EIP DISCHARGE TO GP
A NEW APPROACH
WHAT DO WE KNOW?

- GPs are under confident in treating psychosis/schizophrenia
- Psychiatrists are under confident in treating physical health disorders
- Our patients need both addressed
Primary care could be better utilised, even when service users are actively engaged with early intervention services, to help ensure physical health needs are met from the start of treatment.
Early Intervention Service (EIS) Clients across the UK

Case note review

How many patients discharged to GP?

How many referred back into secondary services?
Huge variation in EIP practice discharging to GPS

- Cambridge 77%
- Norfolk 74%
- Cornwall 58%
- North West 47%
- Birmingham and Solihull 33%
Spoke to EIP clinicians to identify barriers to GP discharge

- EIP clinician concern - what will happen in event of relapse?
- Patient/family concerns - safety net
- GPs refusing to take patients on depots, especially SGA LAI, Penfluridol, some oral medications eg Aripiprazole

So we needed a novel approach
DISCHARGE MEETING AT GP SURGERY

If the mountain won’t go to Mohammed, then Mohammed will go to the mountain
Quick
Enhances collaborative care
Potential to improve both physical and mental healthcare of our patients
Potential to reduce referral rate back into secondary care by improving GP confidence in treating psychosis/schizophrenia
Get to know local GPs and an opportunity to promote EIP
Identify suitable time and request a double appointment.

In advance write to GP with notice of discharge meeting, explaining purpose and benefits of the meeting.

Consider who should be present - Patient, Care coordinator, Psychiatrist, family member?

Prepare discharge summary, Early warning signs and staying well plan. Bring these to the meeting.
Brief history
Discuss Diagnosis- GPs confused about our diagnoses!
Treatment- previous, current and future
What to do in the event of EWS
What Physical health monitoring is required (reminder of our patients reduced life expectancy and poorer access to physical health care)
What to do if patient on meds and wants to stop
What to do if patient eg on Olanzapine develops early diabetes
When to refer back to secondary care (and to whom)
- EWS include anxiety, and poor sleep

- Go advised to prescribe 1 week hypnotic if coping strategies no longer working and 2 weeks off work

- If no improvement and transient referential ideas present, restart Aripiprazole 5mg

- If still no improvement re refer to CMHT
Discussion with GP regarding long-term maintenance of AP. What should GP do if he stops collecting prescription or request discontinuation?

Discussion re need for regular metabolic syndrome monitoring and management obesity/early onset diabetes including potential benefit of changing AP medication

If changing AP medication, can GP undertake this under specialist advise or should patient be referred to CMHT?
IS IT SAFE PRACTICE?

- Retrospective audit of patients discharged from Solihull EIS to general practice over the last three years
- 34% come back into services
- Average length of time before contact again with mental health services was 9 months (range 48 to 687 days)
- They get back into services QUICKLY
- 38% within 1 day
- The rest within 10 days
Most GPs like it! (a small minority possibly feel uncomfortable)

GPs value discussion particularly about medication and monitoring and contingency management

Patients and families very positive about the experience

Sue and I like meeting local GPs and feel it is time well spent
Early intervention services should focus on actively establishing relationships between service users and GP from outset

Huge variation in GP discharge rate

Discharge CPA IN GP SURGERY offers many advantages for patient, GP and family

Appears safe to discharge to GP- evidence suggests patients are getting back into secondary care quickly in relapse