Orygen
The National Centre of Excellence in Youth Mental Health

Clinical practice in youth mental health

# Managing transitions in care for young people with early psychosis

## Introduction

Changes in a young person's care can be confusing, disruptive and may require extra practical support for the young person and their family. Perhaps related to these factors, transitions in care also represent a period of increased risk for young people with early psychosis, including risk of suicide and risk of disengagement and therefore relapse and associated decline in functioning.[1,2]

How transitions in care are managed by services and clinicians will affect outcomes. Significant transitional periods in care include:

- discharge from an early psychosis service
- changes in care between clinical staff (e.g. case managers, medical staff)
- transition from acute (including inpatient) care to non-acute care.

This clinical practice point outlines some of the issues that arise at these key periods of transition in care and how to manage them.

## General principles for managing transitions in care

For all transitions in a young person's care, the following elements will help you manage the process effectively.

### Planning

Planning for transitions is essential, and it should involve the young person, their family or other key supports, treating clinicians, new treating clinicians and other service providers. Having a clear plan for a young person's change in care helps ensure that everyone involved is 'on the same page' and that there is minimal disruption to the young person's care.

Equally important is good communication with young people about the planned changes to their care, so that they feel prepared for the transition, in control and cared for.[3]

**The aim is always to ensure a safe, smooth transition in care for the young person.**

### A good handover

Whether a young person is transitioning between clinicians or teams or to a new service provider, there must be a proper handover of their care. This should include:

- at least one meeting, depending on the young person's needs, attended by the new and old treating team or clinicians
- a period of liaison between the two clinicians/teams
- time for the young person and their family to get used to the idea – ideally, the young person should be introduced to new clinicians, or familiarised with a new service, while they are still in the care of the old team
- provision of full documentation to the new care provider, including the young person's treatment plan, case history (including what medication they have previously been prescribed, their response to them and any side effects they experienced), early warning signs or relapse plan and risk management plan.

### Family involvement and support

Wherever possible and appropriate, each young person's family should be consulted and informed about changes in the young person's care. They also need to be supported during such a change. For example, when a young person finishes their period of care with an early psychosis service, their family may need reassurance that they will be able to cope. This might mean ensuring that family members are comfortable with the young person's relapse plan, feel capable of implementing it independently and know exactly how to seek help if needed.

### Risk assessment

All significant points of transition in care (e.g. from inpatient care to community care, or at discharge from an early psychosis service) can be times of heightened risk for young people; therefore, a young person's full risk assessment should be reviewed at each significant transition and incorporated into the transition planning.

### Case formulation approach

As with other aspects of a young person's treatment, a case formulation-based approach can be used to understand how the young person is likely to respond a major transition in their care and manage the transition accordingly. For example, What might the young person find challenging about this transition? What strengths do they have they that will help them? What support might their friends or family need?

## Discharging young people from an early psychosis service

Early psychosis services aim to work with young people for 2–5 years, after which they may transition back to other community services (a GP at a minimum) or to another mental health service, depending on their individual clinical needs.

Ideally, all young people referred to an early psychosis service will spend the maximum period of care with the service; however, some may be discharged before the ideal period of care has ended. In either case, a formal discharge process should be followed.

### Preparing for discharge

It's important to be aware that ending the period of care with an early psychosis service can be daunting and anxiety-provoking for young people and families, particularly if the young person has not fully recovered and is being discharged to another mental health service. Even if a young person has made a good symptomatic and functional recovery, they and their family may be anxious about what they will do if 'things go wrong'.

Young people therefore need to be prepared for their discharge from an early psychosis service from the beginning of their period of care. The likely duration of the young person's treatment can be discussed with the young person and family in initial sessions. This should be included in the young person's formal treatment plan, along with the process for discharge from the service. At a minimum, discharge should be discussed with young people and their families at least 3 months before it is due to occur.[4]

TIP

Develop a 'discharge pack' for your service that can be given to all young people and families in preparation for discharge from the service. This might contain a list of sources of ongoing support, tips for managing stress or early warning signs and contact numbers for help in a crisis or emergency.

The timing of discharge should be considered, and services must be as flexible as possible about this. For example, avoid discharging young people at times when they might be under more stress than usual (e.g. exam time, anniversaries of distressing events, when they are starting a new job), or if their family is temporarily unable to provide enough support (e.g. due to illness in a family or loss of income).

Finally, in preparation for discharge from the service, clinicians should ensure:

- the young person has a good relapse plan in place
- this plan is shared with the young person's supports, such as family members, their GP or private psychiatrist or psychologist
- everyone knows their role in the plan
- the young person and family members feel confident they can use the plan if required.

> "There's not going to be some sort of, like, perfect end note. It doesn't work like that, 'cause your life just goes on anyway.
>
> Young person, EPPIC,
> Orygen Youth Health Clinical Program

## Decisions about ongoing care

The decision about where a young person is discharged to should be made in collaboration with the young person, their family and the multidisciplinary team. It should consider factors such as the young person's wellness, stage of recovery, need for ongoing medication, complexity, level of risk and risk history, available supports, overall functional recovery and developmental stage. This will include social care and physical health needs and should always incorporate thorough risk assessment and planning.

Referrals made to other services ideally should allow enough time for the young person to engage well with the new service (see 'Transitioning to other mental health services' on page 6).

If a young person wishes to be discharged from an early psychosis service before the ideal period of care is up, the treating team should try to negotiate a role for themselves in the young person's life for a period of time. This could mean focusing on practical support rather than treatment for their illness. For example, helping the young person with schooling, housing or relationship issues or helping them deal with other services or agencies, such as Centrelink. See also the clinical practice point *Working with clinical complexity and challenges in engagement*.

## Box 1. Documentation of the discharge process

Ensure there is clear documentation of discharge consultations and arrangements. This will include routine documentation of all consultations with the multidisciplinary team about the young person's discharge, all discussions with the young person and their family about discharge and any contact you have with other service providers (e.g. discussions about discharge with receiving services, copies of referral paperwork). This documentation should be entered in the young person's clinical record. As this is a high-risk time, clear documentation of the discharge process will ensure that everyone understands what arrangements have been made and can refer to them when needed.

Aside from this routine documentation, two key documents can assist with the discharge planning and implementation process.

### Collaborative care plan

All young people within an early psychosis service will have an ongoing, collaborative care plan that is developed throughout their period of care. Depending on the service, this document might be called an 'Individual service plan', 'Recovery plan' or 'Management plan,' and it sets out the young person's goals for all aspects of their care, along with their expectations of the service.

Discharge planning should be incorporated in this plan from the beginning; however, it will feature more prominently during the time leading up to a young person's discharge from the service, as the young person and family decide with the treating team what strategy will work best for them. This includes where the young person will be discharged to, timing and any 'goals' for the discharge process. For example, the young person may decide a goal is to attend four appointments with their GP once they have been discharged.

### Discharge summary

A clinical document should be produced that summarises clinical information relevant to the young person's discharge. It should be about 1–2 pages and include:

- a history of the young person's presenting condition, symptoms and treatments (including any medication that was not effective or discontinued because of side effects)
- an overview of the young person's progress since entering the service
- other significant medical notes or investigations
- a short case formulation if possible
- any agreed follow-up actions by the current and receiving services.

This document should be developed by the clinical team and be distributed to new service providers. A copy can also be given to the young person or their family, which they can provide to any other services they use, such as a private psychiatrist.

## The discharge process

Once a discharge plan has been made, the following steps should take place to complete the discharge process.

- A comprehensive clinical review is undertaken and the treating team reviews the discharge plan.
- The discharge process is formalised in a discharge summary (see Box 1).
- Enough time is allowed before the final appointment for the discharge summary to be reviewed by the clinical team.
- The discharge summary is provided to all parties involved, including, if appropriate, the young person and family. It is also recommended that you document who the discharge summary has been sent to and that consent has been given, if necessary.
- All requested follow-up is clearly indicated to relevant service providers.
- The young person, family, as appropriate, and any relevant service providers are advised about how to re-access mental health services if necessary in the future, and are provided with emergency contact numbers.
- Where a young person has had significant or extended contact with a service, there should be a period of transition to the new service provider. This period should include regular contact between the case manager, the young person and the new service provider to ensure effective engagement and help establish the new treatment alliance.
- Necessary follow up with other services is done within a reasonable time frame. Questions to ask on follow-up include: Has the young person attended their appointment? Are there any concerns they or the new service has? Do they need more information? Have there been any gaps in the handover process?

TIP

Before they are discharged, consider asking young people to enter useful contact numbers in their phone (e.g. mental health services, other services that can offer support). The numbers will be less likely to be lost and will be accessible at any time.

## What if a young person relapses just before they are to be discharged?

If a young person is due to be discharged but experiences a relapse, even if they have reached the end of their period of care with the service, they must not be discharged until their mental state has stabilised. Plans should instead be made for an extended handover with the receiving service. In some cases, the receiving team may be involved in managing the relapse, in others they may only focus on engaging the young person while they recover from the relapse. The aim is always to ensure a safe, smooth transition in care for the young person.

## What if the young person 'drops out'?

Despite the best efforts of clinicians, some young people will stop attending services. This may be because of active disengagement or circumstance (e.g. the young person has moved away from the area). In such cases, the issue will be discussed in clinical review meetings, and the clinical team may decide to discharge the young person from the service. This is a complex decision, and will be made according to each service's protocols, but it should take into consideration:

- What is the risk associated with the young person's dropping out and being discharged?
- What support do they have?
- What is their risk of relapse?
- Is the young person likely to contact the service again if they become further unwell or to seek assistance for other issues?
- Has the young person been made aware that if they stop attending the service, they will be discharged (and do they know what this means)?

Although discharging a young person in these circumstances is not ideal, how it is managed may decide whether or not the young person re-engages with the service later on, and may even influence the young person's chances of recovery.

When a decision is made to discharge a young person, all effort must be made to notify them, even if they have previously been difficult to contact. This may include allowing a period of time where the service makes frequent attempts to contact the young person before discharging them, using a variety of methods (e.g. written letters, text messages, phone calls). These communications should provide contact details for the service and be clear that the young person will be discharged by a certain date if they do not get in touch. It is important to also be clear that the young person may access the service again at any time after discharge.

All people and services involved in the young person's care should be notified, such as the young person's family and services such as DHS and housing. An unplanned discharge still requires a discharge summary, which should be discussed with and provided to the young person's GP if possible.

**TIP** Sending a letter to the young person's last known address, including their list of early warning signs and relapse plan, gives them the option to reconnect with the service. If the young person does experience a relapse, having this information to hand may prompt them to seek help before they experience a full relapse. Consider sending this information to one of the young person's key supports as well.

### Transitioning to other mental health services

Young people who reach the end of their period of care with an early psychosis service without completely recovering will most likely be transferred to the care of another mental health service. This can be daunting and disheartening for young people and their families, particularly if recovery has been difficult or slow. They may face learning a new system, approach and even language about psychiatric disorders. For example, the new service's model of care may mean the young person sees their case manager or doctor less often.

> "[The adult service] was really scary ... I walked out into the main communal area and I'm like, "I don't want to be here, I'll do anything if I can just get out of here".
>
> Young person, EPPIC,
> Orygen Youth Health Clinical Program

To make the transition as smooth as possible, and to facilitate engagement with the new service, talk to the young person and family about why the young person needs to continue their care with another mental health service. This will involve psychoeducation about the meaning of prolonged recovery and the need for ongoing support, but also that needing ongoing care now does not mean the young person won't recover or will always have to be involved with mental health services.

Practically, it can be helpful to arrange a number of crossover appointments with clinicians from the new service, to discuss how the new service operates and the level of support they can provide.

## Changing care between clinicians

Changes in a young person's key clinical relationships within a service (e.g. a change of case manager or treating doctor) may be disruptive and risk discontinuity in the young person's care, especially if the change-over happens at short notice. The young person may feel loss or disappointment at the ending of the therapeutic relationship and resentment or frustration at having to begin a new one and tell their 'story' again to the new clinician.

A collaborative, team-based care model will minimise most of these issues by allowing for more continuity of care, even if a key clinician leaves the service at short notice. It should also mean the young person and family are familiar with other clinicians who might take on the new key role.

If a treating clinician is on a temporary contract or a clinical rotation, this should be made clear to the young person from the beginning of their contact with that clinician. Transfer plans for when the clinician leaves should be discussed.

> “You’ve just started to trust them, and then they have to leave, and you have to tell your whole life story again.
>
> Young person, EPPIC,
> Orygen Youth Health Clinical Program

The young person should be allowed time and opportunity to discuss their feelings about any changes in care with their treating clinicians and supported to use the avenues for feedback that exist in the service.

Before the changeover, hold a ‘goodbye’ session where the young person and the outgoing clinician review the work they have done so far, highlight the strengths and resources of the young person and reflect on any challenges the young person is experiencing or may face in the future that might affect ongoing treatment.

A joint handover session with the old and new clinician will help the young person feel more comfortable with the new clinician and reduce the number of times they need to retell their story. It can also provide a chance to openly discuss and solve possible barriers to engagement with the new clinician and young person. For more on engagement and the therapeutic relationship, see the ENSP manual *Get on board: engagement in early psychosis.*

## Transitioning from acute to non-acute care

Transitioning from acute to non-acute mental health care (e.g. from an inpatient unit of a hospital to a community service, or from acute outreach care to case management) can present a number of risks for young people. These include increased risk of suicide (see Box 2), disengagement and non-adherence to medication.

In addition to the general principles for managing transitions in care, some particular strategies have been shown to improve outcomes following a transition from acute to non-acute care:

### Discharge planning

Having a clear discharge plan for each person who is discharged from acute care has been shown to:[1]

- reduced the risk of readmission
- increase the probability of adherence to medication
- improve mental health outcomes.

Elements of discharge planning that are effective for the above include: prompts to young people to engage with the new service (letters or telephone follow-ups), assigning a care coordinator to the inpatient team (if agreed to by they inpatient unit), compiling a pharmacy discharge plan, contacting the new care team before someone is discharged and offering peer support to the young person.[1]

### ‘Bridging’ strategies

Linking young people with the new care service in a structured way can increase the likelihood of their engaging with outpatient care after discharge. Effective strategies include:[5]

- a crossover period of care where the young person begins or even just visits the receiving service before they are discharged from acute care
- clear communication channels, for example between inpatient and outpatient staff, about the plans for discharging the young person
- a dedicated clinician who acts as a liaison between acute and non-acute services.


It can be helpful for non-acute services to have an ‘inreach’ approach, where clinicians visit young people in acute services who are coming into their care and begin to engage them before they transition to the non-acute service.

## Box 2. Suicide risk following discharge from acute care

Up to 75% of people with a first episode of psychosis who commit suicide do so in the early recovery phase, usually with a few months of being discharged from an inpatient unit.[2]

The increased risk of suicide at this time may be a result of:[2]

- the young person's having newly gained insight into their condition
- feelings of hopelessness or stigma
- significant losses (e.g. of employment or relationships) as a result of symptoms of psychosis
- persistent distressing symptoms of psychosis
- the presence of post-psychotic depression
- negative symptoms
- the effects of treatment or service interactions (e.g. traumatic pathway to care, side effects of medication, poor continuity of care)
- remission of symptoms that in the acute phase prevented the young person from acting on suicidal thoughts (e.g. acute mania, thought disorder and negative symptoms)
- hospitalisation due to a relapse, which may mean the young person is particularly despairing.

Furthermore, there is a risk that services and clinicians perceive a young person who is out of the acute phase to be no longer in crisis and therefore no longer at high risk. This may result in a lessening of clinical support or attention.[2] It is therefore crucial that services remain vigilant of suicide risk at this point in a young person's care. Reviews of a young person's risk assessment and mental state examination are paramount.

## Service recommendations for managing transitions in care

The following are recommendations for services to help establish a coordinated approach to transitions in care.

- Ensure necessary service-level agreements are in place, for example, between community teams and inpatient units.
- Consider having a dedicated clinician act as a liaison with other services such as inpatient units to plan transitions to the early psychosis service.
- Establish a clear protocol for handovers between teams or between key clinicians (e.g. between the mobile outreach team and case managers), including what documentation is required during this process.
- Ensure there is a clear protocol for both planned and unplanned discharge of young people from the service.

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## Disclaimer



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