

Planning for the discharge of a person with intellectual disability after a mental health admission

A planning tool

AUTHORS

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Description of resource

This discharge planning tool outlines key considerations and actions to take before a person with intellectual disability is discharged from hospital after a mental health admission. It is designed for mental health or allied health professionals to use as a checklist and planning tool when discussing discharge with the person with intellectual disability and their support networks.

See the Discharge [Transfers of care](#) section on the [Intellectual Disability Mental Health Connect](#) website for more details



This is a PDF Form. Fill it out using [Acrobat Reader](#) (version 8 or later) or Adobe Acrobat Pro DC.





You can navigate through this form using the tab button on your keyboard

To consider and discuss with the person with intellectual disability and support networks

Items	Notes	Completed	N/A
Goals for recovery			
(If applicable), discuss medication usage and the need to continue taking medication (e.g. even if you start to feel better, you still need to continue taking your medication)			
What supports may be required to take the medication and if they are available to the person in the community (e.g. do they have access to a registered nurse if required?)			
Who will be responsible for different aspects of care after discharge including who will implement other therapies/strategies for recovery?			
(If applicable), review current NDIS plan and whether modifications/new services are indicated.			



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To consider and discuss with the person with intellectual disability and support networks (CONTINUED)

Items	Notes	Completed	N/A
<p>If no NDIS plan, discuss whether the person could benefit from one and how the person and their support networks can start the process.</p>			
<p>Consider other required services. For example:</p> <ul style="list-style-type: none"> • Behaviour support practitioner • Allied health services (e.g. speech pathologist, occupational therapist) • Support worker/case manager • Housing services • Employment services • Community activities and support groups • Services for First Nations peoples • Services for culturally and linguistically diverse people • Services for people in contact with the justice system including Legal Aid 			
<p>How the person will get to appointments</p>			
<p>Support needs of carers, family</p>			



To arrange

Items	Notes	Completed	N/A
People to inform of discharge			
Who will collect the person from hospital?			
Follow-up appointment or phone call with e.g. outpatient clinic, psychiatrist, psychologist, counsellor, social worker etc.			
Baseline/repeat neuropsychological testing (if required)			
Suitable accommodation (if required)			



To include in plan

Items	Notes	Completed	N/A
Recovery goals			
Professionals and services involved in care and their role and arrangements for follow-up			
Medication instructions (if applicable)			
Coping strategies/tools the person can continue using at home			
Signs/symptoms that mental health may be deteriorating, and how to get support			



To include in plan (CONTINUED)

Items	Notes	Completed	N/A
Steps to take in a crisis			
How support networks will support the discharge plan/ monitor progress			
Other information as required e.g. care for any physical health conditions			



People to provide discharge plan to

Items	Notes	Completed	N/A
Person with intellectual disability			
Family, carers, and support workers			
GP and multidisciplinary team			
Community nurse (if applicable)			
Aboriginal Community Controlled Health Service (ACCHS) (if applicable)			
Others			

Additional items

Items	Notes	Completed	N/A

Additional items (CONTINUED)

Items	Notes	Completed	N/A