Guidelines for Discharge Review and Discharge Planning
Fraser South EPI Program

Discharge Review

EPI Guideline: *Due to the nature of the early course of illness, clients and families are expected to remain in the program for at least two years and then reviewed annually for continuation into the program. Those with earlier age at onset may benefit from being in the program longer, due to developmental issues.*

EPI Guideline: *Failure to engage should intensify efforts (e.g., assertive outreach) and not lead to case closure.*

- Discharge review should be done after two years in the program and then annually.
- The discharge review should also be done whenever a client is being considered for discharge (for example, two and a half years).
- This review should be done at least three months in advance of discharge to allow time to develop a comprehensive discharge plan.
- Discharge prior to two years in the program must be done in collaboration with the Central Team.
- If efforts to engage a client do not met with success this should lead to collaboration with the Central Team and not necessarily lead to discharge.

Considerations for Discharge Readiness

- Are all core psychosocial interventions complete?

  For example,
  Individualized education provided regularly over an extended period of time to both client and family.
  Groups for education or intervention provided to both client and family.
  Client and family have acquired good stress management skills including goal setting and problem solving.
  Relapse prevention plan developed and client and family have the needed skills to detect and attempt to prevent a relapse.

Reference the EPI Guidelines for a complete list of all core psychosocial interventions and pharmacotherapy strategies.

- Are there any ongoing problems that are best addressed within the EPI Program? Consider both medication strategies and needs-based psychosocial interventions.

  For example:
  Persistent psychotic symptoms - Has an antipsychotic switch been done? Clozapine considered?
  Problems returning to work – Has the client seen the vocational rehabilitation counsellor?
  Drug and alcohol abuse – Has a harm reduction approach been tried by the EPI Clinician or an integrated specialist service?
  Comorbid anxiety or depression – Have psychological or medication strategies been tried to address anxiety or depression?

Reference the EPI Guidelines for a complete list of needs-based psychosocial interventions and pharmacotherapy strategies.

- As a guideline, use the client's overall level of symptoms and functioning to determine where the client should be transitioned to:

Self-management with family physician support: GAF > 60; CGI-1 = 1, 2 or 3

ACSS team: GAF = 31 to 60; CGI-1 = 4 or 5

ACM team or intensive case management: GAF = 1-30; CGI-1 = 6 or 7

Remember
The GAF is comprised of ratings of psychopathology (symptoms) and SOFAS (functioning). The lower score of these two ratings is the GAF score. When there is considerable discrepancy between symptoms and functioning, consult with the EPI Central Team about transitioning.

For Child and Youth Mental Health
If youth is turning 19 and still requires EPI services, client should be transitioned to adult EPI clinician rather than generic ACSS team

Review of Current Problem Areas and Services Provided

Current Problem Areas	Services Provided
❑ Persistent psychotic symptoms ❑ Depression or mood regulation ❑ Anxiety ❑ Substance use/abuse ❑ Other comorbid problems ❑ Poor stress management skills ❑ Medication nonadherence ❑ Poor engagement ❑ Work or school problems ❑ Social or recreational problems ❑ Housing problems ❑ Financial problems ❑ Family problems ❑ Self harm or suicide ❑ Aggression or violence ❑ Forensic problems ❑ Activities of daily living ❑ Cognitive problems ❑ Medical problems ❑ Other problems	❑ Medication switch ❑ Clozapine ❑ Intermittent-targeted medication strategy ❑ Medication for comorbid problems ❑ Education and skill-building with client (carepath) ❑ Education and skill-building with family (carepath) ❑ Groups for client ❑ Groups for family ❑ Substance abuse counselling ❑ Psychological therapies for comorbidity ❑ Cognitive therapy for persistent symptoms ❑ Vocational rehabilitation ❑ Family therapy ❑ Housing support ❑ Financial support ❑ Assertive outreach ❑ Neuropsychological testing ❑ Peer support ❑ Community supports (e.g., youth care or CLS worker) ❑ Other services

Discharge Process

EPI Guideline: *Discharge or transition plans are developed in consultation with the client and family at least three months in advance. At least one joint transition meeting is held prior to transfer. A discharge summary is completed prior to discharge and sent to the client's physician and other treatment providers, as well as the Central Team.*

- If your discharge review suggests that discharge is appropriate, there should be at least three months between the review and the time of actual discharge.
- The client and family should be involved in developing discharge or transition plans as early on as possible.
- At least one joint transition meeting should be held with the new treatment providers, client and family.
- The above three points all apply to transition from Child and Youth Services to Adult Services. Where necessary, please refer to the *Mental Health Transition Protocol Agreement between MCFD Fraser and Fraser Health Authority for Older Youth and Young Adults*.
- The discharge summary should be sent to all treatment providers and Central Team prior to discharge.

Considerations for Discharge Planning

- Are the client and family well prepared for discharge?

  For example,
  Has the relapse prevention plan been revised to be appropriate at the time of discharge?
  Have practical concerns about transition been worked out (e.g., transportation to new services)?
  Do the client and family seem to have the beginnings of engagement with their new service provider or are further joint meetings required?

- Are there adequate and appropriate resources in place to address all of the client and family needs?

  For example,
  Does the client have a family physician in place even if transitioned to other mental health services?
  Has the family been connected with an appropriate support group in advance of discharge?
  Will the new treatment provider be able to work with the client and family around all their needs or are other supports needed (e.g., addictions services)?