain. The certainty of evidence for the measured outcomes was low or very low. Further, suitably powered studies that use a consistent approach to outcome selection are needed, but with only one further ongoing trial, there is unlikely to be any definitive conclusion for the effectiveness of extended SEI for at least the next few years.	
Roson Rodriguez P, Chen X, Arancibia M, Garegnani L, Escobar Liquitay CM, Mohammad HA, Franco JVA**. Transitional discharge interventions for people with schizophrenia.** Cochrane Database of Systematic Reviews 2024, Issue 8. Art. No.: CD009788. DOI: 10.1002/14651858.CD009788.pub3. Accessed 15 July 2025.	Background Schizophrenia is a chronic mental illness characterized by delusions, hallucinations, and important functional and social disability. Interventions labeled as 'transitional' add to care plans made during the hospital stay in preparation for discharge. They also include interventions developed after discharge to support people with serious mental illness as they make the transition from the hospital to the community. Transitional discharge interventions may anticipate the future needs of the patient after discharge by co-ordinating the different levels of the health system that can effectively guarantee continuity of care in the community. This occurs through the provision of therapeutic relationships which give a safety net throughout the discharge and community reintegration processes to improve the general condition of users, level of functioning, use of health resources, and satisfaction with care. Objectives To assess the effects of transitional discharge interventions for people with schizophrenia. Search methods On 7 December 2022, we searched the Cochrane Schizophrenia Group's Study-Based Register of Trials, which is based on CENTRAL, MEDLINE, Embase, PubMed, CINAHL, ClinicalTrials.gov, ISRCTN, PsycINFO, and WHO ICTRP.	Transitional discharge care may make no difference in admissions to hospital and quality of life It may improve how well a person functions in day to day life Results of costs of running discharge care program are inconclusive – no information on relapse or unwanted effects However, it's important for clinician to discuss transitional period from psych ward to the community, considering adequate discharge plan and coordinating with outpatient care Important to encourage active participation of patients and caregivers in transitions

	Selection criteria Randomized controlled trials (RCTs) evaluating the effects of transitional discharge interventions in people with schizophrenia and schizophrenia-related disorders. Eligible interventions included three key elements: predischarge planning, co-ordination of care and follow-up, and postdischarge support. Data collection and analysis We used standard Cochrane methods. Outcomes of this review included global state (relapse), service use (hospitalization), general functioning, satisfaction with care, adverse effects/events, quality of life, and direct costs. For binary outcomes, we calculated risk ratios (RRs) and their 95% confidence intervals (CIs). For continuous outcomes, we calculated the mean difference (MD) or standardized mean difference (SMD) and their 95% CIs. We used GRADE to assess certainty of evidence. Main results We found 12 studies with 1748 participants comparing transitional discharge interventions to usual care. All were parallel-group RCTs. No studies assessed global state (relapse) or reported data about adverse events/effects. All studies had a high risk of bias, mainly due to serious concerns about allocation concealment, deviations from intended interventions, measurement of the outcomes, and missing outcome data. Transitional discharge interventions may make little to no difference in service use (hospitalization) at short- and long-term follow-ups, but the evidence is very uncertain (RR 1.18, 95% CI 0.55 to 2.50; I2 = 54%; 4 studies, 462 participants; very low-certainty evidence). Transitional discharge intervention may increase the levels of functioning after discharge (clinically important change in general functioning) (SMD 0.95, 95% CI −0.06 to 1.97; I^2 = 95%; 4 studies, 437 participants; very low-certainty evidence) and may increase the proportion of participants who are satisfied with the intervention (clinically important change in satisfaction) (RR 1.96, 95% CI 1.37 to 2.80; 1 study, 76 participants; very low-certainty evidence), but for both outcomes the evidence is very uncertain.	

	Transitional discharge intervention may make little to no difference in quality of life compared to treatment as usual (SMD 0.24, 95% CI −0.30 to 0.78; $I^2 = 90\%$; 4 studies, 748 participants; very low-certainty evidence), but we are very uncertain. For direct costs, one study with 124 participants did not report full details and thus the results were inconclusive. Authors' conclusions There is currently no clear evidence for or against implementing transitional discharge interventions for people with schizophrenia. Transitional discharge interventions may improve patient satisfaction and functionality, but this evidence is also very uncertain. For future research, it is important to improve the quality of the conduct and reporting of these trials, including using validated tools for measuring their outcomes.	
Hegedüs A, Kozel B, Richter D, Behrens J. **Effectiveness of Transitional Interventions in Improving Patient Outcomes and Service Use After Discharge From Psychiatric Inpatient Care: A Systematic Review and Meta-Analysis.** Front Psychiatry. 2020 Jan 21;10:969. doi: 10.3389/fpsyt.2019.00969. PMID: 32038320; PMCID: PMC6985781.	Background: The transition from psychiatric hospital to community is often hindered by challenges that influence community adjustment and continuity of care. Transitional interventions with bridging components are provided prior to discharge and continue beyond inpatient care. They provide continuity of care and may be effective in preventing readmission. We aimed to assess the effectiveness of transitional interventions with predischarge and postdischarge components in reducing readmissions and improving health-related or social outcomes of patients discharged from psychiatric hospitals. Methods: We conducted a systematic review by searching electronic databases (MEDLINE, Embase, Cochrane Library, CINAHL, PsycINFO, and Psyndex) and included randomized, nonrandomized, and one-group study designs. A random effects meta-analysis was conducted with randomized controlled trials (RCTs) reporting data on readmission rates. Other study designs were synthesized qualitatively. Results: After screening 2,673 publications, 16 studies (10 RCTs, three quasi-experimental, and three cohort studies) were included and nine RCTs were included in the meta-analysis. The tested interventions included components from case management,	Systematic review of 16 studies (10 RCTs, 3 quasiexperimental, and 3 cohort), 9 RCTs included in meta-analysis; aimed to assess effectiveness of transitional interventions with predischarge and post-discharge components in reducing readmissions and improving health-related or social outcomes of patients discharged from psych hospitals. All studies with significant findings provided case management, in combination with CBT and psychoeducation. From patient perspective, discharge planning, follow up after discharge, individual coping measures, peer support, networks are essential to preventing readmission

	psychoeducation, cognitive behavioral therapy, and peer support. All studies with significant improvements in at least one outcome provided elements of case management, most frequently in combination with cognitive behavioral therapy and psychoeducation. Readmission rates during follow-up ranged between 13% and 63% in intervention groups and 19% and 69% in control groups. Overall, we found an odds ratio of 0.76 (95% confidence interval = 0.55–1.05) for readmission due to transitional interventions. Heterogeneity was low at only 31% (p = 0.17) and the funnel plot indicated no obvious publication biases. Conclusions: We observed that transitional interventions with bridging components were no more effective in reducing readmission than treatment as usual; however, these results are based on limited evidence. Therefore, additional high-quality research is required to conclude the effectiveness of transitional interventions. Nevertheless, transitional interventions with bridging components are preferred by service users and could be an alternative to strategies regularly employed.	Other articles have found collaborative care interventions, transition managers and timely communication to be effective (included under case management for this study's purposes)
Midura S, Fodstad JC, White B, Turner AJ, Menner S**. Supportive Transition Planning for Adolescents Transitioning From Psychiatric Hospitalization to School: A Systematic Literature Review and Framework of Practices**. Contin Educ. 2023 Jan 30;4(1):23-40. doi: 10.5334/cie.61. PMID: 38774904; PMCID: PMC11104309.	School-aged youth with behavioral health needs often struggle in the academic environment. When admitted to acute psychiatric hospital settings, the student's difficulties and needs increase upon discharge and return to the school setting. While the literature describes systemic issues in transitioning from an acute psychiatric hospital to the school setting, limited resources exist for practitioners to plan for and support the successful reintegration of affected students. Using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, the purpose of the current systematic review was to collect and synthesize evidence from the literature (N = 20) in the areas of barriers, challenges, and significance of the need for a formal transition planning framework. Four major key factors emerged as important to assist in creating a transition planning framework for acute psychiatric hospitals to school-based settings: (a) Stakeholder Voice (Student, Caregiver, Hospital/Treatment Team, or School Team Voice); (b) Establishing a Point Person for Transition (Medical or School Point Person); (c) Recommendations/Accommodations (Formal or Informal Supports); and (d) Having a Transition Meeting.	Systematic review of 20 studies to identify best practices for transitions from psych hospital to school settings. Transition planning frameworks need stakeholder voice (student, hospital/treatment team, school team); establishing point person for transitions; recommendations/accommodations; and having a transition meeting

	Other common factors are discussed, and recommendations are provided to aid practitioners in increasing the likelihood that school-age youth succeed in the school environment post-discharge from acute psychiatric settings. Finally, gaps in the literature are identified as areas for further research.	
	The period immediately following discharge after inpatient stay for mental illness has been found to be the time of greatest risk for adverse outcomes (e.g., rehospitalization, relapse, suicide). However, the experiences of patients as they transition from the hospital to the community are not well understood. The purpose of the present review was to systematically search and synthesize the literature examining the transition experiences of individuals following inpatient psychiatric stay. A systematic search was conducted for studies examining the experiences of patients as they transition back into their communities, using qualitative or quantitative methods. Qualitative articles were analyzed using thematic content analysis. Quantitative articles were extracted and summarized. The search identified 1614 abstracts, of which 27 (18 qualitative; 9 quantitative) were included in the review. The results of the analysis identified themes necessary for transition including safety, supported autonomy, and the opportunity to engage in a number of reintegration activities. A number of barriers were found that prevent integration, such as poverty, interpersonal difficulties, and stigma. The results highlight the disconnect that occurs for patients as they transition from hospital, pointing to the need for effective transitional interventions that target these challenges	Aim to understand experience of individuals post-discharge who are transitioning back to community from psychiatric hospitalization; 27 articles included – most studies were high rigor; themes included lack of autonomy, wanting independence but needing support; lack of self-efficacy, and when feeling they had inability to cope they could seek readmission; inadequate transition – individuals with comprehensive discharge plan felt it was easier; those with outpatient support reported varying levels, and quality; social support is important to prevent further readmissions; peer support is vital; self care as a coping strategy – identifying activities that help self-regulation; normalization, challenges with integrating back into life and re-engaging with responsibilities, need for meaningful activity; external factors that hindered recovery and transition including poverty, interpersonal difficulties, stigma all worsened transitions.
Redmond P, Grimes TC, McDonnell R, Boland F, Hughes C, Fahey T**. Impact of medication reconciliation for improving transitions of care.** Cochrane Database of Systematic Reviews 2018, Issue 8. Art. No.: CD010791. DOI:	Background Transitional care provides for the continuity of care as patients move between different stages and settings of care. Medication discrepancies arising at care transitions have been reported as prevalent and are linked with adverse drug events (ADEs) (e.g. re-hospitalization).	Systematic review to identify if medication reconciliation improves medication discrepancies, healthcare utilization outcomes and patient-reported outcomes. 25 studies included in 8 different countries, low to very low quality evidence, primarily pharmacist-

10.1002/14651858.CD010791.pub2. Accessed 15 July 2025	Medication reconciliation is a process to prevent medication errors at transitions. Reconciliation involves building a complete list of a person's medications, checking them for accuracy, reconciling and documenting any changes. Despite reconciliation being recognised as a key aspect of patient safety, there remains a lack of consensus and evidence about the most effective methods of implementing reconciliation and calls have been made to strengthen the evidence base prior to widespread adoption. Objectives To assess the effect of medication reconciliation on medication discrepancies, patient-related outcomes and healthcare utilisation in people receiving this intervention during care transitions compared to people not receiving medication reconciliation. Search methods We searched CENTRAL, MEDLINE, Embase, seven other databases and two trials registers on 18 January 2018 together with reference checking, citation searching, grey literature searches and contact with study authors to identify additional studies. Selection criteria We included only randomised trials. Eligible studies described interventions fulfilling the Institute for Healthcare Improvement definition of medication reconciliation aimed at all patients experiencing a transition of care as compared to standard care in that institution. Included studies had to report on medication discrepancies as an outcome. Data collection and analysis Two review authors independently screened titles and abstracts, assessed studies for eligibility, assessed risk of bias and extracted data. Study-specific estimates were pooled, using a random-effects model to yield summary estimates of effect and 95% confidence intervals (CI). We used the GRADE approach to assess the overall certainty of evidence for each pooled outcome. Main results	delivered, studies mainly included older people prescribed multiple medications. There was no clear effect on patient-focused outcomes and medication discrepancies.

	We identified 25 randomised trials involving 6995 participants. All studies were conducted in hospital or immediately related settings in eight countries. Twenty-three studies were provider orientated (pharmacist mediated) and two were structural (an electronic reconciliation tool and medical record changes). A pooled result of 20 studies comparing medication reconciliation interventions to standard care of participants with at least one medication discrepancy showed a risk ratio (RR) of 0.53 (95% CI 0.42 to 0.67; 4629 participants). The certainty of the evidence on this outcome was very low and therefore the effect of medication reconciliation to reduce discrepancies was uncertain. Similarly, reconciliation's effect on the number of reported discrepancies per participant was also uncertain (mean difference (MD) –1.18, 95% CI –2.58 to 0.23; 4 studies; 1963 participants), as well as its effect on the number of medication discrepancies per participant medication (RR 0.13, 95% CI 0.01 to 1.29; 2 studies; 3595 participants) as the certainty of the evidence for both outcomes was very low. Reconciliation may also have had little or no effect on preventable adverse drug events (PADEs) due to the very low certainty of the available evidence (RR 0.37. 95% CI 0.09 to 1.57; 3 studies; 1253 participants), with again uncertainty on its effect on ADE (RR 1.09, 95% CI 0.91 to 1.30; 4 studies; 1363 participants; low-certainty evidence). Evidence of the effect of the interventions on healthcare utilisation was conflicting; it probably made little or no difference on unplanned rehospitalisation when reported alone (RR 0.72, 95% CI 0.44 to 1.18; 5 studies; 1206 participants; moderate-certainty evidence), and had an uncertain effect on a composite measure of hospital utilisation (emergency department, rehospitalisation RR 0.78, 95% CI 0.50 to 1.22; 4 studies; 597 participants; very low-certainty evidence). Authors' conclusions The impact of medication reconciliation interventions, in particular pharmacist-mediated interventions, on medication discrepancies is uncertain due to the certainty of the evidence being very low. There was also no certainty of the effect of the interventions on	

	the secondary clinical outcomes of ADEs, PADEs and healthcare utilisation	
Randomized Clinical Trials		
Kidd SA, Mutschler C, Lichtenstein S, Yan S, Virdee G, Blair F, Mihalakakos G, McKinney C, Collins A, Guimond T, George TP, Davidson L, Velligan D, **Voineskos A. Randomized trial of a brief peer support intervention for individuals with schizophrenia transitioning from hospital to community.** Schizophr Res. 2021 May;231:214-220. doi: 10.1016/j.schres.2021.03.019. Epub 2021 Apr 22. PMID: 33895598.	This phase 2 randomized trial examined the outcomes of a brief, transitional, peer support intervention designed to address the poor outcomes that are common for individuals with schizophrenia spectrum illnesses in the period immediately following hospitalization. In the context of treatment-as-usual, participants were provided with a peer support intervention, 'the Welcome Basket,' in which participants received 1-2 sessions of peer support in the two weeks before discharge and met weekly for a month post-discharge. The study also piloted a brief version of this intervention with only one community session post-discharge with the same pre-discharge process. It was hypothesized that the full intervention would improve community transition outcomes, with community functioning (Multnomah Community Ability Scale) being the primary measure and secondary measures including symptomatology, community integration, personal recovery, quality of life, and social support. The examination of the brief intervention was exploratory. Measures were completed at baseline, 1-month post-discharge, and follow-up at 6 months. A total of 110 participants were randomized to one of three interventions, with outcome data obtained from 82 and follow-up from 74. While feasible, we did not find that the Welcome Basket intervention was superior to treatment as usual for any of our primary or secondary outcome measures. Future work is needed to determine whether a more extended intervention is required and whether specific subgroups of patients may benefit (e.g. those without access to immediate psychiatric care or those better able to engage with a peer).	RCT designed to test brief peer support intervention immediately after hospitalization for schizophrenia spectrum illness on improving community transition outcomes (using community functioning ability scale); collected outcome data at 1 month post discharge and at 6 mo post discharge Found it was not superior to treatment as usual, but this intervention was provided for a significantly shorter period of time that other previous similar interventions. Gross measures of community functioning may not provide the expected benefit, may not be specific enough to measure benefit of peer support without other psychosocial supports.
Other References		
Brown H, Ongur D, Smurawska L, Valcourt S. **Inpatient - Outpatient transitions in first episode psychosis care.** Schizophr Res. 2022 Dec;250:123-124. doi: 10.1016/j.schres.2022.10.014. Epub 2022 Nov 17. PMID: 36401993; PMCID: PMC9742132.	The standard of care for people in early phases of a psychotic disorder is coordinated specialty care, an evidence-based outpatient treatment modality e.g. as implemented in the NIMH-funded RAISE study (Kane et al., 2016). But it is common for such individuals to also experience inpatient hospitalization for acute disease exacerbations especially involving safety issues. Hospitalization is the first contact with the mental health care	Many challenges in transitioning patients to coordinated specialty care and out of CSC. But best practices for transition have been left out of the literature.

	system for some; of individuals referred to a first episode clinic, 25% get hospitalized in the first 12 months and 50% in the first 24 months (Craig et al., 2004). Many individuals get hospitalized more than once during the course of treatment, further amplifying the impact. Hospitalizations are significant also because they are a frequent source of disagreement and concern for the affected individual, among family and other stakeholders, and among clinicians. Finally, hospitalizations account for roughly half the cost of care in early psychosis services because hospitalization is expensive (Rosenheck et al., 2016). Despite these factors, best practices for inpatient-outpatient transition have not been discussed adequately in the literature. In this article, we highlight some common challenges and discuss potential solutions. We focus our discussion on experiences within the United States where healthcare is fragmented and access to care is poor. In countries with national healthcare systems some of the issues we discuss below are less damaging, although many still apply. In addition, we recognize that resource constraints in low- and middle-income countries may also limit generalization of this discussion.	Goal of every psych hospitalization should be to make a collaborative plan driven by the patient Outpatient clinicians can encourage patient to sign for a healthcare proxy for when they are unwell, and delineate wishes Clear comprehensive discharge planning can reduce readmission rates
Gallagher K, Ferrara M, Pollard J, Yoviene Sykes L, Li F, Imetovski S, Cahill J, Mathis W, Srihari VH**. Taking the next step: Improving care transitions from a first-episode psychosis service**. Early Interv Psychiatry. 2022 Jan;16(1):91-96. doi: 10.1111/eip.13127. Epub 2021 Feb 8. PMID: 35029048.	Aims: First-episode services (FES) improve outcomes in recent onset psychosis, but there is growing concern about how patients fare after discharge from these time-limited services. Methods: A quality improvement approach (QI) was used to improve patient engagement in the discharge planning process (disposition), and successful engagement in care 3 months after discharge from the FES (transfer). Data from 144 consecutive discharges over 62 months are presented. A planning phase was followed by recurrent Plan-Do-Study-Act cycles (PDSA) that included the introduction of proactive efforts targeting disposition planning (with patients and families) and follow-up to facilitate transfer after discharge. Fisher's exact test was used to compare disposition and transfer outcomes across the QI phases. Results: This QI approach was sustained through a three-fold escalation in discharge volume. Transfer status at 3 months was significantly different between the pre- and post PDSA phases (p =	QI initiative to improve patient engagement in discharge process for a first episode psychosis CSC program - looking at Interventions to improve successful transfers were considered, including calls to clinics and patients at 1 month post discharge, earlier disposition planning. Tracking of transfer disposition and discussion of outlier cases where transitions did not go smoothly also improved percent of those transitioned into continuing treatment.

	.02). A greater proportion were confirmed transfers post-PDSA (54.3 vs. 37%), but of those with known status at 3 months, similar proportions were successfully transferred (76, 73%). Patients discharged post-PDSA were less likely to have unknown treatment status (26 vs. 51%). Disposition outcomes were also significantly improved post-PDSA (p = .03). Patients were more likely to engage with discharge planning (69.7 vs. 48.6%) and less likely to be lost to follow-up (13.8 vs. 25.7%), or to refuse assistance (11.0 vs. 20.0%). Conclusion: This QI approach offers a feasible way to improve disposition and transfer after FES and can be built upon in efforts to sustain functional gains in onward pathways.	
Jones, N., Gius, B., Daley, T., George, P., Rosenblatt, A., & Shern, D. (2020). **Coordinated specialty care discharge, transition, and step-down policies, practices, and concerns: Staff and client perspectives.** Psychiatric Services, 71(5), 487–497. https://doi.org/10.1176/appi.ps.201900514	Objective: In recent years, optimizing the process of transition and discharge from coordinated specialty care (CSC), a program that provides early intervention in psychosis, has emerged as an important focus area for program administrators, clinicians, and policy makers. To explore existing CSC policies and practices and to understand frontline provider and client views on discharge, the authors conducted a comprehensive analysis of staff and client interview data from the Mental Health Block Grant 10% Set-Aside Study. Methods: Data from 66 interviews with groups of CSC providers and administrators representing 36 sites and 22 states were analyzed, as well as data from interviews with 82 CSC clients at 34 sites. Transcripts were coded by using systematic content analyses. Results: Analyses of data from providers and administrators showed the heterogeneity of CSC program practices and strategies regarding discharge and highlighted a range of concerns related to post-discharge service accessibility and quality. Analysis of data from client interviews reflected the heterogeneity of transition challenges that clients confront. A significant number of participants reported concerns about their readiness for discharge. Conclusions: CSC discharge policies and practices vary across CSC programs and states. Frequent clinician and client concerns about optimal program length, transition, and postdischarge services highlight the	Current policies and practices regarding discharge and transition from coordinated specialty care (CSC) programs vary across the United States, and the number of programs with formal step-down or discharge services is very limited. Both clinicians and current and former clients expressed concerns about post-discharge service availability and quality. The development and rigorous evaluation of discharge-related programming and step-down or extension strategies are critical priorities for the field. Two of 36 programs provided targeted post- discharge extension or step-down services, and only 1 had regular clinically oriented follow up to ensure or assess success of transition

	importance of sustained policy and research efforts to develop evidence-informed practice guidelines and possible modifications to the time-limited CSC model that currently dominates the field.	
Phalen, P. L., Smith, W. R., Jones, N., Reznik, S. J., Marti, C. N., Cosgrove, J., Lopez, M., Calkins, M. E., & Bennett, M. E. (2024). **Reasons for discharge in a national network of early psychosis intervention programs.** Schizophrenia Bulletin. Advance online publication. https://doi.org/10.1093/schbul/sbae100	Background: Discharge from early psychosis intervention is a critical stage of treatment that may occur for a variety of reasons. This study characterizes reasons for discharge among participants in early psychosis intervention programs participating in the Early Psychosis Intervention Network (EPINET) which comprises >100 programs in the United States organized under 8 academic hubs. Study Design: We analyzed 1787 discharges, focusing on program completion, unilateral termination by the client/ family, and lost contact with the client/family. We performed exploratory analyses of demographic, clinical, and functional predictors of discharge reason. Variables predictive of discharge type were included in multilevel logistic regressions, allowing for the estimation of predictors of discharge reason and variability in rates by program and hub. Study Results: An estimated 20%–30% of enrolled patients completed the program. Program completion rates were higher among participants who were older on admission, had lower negative symptoms severity, spent more time in education, employment, or training, and who were covered by private insurance (a close proxy for socioeconomic status). Programs were more likely to lose contact with male participants, Black participants, and participants who were never covered by private insurance. After accounting for patient-level factors, there was substantial program-level variation in all 3 discharge outcomes, and hub-level variability in the proportion of participants who completed the program. The impact of race on program completion varied substantially by program. Conclusions: Participants were discharged from early psychosis intervention services for diverse reasons, some of which were associated with sociocultural factors. Disengagement is a widespread problem affecting all hubs	Participants that were more likely to lose contact with the program, were male participants, Black participants, and those never covered by private insurance; patient-level factor influence varied significantly between hubs, including impact of race on completion.
Fraser ER, Silva Garcia K, Oluwoye O. **Transitioning Out of Coordinated Specialty**	**Objective:** This study aimed to describe the goals of service users with first-episode psychosis who enrolled in coordinated specialty	Transitioning out of coordinated specialty care can be an anxiety

Care: Exploration of Service Users' and Families' Goals and Needs. Psychiatr Serv. 2025 Jul 1;76(7):635-641. doi: 10.1176/appi.ps.20240199. Epub 2025 Apr 23. PMID: 40264341.	care (CSC), along with the goals their family members have for them, and to understand service users' and family members' perceived needs for recovery after discharge from the program. **Methods:** The authors conducted 32 in-depth interviews in English or Spanish with service users and their family members recruited between September 2021 and December 2022. Transcripts were analyzed to determine the common concerns and expectations of service users and family members. **Results:** Most service users described wanting financial and social independence from their families of origin, including an education that would allow them to obtain well-paid, stable employment; transportation; and an independent residence. Service users described hoping to replace some of the support they received from CSC with friends they would make in the future; some family members hoped their loved one would be able to develop and sustain romantic relationships. Most family members described not feeling ready to leave CSC at the 2-year mark, whereas service users expressed mixed opinions about their readiness to exit the program. **Conclusions:** Although service users were excited about the prospect of discharge, they, along with their family members, agreed that ongoing support was needed after CSC. On the basis of the findings, the authors delineate supports that service users and family members believe are necessary for a successful step-down.	inducing experience; Many participants need and want some form of continued services or periodic check is after completing the program to ensure progress is maintained. This article was published from work **in WA state!** Most family members described not feeling ready to leave CSC at the 2 year mark, but mixed views from service users. Services viewed as necessary in step-down include: mental health services (fewer appointments) vocational services (education, employment, housing needs) social skills and intimate relationships
Jones, N., Gius, B., Daley, T., George, P., Rosenblatt, A., & Shern, D. (2020). **Coordinated specialty care discharge, transition, and step-down policies, practices, and concerns: Staff and client perspectives**. Psychiatric Services. Advance online publication. https://doi.org/10.1176/appi.ps.201900514	Objective: In recent years, optimizing the process of transition and discharge from coordinated specialty care (CSC), a program that provides early intervention in psychosis, has emerged as an important focus area for program administrators, clinicians, and policy makers. To explore existing CSC policies and practices and to understand frontline provider and client views on discharge, the authors conducted a comprehensive analysis of staff and client interview data from the Mental Health Block Grant 10% Set-Aside Study. Methods: Data from 66 interviews with groups of CSC providers and administrators representing 36 sites and 22 states were analyzed,	Current policies and practices regarding discharge and transition from coordinated specialty care (CSC) programs vary across the United States, and the number of programs with formal step-down or discharge services is very limited. Both clinicians and current and former clients expressed concerns about post-discharge service availability and quality.

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