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| **Purpose** | The discharge/transfer processes aim to facilitate the gains made during service delivery are maintained and there is a safe discharge or transfer process. |
| **Scope** | All service users and service providers involved in service delivery and the discharge processes. |
| **Policy** | Discharge planning occurs as part of the initial assessment and will be re-visited at each service delivery review. |
| Discharge planning is essential to gain and maintain optimal wellness for service users. It is recommended that the following publications – additional to the contractual requirements - are considered in the discharge processes: |
| [Mental health: Effectiveness of the planning to discharge people from hospital (2017).](http://www.oag.govt.nz/2017/mental-health/docs/mental-health.pdf)[Common European guidelines on the transition from institutional to community based care (2012)](http://www.deinstitutionalisationguide.eu/wp-content/uploads/2016/04/GUIDELINES-Final-English.pdf)[Road to recovery Client Experiences in Supportive Housing (2012)](https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/Road_to_Recovery-Client_Experiences_in_Supportive_Housing.pdf)[Stories of Success: Mental health service users’ experiences of social inclusion in Aotearoa New Zealand: Na pukorero rangatira: Na tangata waiora i whaiora i enei tuahuatana (2014).](https://www.mentalhealth.org.nz/assets/Uploads/Stories-of-Success-26-05-14.pdf) [Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/ Alcohol and Other](https://www.health.govt.nz/system/files/documents/publications/transition-planning-guidelines-infant-child-adolescent-mental-health-alcohol-other-drugs-services-may14-v2.pdf) [Drugs Services (2014).](https://www.health.govt.nz/system/files/documents/publications/transition-planning-guidelines-infant-child-adolescent-mental-health-alcohol-other-drugs-services-may14-v2.pdf) |

**Discharge/transfer final planning meeting**

**During the month the discharge/transfer is anticipated**

**Participants**

**Service user and service provider(s)**

Options:

* cultural supports
* referrer
* any other supports the client wishes to have
* family/whānau/carer
* interpreter if need has been identified
* peer support

**Review:**

* discharge goals
* discharge plan
* service provision
* strengths
* effectiveness of support/intervention
* risk/safety
* supports
* medication arrangement
* general practitioner visit requirements
* apply outcome measure tool (examples):
	+ [Hua Oranga](http://www.oradatabase.co.nz/aboutus.php)
	+ [Recovery Star](http://www.outcomesstar.org.uk/using-the-star/see-the-stars/recovery-star/)
	+ [HoNOS](https://www.tepou.co.nz/outcomes-and-information/honos-family-of-measures/30)
	+ [BASIS32](http://ebasis.org/pdf/Basis32SurveyRevB320108Eng.pdf)
	+ [ADOM](https://www.matuaraki.org.nz/uploads/files/resource-assets/141111-tp-adom-form-v2_0.pdf)
	+ [SACS](http://www.werryworkforce.org/sacs)



**Planned discharge/transfer**

**Goals achieved**

**Goals Not Achieved**

**Consider:**

* Identify barriers to achieving goals.
* Provide information and education.
* Make necessary adjustments to current plan.
* Discuss alternative options.
* Refer on.
* Communicate with other service providers.
* Communicate with family/ whānau/

custodian.

* Initiate handover to future service provider.
* Support the service user and their family/supports in updating the wellness plan.
* Update early warning signs and relapse prevention plan.
* Update advanced directives.

**Provide information on**:

* Re accessing the service.
* Relevant service providers.
* Alternative support, interventions or treatment.
* Self-help groups.
* Peer support.
* Helpline, crisis support.
* Internet self-help interventions.

**If relevant:**

* Arrange handover and follow-up.
* Provide a discharge summary to

 the service user.

* Arrange supports as defined by the service user and their family/supports.
* Ensure relevant service providers/referrer are ready to provide services as arranged.

**Offer the service user a farewell ceremony**



**Unplanned discharge/exit**

Service user does not attend appointments.

Service user expresses no longer wishing to engage with the service.

**Service user and service provider(s)**

Attempt to re-engage:

* Try to contact the service user.
* Contact family/ whānau/custodian – if safe and appropriate.
* Contact other service providers.
* Explore the reason why the service user does not engage.
* Fulfil statuary reporting obligations.
* Implement the exit plan (advanced directive).

If safety/risk issues are evident:

* Review situation with supervisor/clinical team.
* Develop a risk/safety plan.
* Communicate the risk/safety plan with relevant stakeholder(s).

If service users’ address is known:

* Send information on emergency contacts, self-help groups and/or other supports.
* Provide the service user with a discharge summary.
* Provide relevant service providers with a discharge summary.

# Consultation

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| **Group/Role** | **Date** |
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