Schizophrenia Research 204 (2019) 2–3

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Commentary

Commentary: Unmet need for mental health services among people screened but not admitted to an early psychosis intervention program

Emily R. Kline *

Department of Psychiatry, Harvard Medical School at Beth Israel Deaconess Medical Center, USA

ARTICLE INFO

Article history:
Received 26 December 2018
Accepted 27 December 2018
Available online 2 January 2019

Keywords:
Psychosis
Screening
Population health

1. Commentary

In their brief report, "Unmet Need for Mental Health Services among People Screened but Not Admitted to an Early Psychosis Intervention Program," Dr. Edwards et al. (2018) address the important issue of what happens to those who fail to meet intake criteria for, or are otherwise unable to partake of, First Episode Psychosis (FEP) specialty care. By reviewing public health records to examine outcomes for those narrowly missed by FEP treatment infrastructure, they shed light on the ethical dilemma of what populations are selected for enhanced services and what happens to those left behind, so to speak, by the lifeboat.

In this instance, a minority (41%) of expected incident FEP cases within a catchment come to the attention of FEP providers, and of these, a further minority (42%) actually receive specialty treatment. That many potential FEP cases slip through the cracks en route to specialty care is unsurprising news to anyone doing the hard work of screening, triaging, and admitting potential FEP clients for care. Stigma, a perception that services are not needed or relevant, inability to pay for services, wait-lists, transportation and other logistic difficulties, provider shortages, and referral bottlenecks all contribute to the problem of clients arriving late or not at all to treatment. The problem is exacerbated by the fact that FEP programs may have widely varying intake criteria that can create additional confusion and barriers. In the program profiled in this article, for instance, the age criteria are quite inclusive (16–50) but limitations on prior treatment are stringent (less than 30 days of prior antipsychotic use).

So what becomes of the majority of patients who are ineligible for, or unable to attend, FEP services? Edwards et al. find that within this London, Ontario catchment area, those not admitted to care are diagnostically similar in terms of primary psychoses, but somewhat older, less socioeconomically advantaged, and more likely to struggle with substance use disorders than those successfully engaged in FEP treatment. Although the authors cannot comment on exactly which of these factors are fueled by explicit program exclusions (e.g., exclusion of clients with pending legal charges) and which may be a function of clients' own service preferences (e.g., a possible perception among those with substance use disorders that FEP services may not be relevant), they find that following this "sliding doors" moment, trajectories diverge further. Those not admitted continue to exhibit high mental health needs and to circle the mental health system via emergency rooms, primary care, and hospital admission. Thus it is unlikely that many of the "screened but not admitted" cases represent those with spontaneously remitting disorders who do not require ongoing involvement with services.

This finding raises the ethical question of whether FEP programs ought to place any limits on their clinical admission criteria. While these criteria are justified as a best attempt to preserve limited resources for those most likely to maximally benefit (e.g., the RAISE study found less impressive outcomes for patients admitted after more than 72 weeks of untreated psychosis [Kane et al., 2016]), it's fair to acknowledge that this is an economic rather than humanitarian perspective. Clearly there is unmet need and ongoing suffering. No one wants a mental health system that offers "full-service" or nothing, or pits the needs of young adults with newly emerging disorders against those of older and more diagnostically complex patients.

To avoid this perception, FEP care advocates should be mindful of creating and improving systems that serve population health needs rather than focusing narrowly on the outcomes of the minority of FEP patients who do successfully engage with specialty care. The authors point to a potential model (Integrated Care Pathways or ICP) that has supported ongoing follow-up of those who refuse or are not eligible for FEP care in the United Kingdom and Canada. In the United States, where care coordination for non-patients fails to generate revenue, such follow up is even more challenging. One solution could be to work with family members as "identified patients" in short term therapies to help them facilitate care transitions in difficult cases; this approach has worked well in the realm of substance use disorders (Kirby et al., 2017), and could conceivably be leveraged with family members of individuals with emerging serious mental illnesses as well.

* 75 Fenwood Road, Boston, MA 02115, USA.
E-mail address: ekline@bidmc.harvard.edu.

https://doi.org/10.1016/j.schres.2018.12.049

Conflicts of interest

The author has no conflicts of interest to declare.

Contributors

Dr. Kline wrote this commentary and is responsible for all content.

Role of funding source

The funding source had no influence on the content of this commentary or the decision to publish.

Acknowledgements

This work was supported by NIMH grant R01MH103831 as well as the Massachusetts Department of Mental Health via the First Episode Psychosis Technical Assistance Center grant.

References

Edwards, J., Norman, R., Kurdyak, P., et al., 2019. Unmet need for mental health services among people screened but not admitted to an early psychosis intervention program. Schizophr. Res. 204, 55–57.

Kane, J.M., Robinson, D.G., Schooler, N.R., et al., 2016. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. Am. J. Psychiatry 173 (4), 362–372.

Kirby, K.C., Benishek, L.A., Kerwin, M.E., et al., 2017. Analyzing components of Community Reinforcement and Family Training (CRAFT): is treatment entry training sufficient? Psychol. Addict. Behav. 31 (7), 818–827.