Canadian
Consortium for
Early Intervention
in Psychosis

Adapting Early Intervention for Psychosis (EPI) Services for Youth

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Disclosures

Dr Sabina Abidi:

- None

Laura Carnegy:

- None

Learning Objectives

After participating in this session, participants will be better able to;

- Review importance of offering timely care for children & youth at risk for Psychotic Spectrum Disorders
- Outline the development, implementation and outcomes of the IWK Youth Psychosis Clinic targeting age 12-19
- Discuss opportunities to offer standardized seamless care for youth and young adults with Psychotic Spectrum Disorders locally, provincially and nationally

Understanding the WHY - Dirk

- 18 year 11 mos African NS male
- Large collective family in isolated township, multiple generations
- Older siblings interactions with police
- Family history schizophrenia maternal uncle – no treatment
- Age 13 traumatic experience: unprovoked assault by police – ongoing trial
- In mental health treatment for 1 year in child/adolescent services for PTSD highlighted by school mental health clinician– trust and rapport established
- New consult to EPP child/adol team
- Delusional fixation the police intend to kill him

Understanding the WHY - Devon

- 14 yo Indigenous male admitted to inpatient unit in child/adol MH care
- Diagnosis Autism Spectrum Disorder in childhood - mild
- Severe presentation, atypical, diagnosis unclear
  - Severe catatonia
  - Obsessive ruminations
  - Schneiderian sxs SZP
- Prolonged admission, rule out neurological etiology
  - ECT
  - Clomipramine
  - Clozapine
- No family support/DCS
- Followed in child/adol EPP services until 19
- Adult services lack comfort to provide care due to complexity and unclear diagnosis

Understanding the WHY - Shelly

- 19 yo white female, TRS diagnosis at age 17
- Followed by child/adol EPP Team
- Multiple mental health contacts
- Family supported, engaged in all aspects of treatment
- In remission for 1 year on LAI
- Approaching age of transition to adult MHS
- Beginning university moving into residence
- Recently started new job
- Parents anxious about all aspects of transition

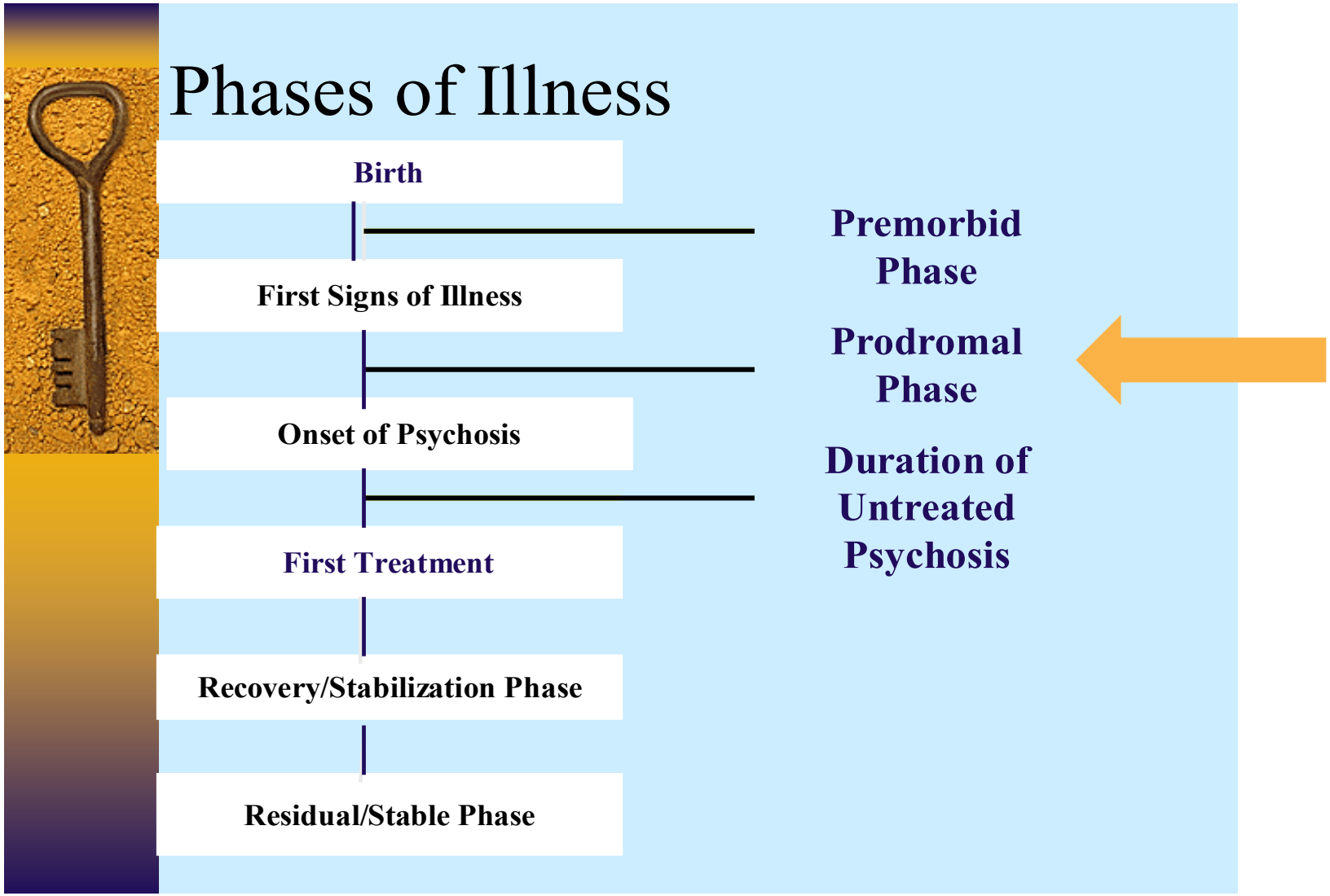
Age of Onset of Schizophrenia

- Childhood onset schizophrenia (COS) <age 13
- Early onset schizophrenia (EOS) age 13-18 – average age of onset 15-17years
- Adult-onset schizophrenia (AOS) >age 18

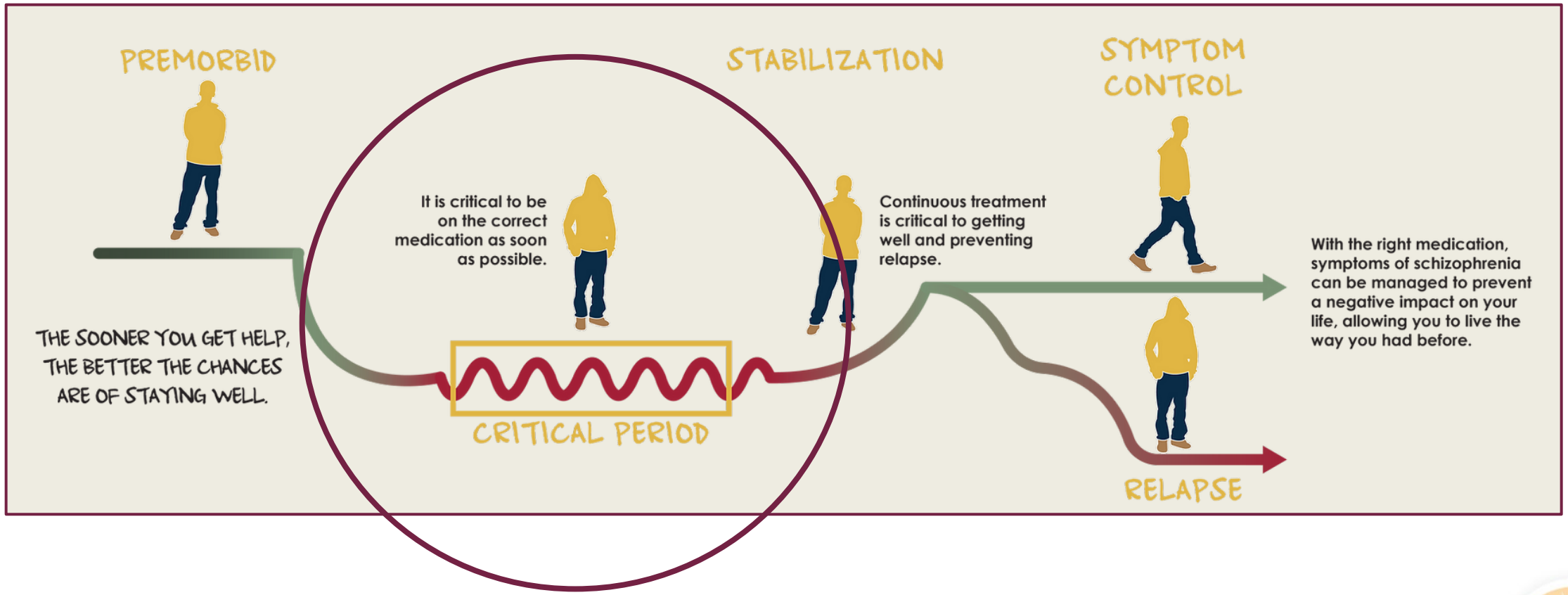
- Less than 8% of schizophrenias are diagnosed before age 18 yet more than 18-20% report first symptoms/have emergence of illness before age 18
- Diagnostic continuity between EOS and AOS however EOS have poorer prognoses overall (more negative symptoms, higher severity of symptoms, more likely to be TRS) and often require longer term specialized intervention
  - Age of onset, affect on neurodevelopment, attainment of developmental milestones are intertwined

- **Preventing long Duration of Untreated psychosis (DUP) is one of best predictors of positive outcomes regardless of age of onset**

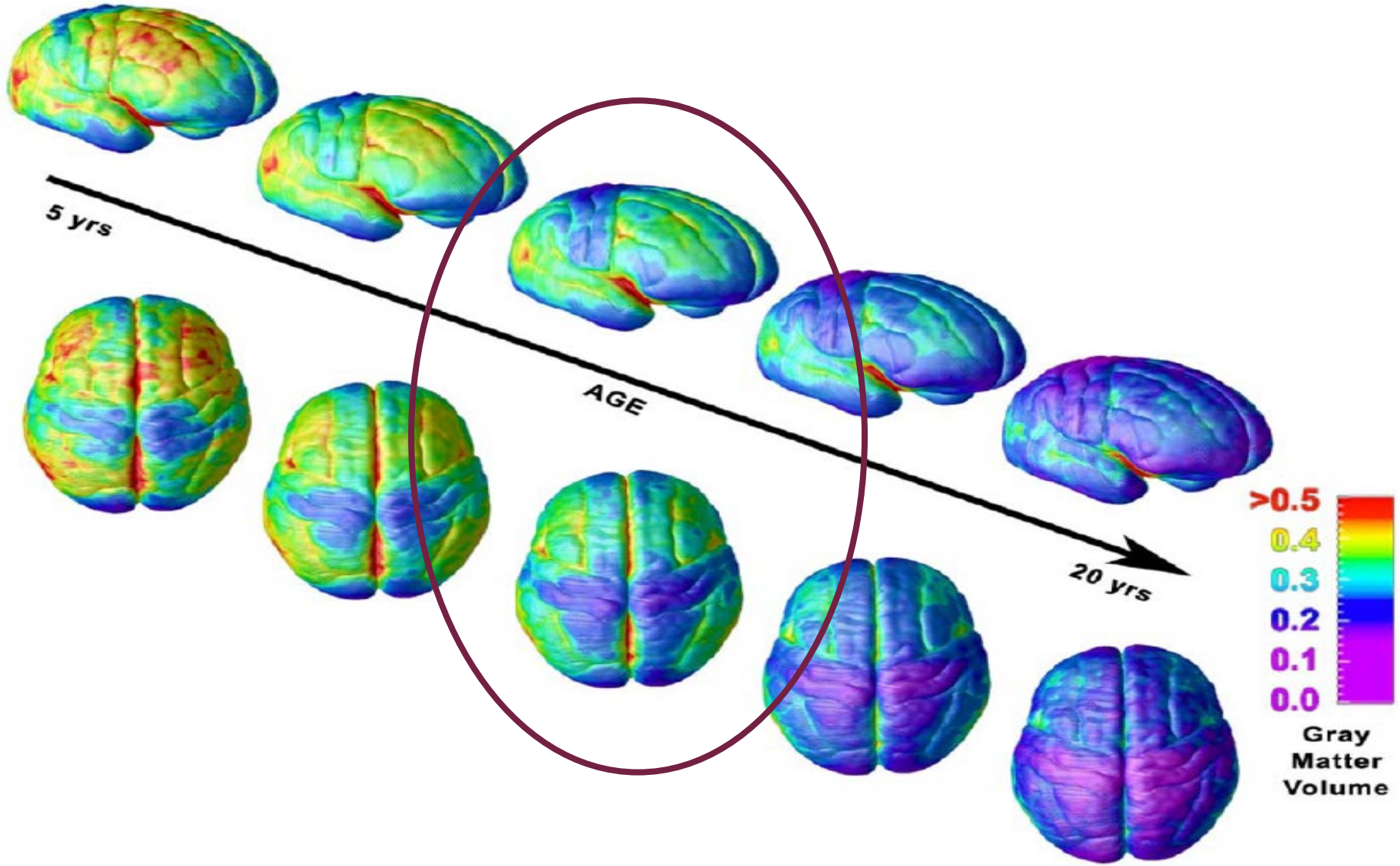
Phases of Illness of Schizophrenia Spectrum Disorders



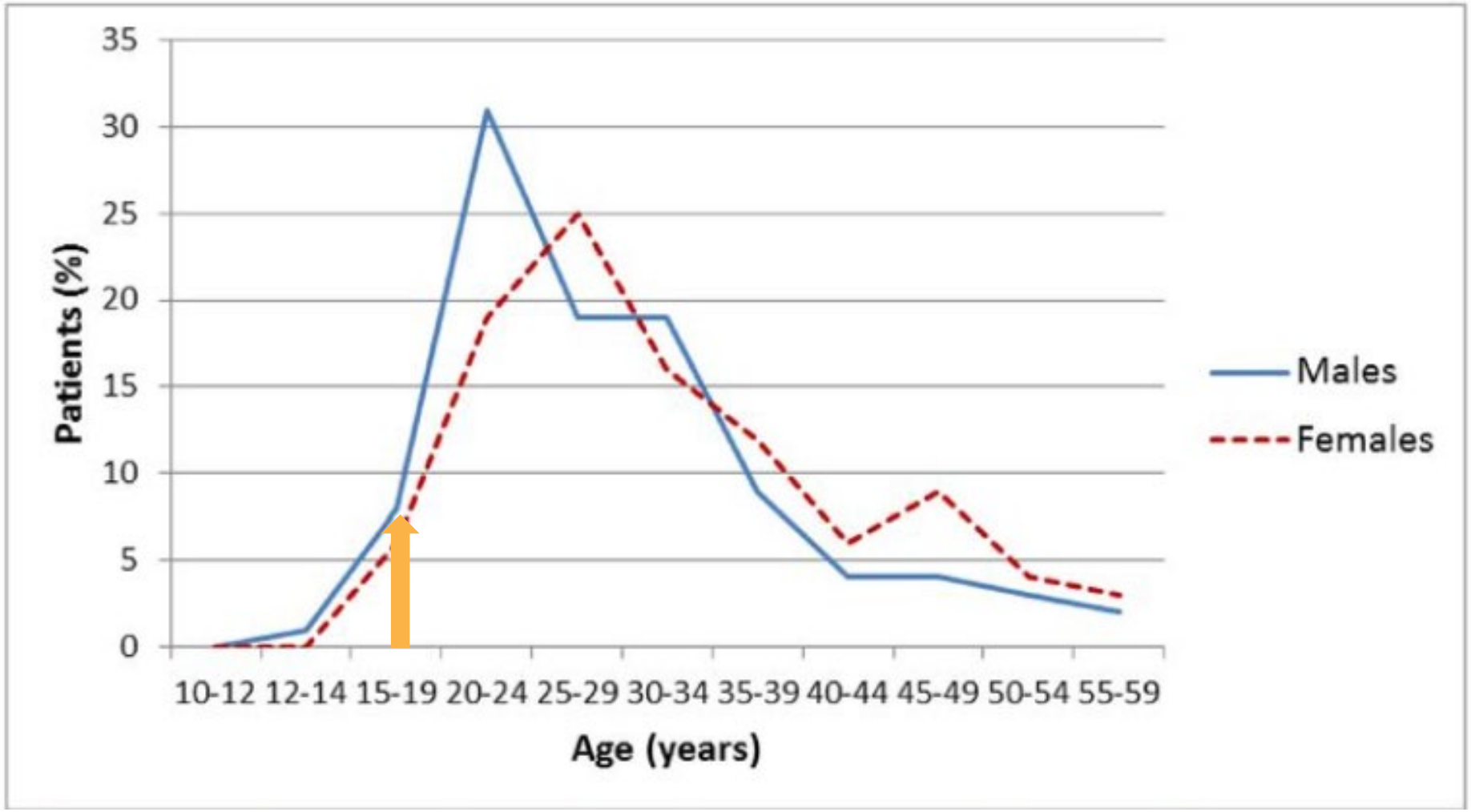
The Sooner the Better to Promote Positive Outcomes for FEP



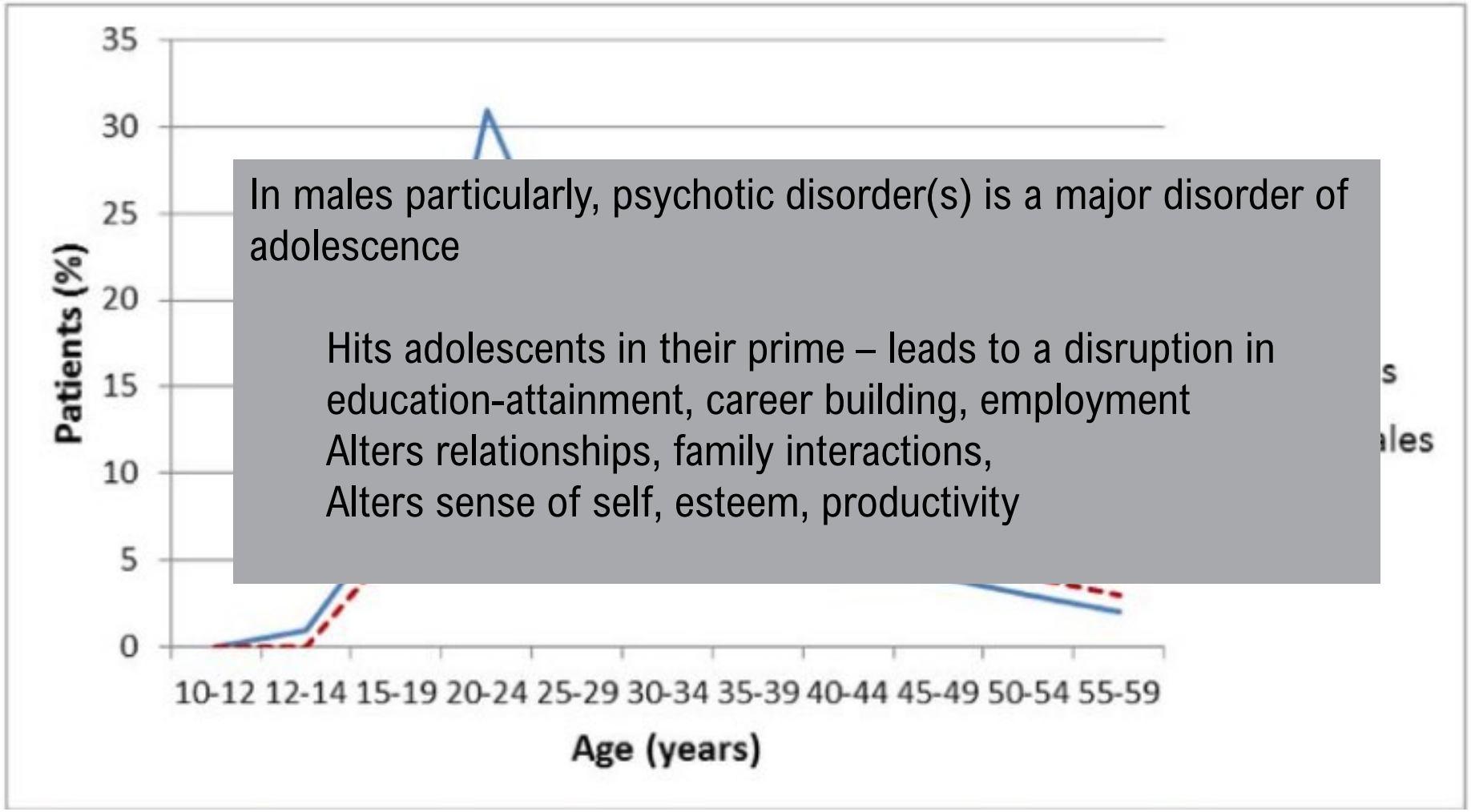
Normal Brain Development



Age of Onset of Psychotic Disorders



Age of onset of psychotic disorders



In males particularly, psychotic disorder(s) is a major disorder of adolescence

Hits adolescents in their prime – leads to a disruption in education-attainment, career building, employment
Alters relationships, family interactions,
Alters sense of self, esteem, productivity

Lost in Translation: Challenges in the Diagnosis and Treatment of Early-Onset Schizophrenia

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Abstract

Early-onset schizophrenia (EOS) is a heterogeneous condition that has a serious, insidious clinical course and poor long-term mental health outcomes. The clinical presentations are highly complex due to the overlapping symptomatology with other illnesses, which contributes to a delay in the diagnosis. The objective of the review is to study if an earlier age of onset (AAO) of EOS has poor clinical outcomes, the diagnostic challenges of EOS, and effective treatment strategies. The review provides a comprehensive literature search of 5966 articles and summarizes 126 selected for empirical evidence to methodically consider challenges in diagnosing and treating EOS for practicing clinicians. The risk factors of EOS are unique but have been shared with many other neuropsychiatric illnesses. Most of the risk factors, including

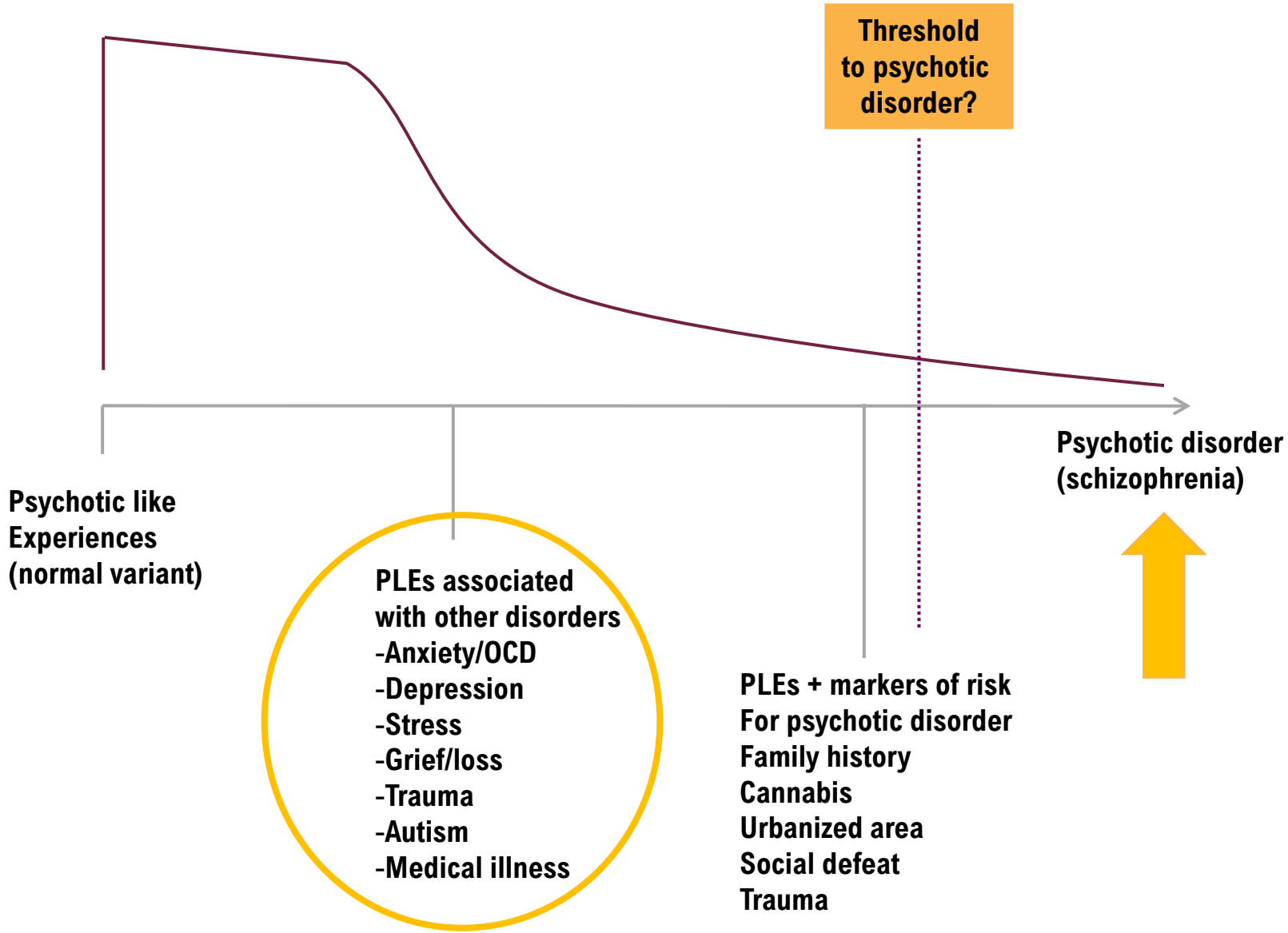
Heterogeneity and Complex Comorbidity

Tolerating diagnostic uncertainty in child/adolescent psychiatry

- Widely debated that EOS phenomenology is indistinguishable from other illnesses, has a more severe debilitating course, and is more often refractory to treatment
- ASD
  - The presence of psychotic disorder and ASD is poorly understood
- Intellectual Disability
- Substance misuse – cannabis of the 2020s
- Anxiety/Attention Deficit Hyperactivity Disorder
- Other comorbidities more common in AOS
- The concept of UHR (overlapping symptoms w developmental phenomena)
  - **Transitions**
- **Ambiguity of early symptoms leads to diagnostic uncertainty**

Stigma
Intergenerational Trauma
Intersectionality
Language
Culture
History of experience with MHS

A Multidimensional Concept of Psychosis – trying to identify EOS



The new life stage of emerging adulthood at ages 18–29 years: implications for mental health

Jeffrey J Arnett, Rita Žukauskienė, Kazumi Sugimura

Since 1960 demographic trends towards longer time in education and late age to enter into marriage and of parenthood have led to the rise of a new life stage at ages 18–29 years, now widely known as emerging adulthood in developmental psychology. In this review we present some of the demographics of emerging adulthood in high-income countries with respect to the prevalence of tertiary education and the timing of parenthood. We examine the characteristics of emerging adulthood in several regions (with a focus on mental health implications) including distinctive features of emerging adulthood in the USA, unemployment in Europe, and a shift towards greater individualism in Japan.

Lancet Psychiatry 2014; 1: 569–76

This is the third in a Series of three papers about adolescent mental health

Clark University, Worcester, MA, USA (J Arnett PhD);

The Construct of Adolescence

- Adolescents **age 10-24 years** currently comprise more than a quarter of the world's population, the largest in history

- Investment in adolescent health is a positive world strategy towards enhancing community wealth, human rights and social change.

- Adolescent health has declined over the last 5 decades
  - Most specifically mental health concerns
- Shift from burden of disease in childhood to issues of sexual and reproductive health, substance use, mental health, injury, obesity and chronic physical illness, requiring a different response

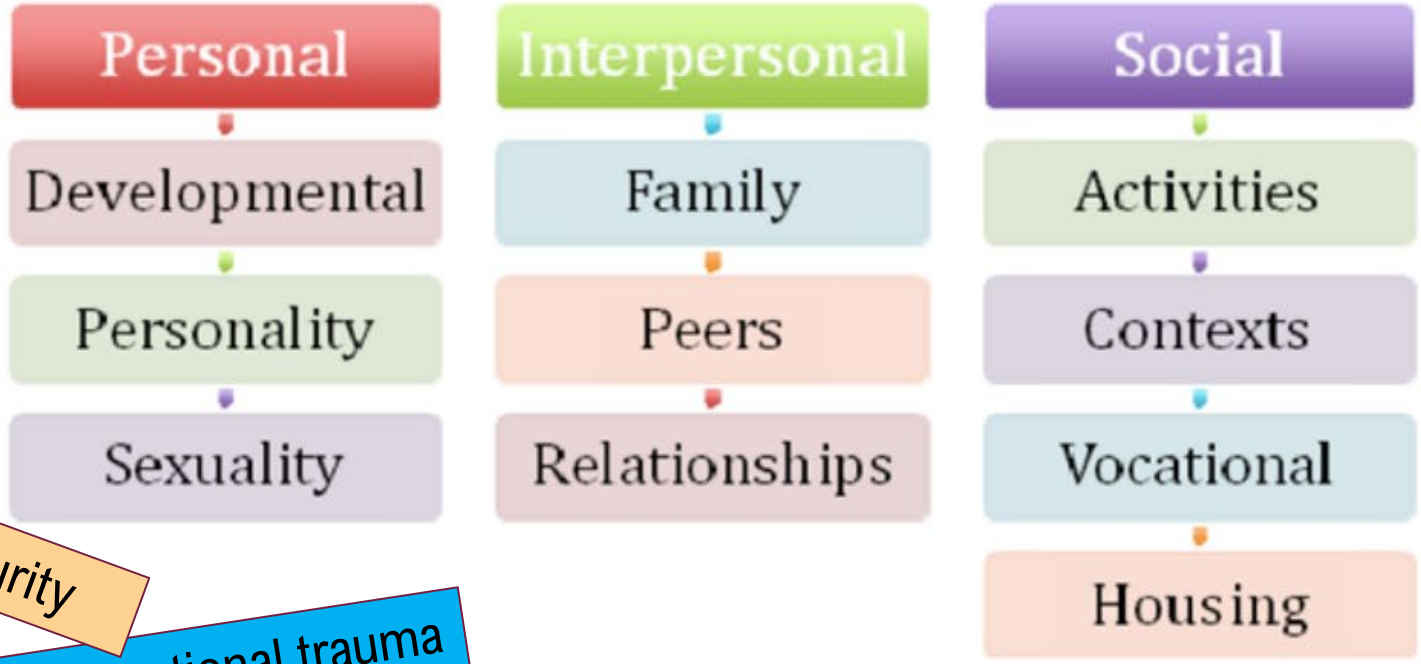
The Construct of Adolescence – Mental Health Concerns

- **Mental illness in adolescence is now the largest contributor to the worldwide burden of non-fatal disease.**
    - 50% of the world's population will meet criteria for one or more mental disorders in their lifetime
        - 70% of these disorders will have their onset in adolescence
        - In Canada, more than 20% of adolescents have at least one mental disorder
- Since 2020 mental illness is projected to be one of the five most common causes of morbidity, mortality and disability in young people.

Mind the Gap - Factors to Consider at Stage of Transition

Not just about Mental Health & Addiction

Multiple transition factors (interface between institutions, community and individual factors)



Social media influence

Newcomers

Language barrier

Food and home insecurity

Intergenerational trauma

Adapted from the MHCC 2015 Consensus Conference on the Mental Health of Emerging Adults

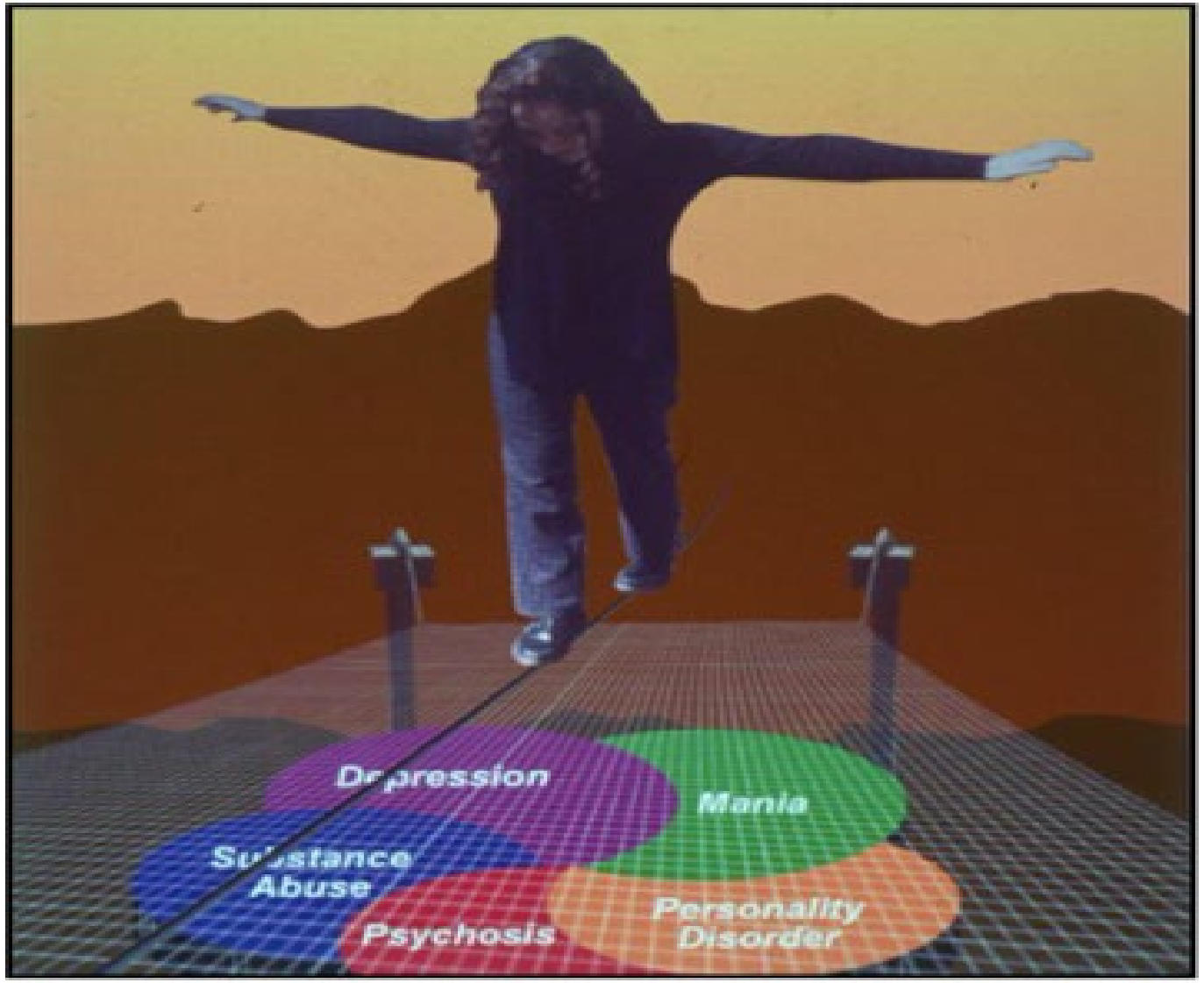
Transitions

- Between child/adolescent mental health systems (CAMHS) and adult mental health systems (AMHS) for emerging adults

- Historical, systems-driven bifurcation of both services – youth who have reached an artificially determined transition age are no longer amenable to services, having “aged out” of the CAMHS system and are deemed only appropriate for AMHS system once they have “aged in”

- At a time when youth are most vulnerable to mental ill-health impacts that could herald the onset of psychiatric illness and in truth at the highest risk of decline in service utilization youth and families are expected to navigate a new system of care

Adolescents – Walking the Tightrope of Transitions



Transition - Reality

- In the US, survey of 41 states found a quarter of CAMHS and half of AMHS offered no transition support despite identified 50% decline in service utilization at the age of transition
- In AUS (2009) many youth referred to AMHS were not accepted despite having substantial mental health needs and functional impairment according to CAMHS referral
- In the UK TRACK study (2008) 4% of youth have optimal transition to AMHS; more than 60% disengage at the point of transition
- In Canada (2008) the absence of a coordinated system of care for transition represents “one of the weakest linkages with the Ontario mental health care system”

Transition - Reality

- Most professionals, caregivers and adolescents experience this process negatively
  - Most transition-aged youth are lost to ongoing care
  - Most commonly identified outcomes:
    - Disengagement and drop-out (predicts poor outcomes for SPMI)
    - Consequent crisis-driven de novo connections with AMHS
    - Many are not referred to AMHS or not accepted despite having identified needs identified by CAMHS
    - Those adolescent with persistent psychiatric diagnoses requiring pharmacotherapy and admissions to hospital were more likely to have made contact with AMHS
      - Those with other illnesses such as ADHD, emotional and behavioral difficulties, neurodevelopmental disorders and personality disorders are left at risk for poor outcomes in transition

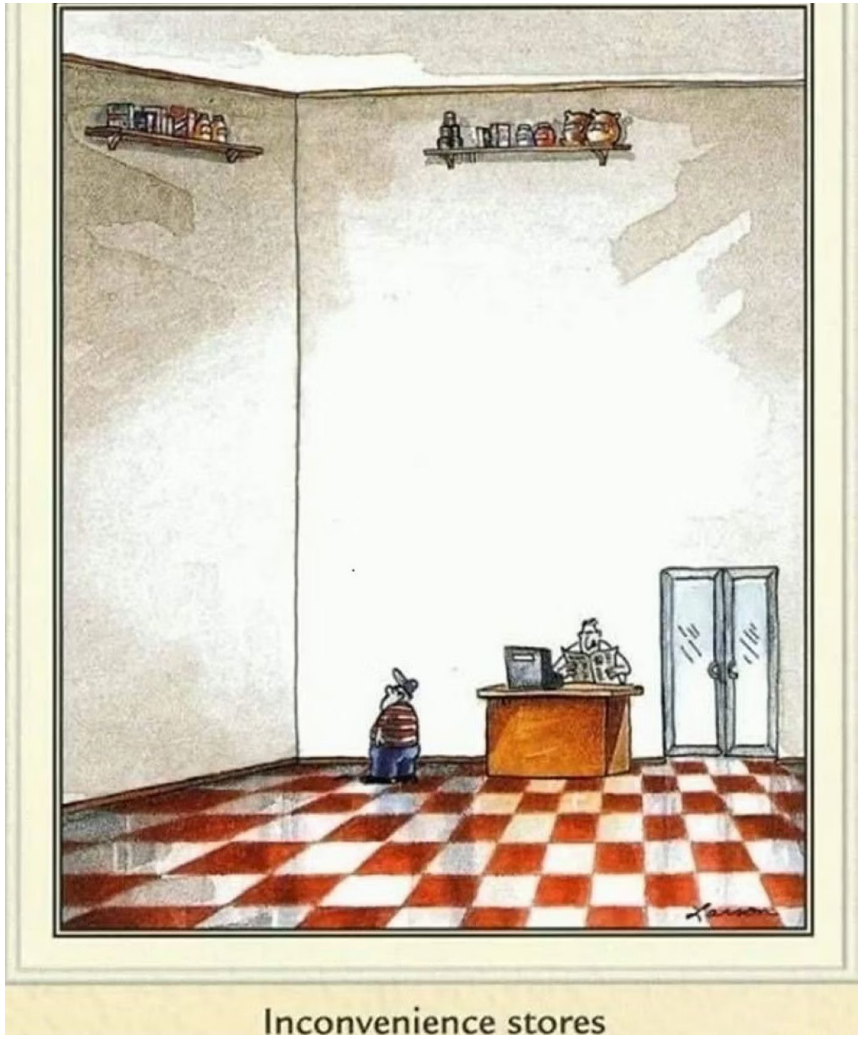
Outcomes of Transition

- Concerns expressed by adolescents (medical and psychiatric services):
  - Lack of readiness
  - Unprepared for the loss regarding CAMHS
  - Ill-prepared to navigate the more rigid AMHS
  - Lacking skills to manage their own illness let alone transition
- Families
  - Feeling isolated from care of their adolescent in the AMHS
  - Concern regarding sudden onset of more stringent confidentiality parameters
- Clinicians in CAMHS and AMHS
  - Anxiety and lack of confidence in skills pertaining to transition-aged youth
  - Unclear processes

Outcomes of Transition

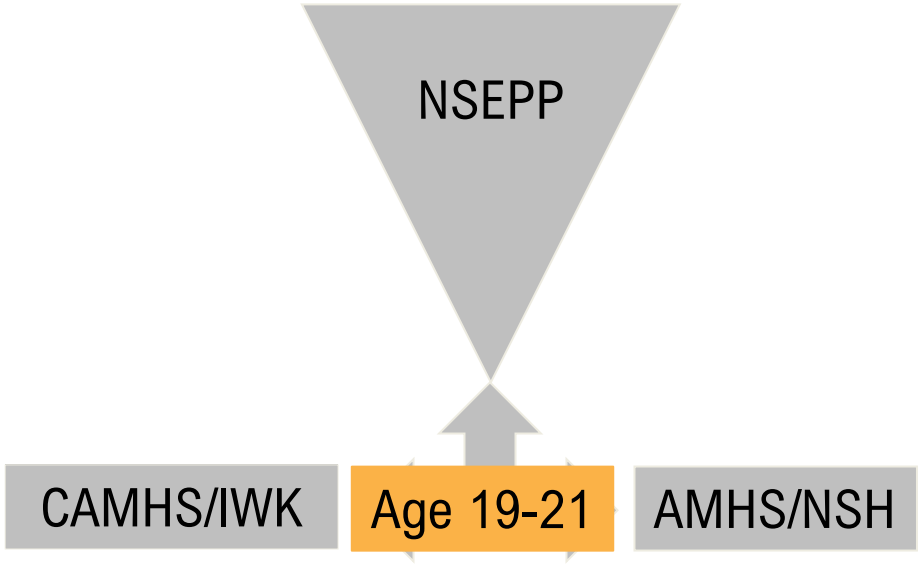
- Most youth have a positive attitude towards the concept of health services transition and are not ignorant of the issues (lack of funding, resources)
- Ask for
  - More collaborative approaches to enhance independence from the pediatric care system and preparation for the adult system
  - Active inclusion in the process and seek opportunities to develop life skills in the pediatric setting
  - Structured transition program with improved coordination and flexibility of services
  - Reduced wait times, minimal repeated assessments and stronger connection
- General principles
  - Avoid transition during acute phase of disorder
  - Best initiated age 21-25 or at least supported if before then
  - Readiness established in patient and family before initiating transition

Need New Models of Intervention



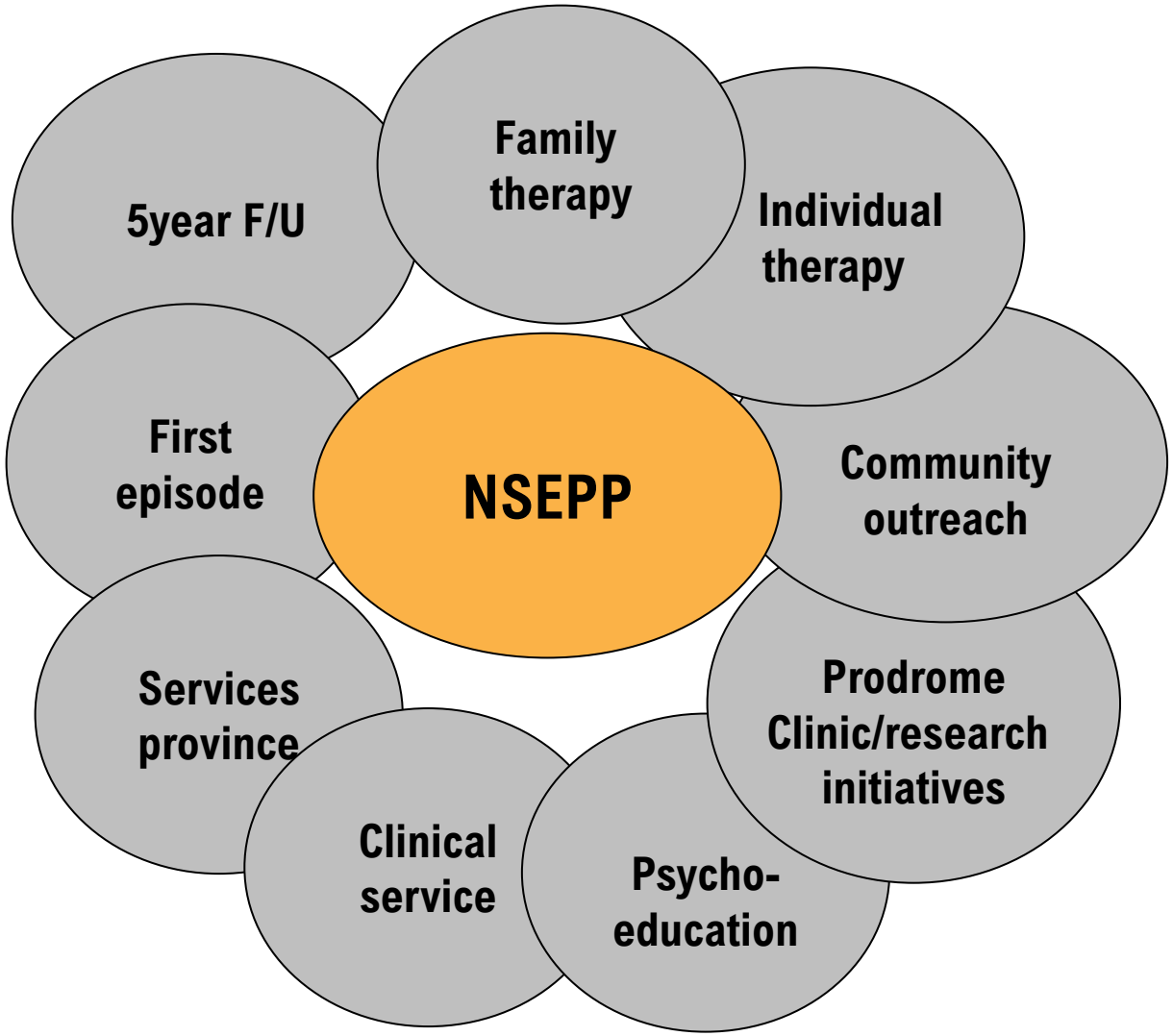
Need New Models of Intervention

A unique system of care provided by both NSH/IWK for persons with psychosis across the lifespan



- Youth/adults seeking help for psychotic sxs as the primary focus
- Offers a seamless transfer of care from youth to adult mental health
- Integrates Clinical care, Education Research and Advocacy
- Rapid response connection with inpatient services
- Comprehensive multidisciplinary tx offered for youth and family across the lifespan during critical time of illness (first 5 years)
- Specialty collaborative mental health services including weekly capacity building/case review

Offering a Different Model



NSEPP team includes:

- Adult psychiatry
- Child/adolescent psychiatry with expertise in development
- Nursing (child/adult)
- OT (goals, QOL)
- RT (social interaction/function)
- Social work/family therapy
- Psychology?
- Research
- Education coordinators
- Central database/shared documentation
- Outcomes evaluation
- Provincial mandate to establish standards across province

Offering Seamless Care

CAMHS IWK Psychosis SCC

Transparent discussion about transition at intake and during care.

Preparing patient & caregiver for transition 12 & 6m in advance (discussing adult services, choosing care team)

Transition Point (age 19)

Preparing adult team for transfer of care (information sharing)

Joint visit with patient +/- caregiver and adult services

Offering support during transition.

AMHS NSEPP

Adult team assumes care

Predetermined minimum 3 year follow up commitment

Maintain relationship with youth team as needed

Offering a New Model NSEPP IWK/NSH

Who else will work with me to support my recovery?

We work in partnership with a number of outside organizations to support recovery. They include peer support organizations such as Laing House, employment supports, education and leisure supports. The team will let you know about those resources and help you connect with them.

How long will I be followed with NSEPP?

- Up to 5 years. If transferring from the IWK Youth Team, up to 3 years.
- Your treating team will regularly assess your progress by completing recovery measures designed for youth recovering from psychosis. You will receive on-going feedback of the results of these measures.
- As your recovery progresses, meetings with the team may decrease.
- Before the end of your follow-up period, we will work with you to ensure your care is transitioned to the community program or service well suited to meet your continuing care needs.

How do I raise any feedback I may have about my treatment/recovery?

- We appreciate receiving feedback and suggestions about our services.
- Bring any concerns or suggestions to your doctor, clinical nurse, or other team members that you are seeing and we will do our best to help you.

What other services are offered by NSEPP?

- We conduct a wide variety of research activities to promote increased understanding of psychosis, treatments and recovery. You and your supporters may be asked if you are interested in participating.
- NSEPP offers educational presentations about psychosis, early detection, and treatment for professionals, schools, universities, community agencies and the public. Young people who have recovered and wish to share their story for others can participate in these activities if interested.

How do I connect with NSEPP?

At NSEPP, Abbie J. Lane Clinic, phone: (902) 473-2976. If you prefer, you can also arrange to text the clinic. Let the clinic know the best way to communicate with you.

IWK Clinic, phone: (902) 470-8375.

NSEPP
Nova Scotia Early Psychosis Program

Welcome to the Nova Scotia Early Psychosis Program (NSEPP)

Information for Patients

nova scotia health
IWK Health Centre
DALHOUSIE UNIVERSITY
Inspiring Minds

What is the Nova Scotia Early Psychosis Program (NSEPP)?

- NSEPP is a specialty mental health outpatient program that is part of Mental Health and Addictions, Nova Scotia Health, and the Department of Psychiatry at Dalhousie University and the IWK Health Centre.
- We promote early detection of psychosis and optimal treatment through our programs four main components: clinical services, research, education, and advocacy.

Who does NSEPP see?

- We help young people between the ages of 12-35 years who are experiencing a first episode of psychosis or are at risk of developing psychosis. **IWK Clinic** (age 12 until age 19). **NSEPP Clinic** (ages 19-35).
- Our services are for patients and families.

Who is on the NSEPP team?

- We are a multidisciplinary team of psychiatrists, general practitioners in psychiatry, registered nurses, an occupational therapist, social worker, peer educator, research and administrative support staff.
- Our staff are specially trained and have experience working with youth with psychosis and their families.

What happens when I go to NSEPP?

You will be assigned a doctor and a clinical nurse who will coordinate your care. They will:

- work with you to develop a personal treatment and recovery plan based on your goals and needs.
- meet with you regularly to get your feedback, track your progress and adjust your plan as needed.
- complete specific questionnaires and rating scales with you to help measure your level of recovery.
- connect you as needed with other team members and services
- ask you to identify your circle of support. At NSEPP, family and friends are an integral part of the treatment team. If you agree, your identified support can attend clinical appointments and access education and support sessions to learn about psychosis and how to best support your recovery.

When are services at the clinic available?

- NSEPP: 8:30 AM to 4:30 PM, Monday to Friday.
- IWK clinic: 9:00 AM to 5:00 PM Monday to Friday .
- some group programs are run later in the day on specific days.
- some group sessions (for example: for families) are offered in the evening or one day on a weekend.

What is my role in my recovery?

- work with your NSEPP team to develop your treatment plan.
- attend your appointments and tell us how the plan is working for you.
- learn about psychosis, recovery and staying well.
- take part in the NSEPP programs /groups/activities that are part of your recovery plan.
- ask questions and share suggestions on what you feel would be helpful for your recovery.

What services are offered at NSEPP?

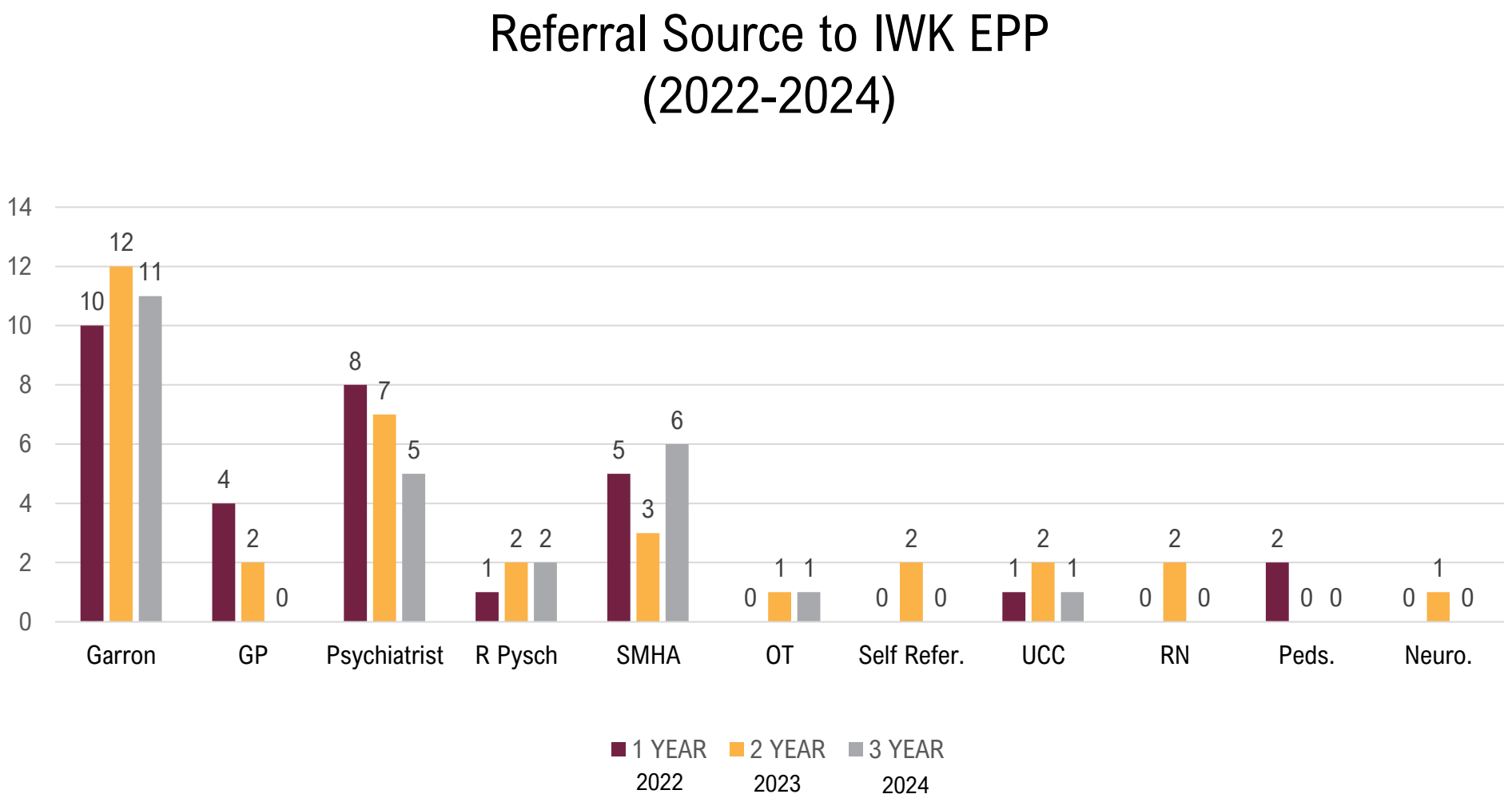
You can access a variety of programs and services at NSEPP. Other programs may be available through our outside partners. NSEPP programs include:

- peer support through individual meetings or in a group setting from a youth with lived experience with psychosis.
- Learn about Psychosis Sessions (LAPS) which provide patients with education on psychosis, treatment, and recovery
- cognitive behavioral therapy on an individual basis or in a group setting to help you understand your thoughts, feelings, and behaviours.
- acceptance and commitment therapy offered on an individual and group basis.
- group education about psychosis, treatment and recovery for caregivers and individuals in the patient's circle of support.
- individual and group support for family caregivers and supporters.
- services provided through our Social worker and Occupational Therapist to help with meeting goals relating to work, housing, financing, education, as well as others.
- recreational activities as scheduled.

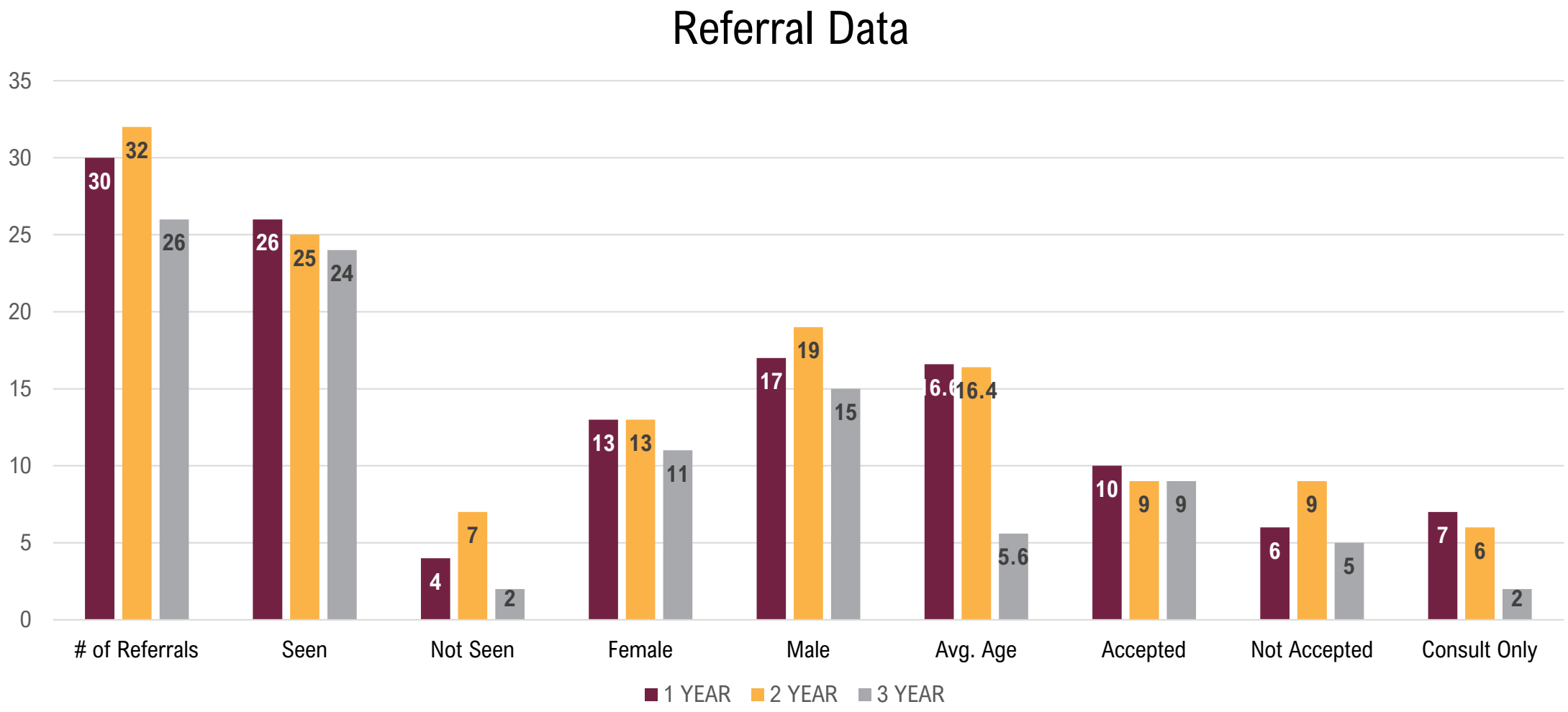
How do I access available group/activities?

- You will be referred to these programs by the NSEPP clinical team.
- Let your doctor, clinical nurse, or other NSEPP team member you are working with know about the groups you are interested in.

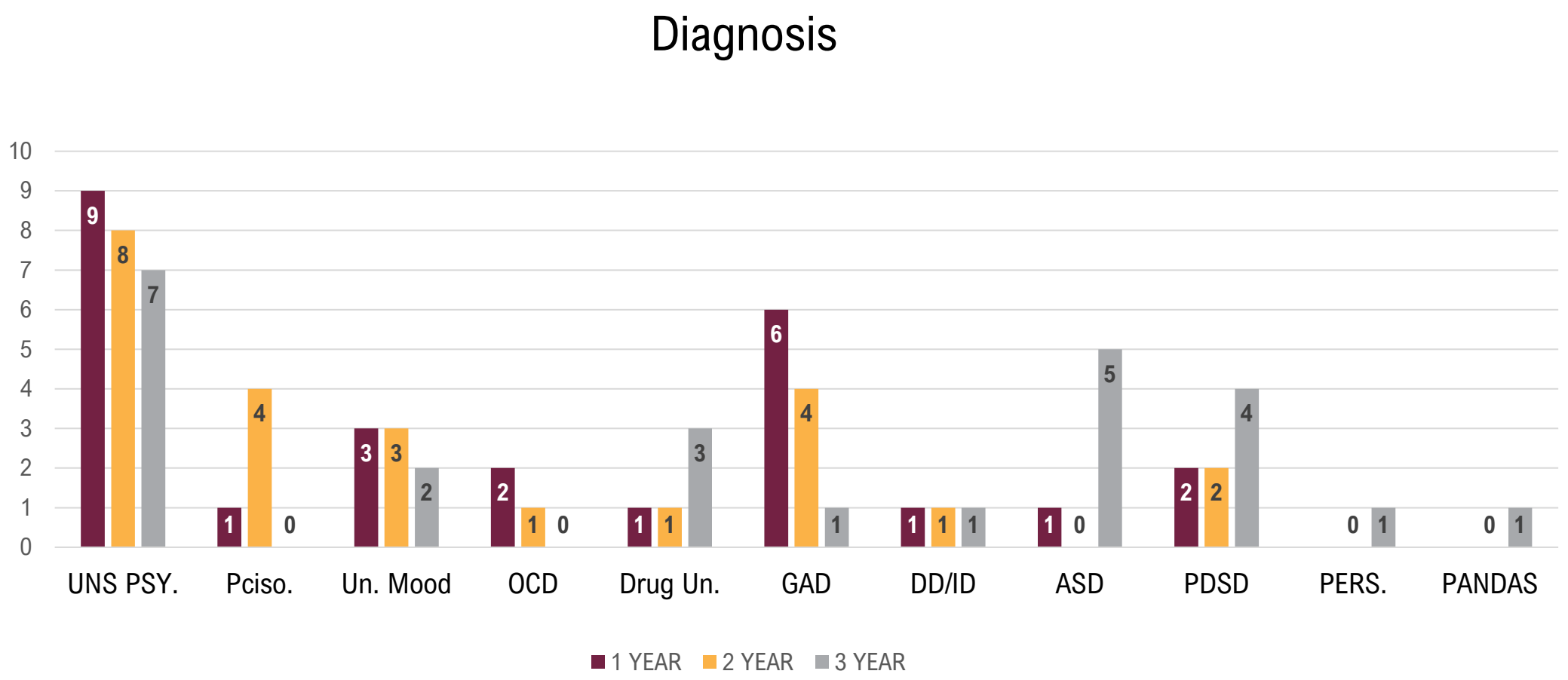
Source of Referral and Demand Data up to Current State IWK EPP



Demand Data 2022 – Current 2024 IWK EPP



IWK EPP Diagnostic Heterogeneity 2022 – 2024



Continuous Improvement/QI Program Initiatives

Examining the qualitative experiences of youth and caregivers in the transition from the IWK Youth Psychosis Clinic to the adult NSH Early Psychosis Program

Nicole Lopez[2], Jeremy Smith[3], Laura Carnegy[3], Jason Morrison[1,2], Sabina Abidi[1,2]

1Department of Psychiatry, 2Dalhousie University Faculty of Medicine, 3IWK Health Centre, Halifax Nova Scotia

BACKGROUND

The transition in care from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS), typically occuring between ages 18 and 21, has been identified as a fragile point in mental health care provision. Despite success of early intervention for psychosis programs, challenges persist at this critical point of transition between services often due to lack of clarity and poor communication between systems. The Nova Scotia Early Psychosis Program attempts to bridge the CAMHS and AMHS gap by offering a seamless transition in care experience for the patient and family as they straddle the bifurcation between services when patients age out of the IWK at age 19.

OBJECTIVE

The aim of the present study was to examine the transition from the IWK Youth Psychosis Specific Clinic to the Nova Scotia Early Psychosis Program (NSEPP) in adult mental health, focusing on youth and caregiver perspectives. By identifying transition challenges, we aim to inform solutions that might enhance continuity of care and improved experience and outcomes for youth navigating this transition locally and provincially.

METHODOLOGY

- **Participants:** Youth age 18–24 who transitioned from youth to adult care between 2018 and 2024.
- **Materials:** Interview guide developed based on literature review and existing frameworks regarding transitions in care
- **Data Collection**: Participants referred by their psychiatrist & contacted by research team. Semi-structured interviews were conducted in person/virtually. Sociodemographic data gathered from clinic records.
- **Analysis:** Interviews recorded, transcribed, and de-identified. Data was coded in NVivo by two independent researchers, with discrepancies reconciled for reliability. Emerging themes identified.

RESULTS

DEMOGRAPHICS	MEAN
Age	20.83 years
Gender	1:1 (male:female)
Age at illness onset	16.2 years
Length of care at IWK EPP	2.5 years
Education	100% completed high school
PANSS score*	53.2 (range 40-82)

**Positive & negative syndrome scale: <48 N, 48-60 borderline illness, >79 mod/severe*

INTERVIEW GUIDE

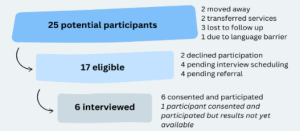
Pre-Transition Experience
1. When did you first engage with the IWK EPP? Why did you start treatment at the IWK EPP?
2. What was your experience with the IWK EPP like?

Transition Preparation/Planning
3. When and how were you first informed that you would transition to AMHS?
4. Based on your understanding of the information you received, how did you feel about the upcoming transition in your care?

Transition Process & Experience
5. What was your experience of transitioning to AMHS?
6. When you look back on your transition in care, what do you think worked well?
7. When you look back on your transition in care, what were some of the challenges you faced?

Post-Transition Experience
8. Since your transition, what has been your experience with AMHS?

Suggestions for Improvement
9. If you were in charge of developing something that would help with the transition, what would that look like?
10. If you could give advice to someone who was about the transition from CAMHS to AMHS what advice would you give?



(1) TRANSITION READINESS

Participants felt prepared for the transition, often describing it as straightforward with minimal confusion or unclear expectations. While mild anxiety was common, it did not cause significant distress.

"I think at the time I was a little bit worried about it. It was a big change at that point, but it wasn't super distressing. I knew I was gonna meet a new doctor, but it was pretty straightforward. I think I was a little bit nervous about who my new doctor would be. I did feel ready for it. It was just the first time it ever happened, so obviously I would feel a little bit unnerved, but I felt pretty prepared for it. I knew my doctor was there to help me through it, so their support was good."

(2) CONTINUITY OF CARE

Some participants felt their providers were aligned on their medical history and care goals while others sensed a disconnect due to limited or indirect communication.

"It literally feels like somebody's playing ping pong. I was kind of worried and a little bit annoyed because you have to explain why you're here and what's going on, and what your experience has been. Sometimes I don't really wanna talk to people because it's the same questions over and over and over again, and it seems repetitive. I feel like when you hear the same questions over and over and over again, you kinda don't wanna answer."

(3) RAPPORT & TRUST BUILDING

Many participants expressed challenges in establishing trust and building rapport with their new providers -the transition meant starting fresh with someone unfamiliar, which created a barrier to open communication.

"I remember the first appointment was a bit awkward. I feel like we went pretty in depth because it was the first time we had met. I think the only challenge that I faced was I didn't tell my new doctor as much because I didn't know her as well; I just wasn't as used to talking with her. So I just wasn't as honest with her for my own needs, as I was with the first doctor. My new doctor was really nice-I just wasn't answering everything I was the one being kind of shy, and didn't wanna like open up totally."

(4) PARENTAL INVOLVEMENT: One caregiver felt less involved due to confidentiality and their child's growing independence which contrasted their more engaged role at the IWK. This raised concerns for the caregiver, who feared that without some communication, early signs of issues might go unnoticed. In contrast, many youth valued the increased autonomy, appreciating the freedom to voice concerns and make treatment decisions independently, seeing this shift as a positive aspect of the transition.

KEY FINDINGS & IMPLICATIONS

(1) Participants generally felt prepared for the transition and reported minimal distress, indicating that f**oundational needs are being met** in the preparation process.

(2) Many patients experienced a disconnect in information transfer, suggesting a need for a **more consistent and structured handover process** (e.g., facilitated meetings where youth and their providers collaboratively discuss the patient's history and treatment goals at the time of transition)

(3) Youth reported that their initial appointments often felt awkward and uncomfortable which limited their openness and honesty. This highlights the potential benefit of **introductory/orientation sessions**. By offering a brief orientation or meet-and-greet rather than an immediate clinical appointment, the transition can be made less daunting, fostering comfort and encouraging openness early in the therapeutic relationship.

LIMITATIONS

- **Small sample size** limits generalizability
- Participants' retrospective reflections could introduce **recall bias**

FUTURE RESEARCH

Next steps include **refining the interview guide** and **continuing to collect data** from youth and caregivers.

We hope to also gather healthcare provider perspectives to uncover local barriers to effective transitions.

We intend to extend learning to provincial EPP teams to foster improved service across lifespan.

Acknowledgements
Ethics approval from Nova Scotia Health Research Ethics Board. Kind thanks to the participants, caregivers and clinicians participating in the study

References
1.Cleverley K, McCann E, O'Brien D, Davies J, Bennett K, Brennenstuhl S, Courey L, Henderson J, Jeffs L, Miller J, Pignatiello T, Rong J, Rowland E, Stevens K, Szatmari P. Prioritizing core components of successful transitions from child to adult mental health care: a national Delphi survey with youth, caregivers, and health professionals. Eur Child Adolesc Psychiatry. 2022 Nov;31(11):1739-1752.
2.Guest O, Namey E, Chen M. A simple method to assess and report thematic saturation in qualitative research. PLoS One. 2020 May 5;15(5).
3.Malla, A., Shah, J., Iyer, S., Boksa, P., Joober, R., Andersson, N., Lal, S. & Fuhrer, R. (2018). Youth mental health should be a top priority for health care in Canada. The Canadian Journal of Psychiatry, 63(4), 216-222.

Continuous Improvement/QI Program Initiatives

(1) TRANSITION READINESS

Participants felt prepared for the transition, often describing it as straightforward with minimal confusion or unclear expectations. While mild anxiety was common, it did not cause significant distress.

"I think at the time I was a little bit worried about it. It was a big change at that point, but it wasn't super distressing. I knew I was gonna meet a new doctor, but it was pretty straightforward. I think I was a little bit nervous about who my new doctor would be. I did feel ready for it. It was just the first time it ever happened, so obviously I would feel a little bit unnerved, but I felt pretty prepared for it. I knew my doctor was there to help me through it, so their support was good."

(2) CONTINUITY OF CARE

Some participants felt their providers were aligned on their medical history and care goals while others sensed a disconnect due to limited or indirect communication.

"It literally feels like somebody's playing ping pong. I was kind of worried and a little bit annoyed because you have to explain why you're here and what's going on, and what your experience has been. Sometimes I don't really wanna talk to people because it's the same questions over and over and over again, and it seems repetitive. I feel like when you hear the same questions over and over and over again, you kinda don't wanna answer."

(3) RAPPORT & TRUST BUILDING

Many participants expressed challenges in establishing trust and building rapport with their new providers -the transition meant starting fresh with someone unfamiliar, which created a barrier to open communication.

"I remember the first appointment was a bit awkward. I feel like we went pretty in depth because it was the first time we had met. I think the only challenge that I faced was I didn't tell my new doctor as much because I didn't know her as well; I just wasn't as used to talking with her. So I just wasn't as honest with her for my own needs, as I was with the first doctor. My new doctor was really nice-I just wasn't answering everything I was the one being kind of shy, and didn't wanna like open up totally."

(4) PARENTAL INVOLVEMENT: One caregiver felt less involved due to confidentiality and their child's growing independence which contrasted their more engaged role at the IWK. This raised concerns for the caregiver, who feared that without some communication, early signs of issues might go unnoticed. In contrast, many youth valued the increased autonomy, appreciating the freedom to voice concerns and make treatment decisions independently, seeing this shift as a positive aspect of the transition.

KEY FINDINGS & IMPLICATIONS

(1) Participants generally felt prepared for the transition and reported minimal distress, indicating that f**oundational needs are being met** in the preparation process.

(2) Many patients experienced a disconnect in information transfer, suggesting a need for a **more consistent and structured handover process** (e.g., facilitated meetings where youth and their providers collaboratively discuss the patient's history and treatment goals at the time of transition)

(3) Youth reported that their initial appointments often felt awkward and uncomfortable which limited their openness and honesty. This highlights the potential benefit of **introductory/orientation sessions**. By offering a brief orientation or meet-and-greet rather than an immediate clinical appointment, the transition can be made less daunting, fostering comfort and encouraging openness early in the therapeutic relationship.

LIMITATIONS

- **Small sample size** limits generalizability
- Participants' retrospective reflections could introduce **recall bias**

FUTURE RESEARCH

Next steps include **refining the interview guide** and **continuing to collect data** from youth and caregivers.

We hope to also gather healthcare provider perspectives to uncover local barriers to effective transitions.

We intend to extend learning to provincial EPP teams to foster improved service across lifespan.

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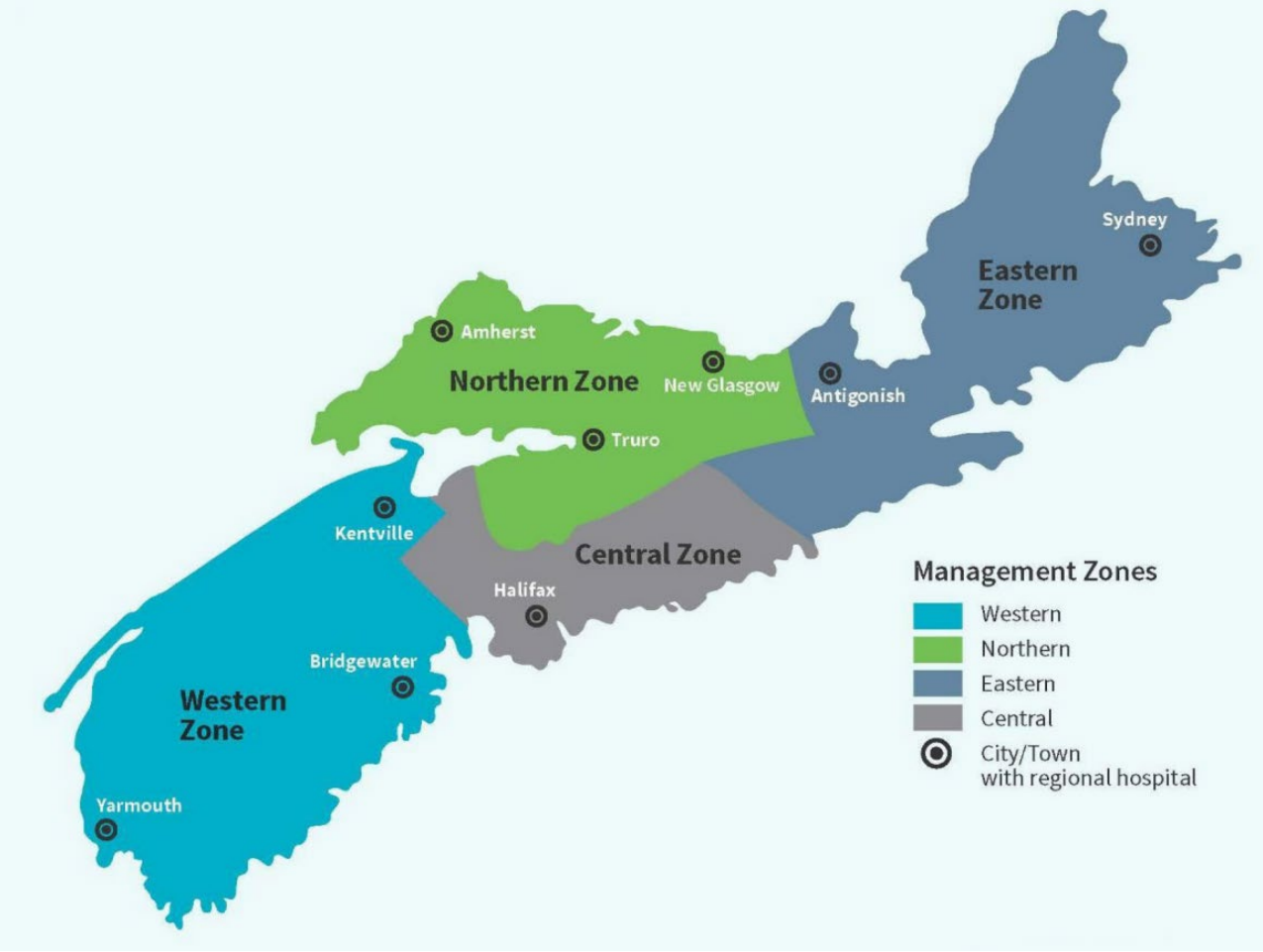
Joint Values, Joint Initiatives, Joint Objectives

- Podcasts (CCEIP)
  - Parallel Realities
  - #2 - Psychosis with Sabina Abidi and Laura Carnegy - Clinician Cast: Youth Mental Health and Addictions Treatment Network Podcast | Podcast on Spotify
- Webinars/websites
  - EPINS Education modules
  - www.becauseyourmindmatters.com
- Family & Clinician Capacity Building
  - About PCTEL | NSH MHA PCTEL
  - IWK Orientation/Forensics/CMHA/Youth Health Centres
- Transition support
- African NS service/Newcomer Clinics
- Integrated Youth Services
- Community engagement
- UHR
- Privileges across health systems facilitated
- EMR to come
- Provincial and National scope

Establishing Provincial Standards for EP Care Across Lifespan



The transition from adolescence to adulthood in patients with schizophrenia: Challenges, opportunities and recommendations

Celso Arango, Jan K. Buitelaar, Christoph U. Correll, Covadonga M. Díaz-Caneja, Maria L. Figueira, W. Wolfgang Fleischhacker, Daniele Marcotulli, Mara Parellada and Benedetto Vitiello

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Abstract

Schizophrenia is a severely debilitating neurodevelopmental disorder that requires continuous multidisciplinary treatment. Early onset schizophrenia (EOS, onset before 18) is associated