[insert organisation name/logo]

Service Exit and Re-entry Policy

Document Status: **Draft or Final**

Date Issued: **[date]**

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Scheduled Review Date: **[date]**

Record of Policy Review

Review Date	Person Initiating/Leading Review	Other People Consulted

Triggers for Policy Review (tick all that apply)

- ☐ Standard review is timetabled.
- ☐ A gap has been identified
- ☐ Additional knowledge or information has become available to supplement the policy.
- ☐ External factors
  - ☐ Policy is no longer relevant/current due to changes in external operating environment.
  - ☐ There are changes to laws, regulations, terminology and/or government policy.
  - ☐ Changes to funding environment, including requirements of funding bod(y)ies
- ☐ Other (please specify).
- ☐ Internal / organisational factors
  - ☐ A stakeholder has identified a need, eg by email, telephone etc
  - ☐ A serious or critical incident has occurred, requiring an urgent review.
  - ☐ Need for consistency in service delivery across programs and organisations.
  - ☐ Separate, stand-alone policy is now warranted
  - ☐ A near miss has occurred, requiring a review to prevent a serious/critical incident in the future

Additional Comments [*for example, policy now covers details related to new legislation*].

Service Exit and Re-Entry Policy

1. Purpose and Scope

The purpose of this policy is to clarify the service exit and re-entry process for **[insert organisation name]** programs and to ensure that the organisation adopts fair and non-discriminatory processes when a participant chooses to or is required to leave the service.

This policy applies to all programs and services provided by the organisation and employees involved in the process.

This policy does not cover referral of participants to other organisations. Refer to Participant Intervention Policy for more detail.

2. Definitions

Exit is the process through which participants transition out of **[insert organisation name]** programs and services. Ideally, the exit process occurs when the participant reaches their goals outlined in the recovery plan; this may include a period of transition to exit and follow up support.

Stakeholder: encompasses (but is not limited to) consumers, carers, advocates, guardians, employers and/or teachers .

3. Principles

Exit planning is integral to the support process and is conducted in close consultation with the participant, and where appropriate with family, advocates or other necessary stakeholders, such as employers.

Participant exit from **[insert organisation name]** programs occurs in a planned, collaborative manner.

Exit procedures will be fair, follow due process and uphold the rights of the participant.

Exit procedures will protect the safety and integrity of **[name of organisation]** staff, participants, programs and services.

4. Outcomes

Participants experience a smooth transition out of **[insert organisation name]** programs.

[name of organisation] staff are provided with effective processes to safely and helpfully support participant exit and re-entry circumstances.

Participants exiting the service will have a process that is safe, fair, transparent and subject to review.
Policy Detail

[insert organisation name] uses fair and non-discriminatory processes when a participant chooses to or is required to leave the service.

[insert organisation name] assists participants to understand the process for leaving the service.

[insert organisation name] assists participants to exit the service and ensures re-entry according to the participant's needs and in accordance with guidelines, eligibility and/or waitlists.

[insert organisation name] assists participants when they exit the service and provides them with sufficient information on how to re-enter the service if / and / or when required.

As appropriate to their circumstances, the participant is given information about, referral or supported introduction to, other community agencies / organizations, which can offer support after they have exited the service.

4.1 Exit Planning

Exit planning is a process used to prepare a participant to transition from **[insert organisation name]** programs.

Exit planning commences at the time the participant enters the service.

The participant and support worker incorporate exit planning into the participant's recovery plan. Follow-up support and referral are means through which the participant may transition from **[insert organisation name]** programs with other supports in place.

Development of exit plans: Exit plans may contain the following:

- measurement of change in perception of quality of life, including health status, personal circumstances and/or vocation.
- satisfaction with service,

- review of progress towards recovery goals,
- methods used to evaluate outcomes, including the participant's preferred evaluation methods.

Exit plans for child, adolescent and aged participants will be developed with consideration for issues specific to their demographic (for example aged care participants transferring to a nursing home and exit plans for child and adolescent participants are not usually discussed at entry to **[insert organisation name]**.)

The participant, and, subject to consent, their carer(s), other service providers and other stakeholders are involved in developing the exit plan. Copies of the exit plan are made available to the participant and with the participant's informed consent, any necessary stakeholders.

Participants, their carers and other stakeholders are offered assistance to identify early warning signs of a relapse.

Exit plans include information about symptoms of pending relapse, and an accompanying relapse management plan, which includes information about accessible crisis services.

[Depending on the type of service the participant has received, the intensity and duration of service and whether the service provider was the primary case manager or a supporting service provider], the exit plan may include the following:

- details of follow-up arrangements with the participant
- the earliest possible involvement of the participant's nominated service provider and arrangements for ongoing follow-up
- community resources likely to be involved in post exit support and, as necessary, referral and facilitated introduction arrangements
- other people to be involved and their roles
- other details identified by the participant and carers
- preferred method of evaluating recovery outcomes for the participant
- plans for identifying early warning signs of relapse
- information on how to re-enter the service
- a clear point of contact in the service provider regarding the most recent period of support
- shared support arrangements with GPs, private psychiatrists and community managed organizations, if applicable.
- information for the preferred health care provider, for example the GP or private psychiatrist

There is a clear and documented follow-up process which identifies the responsible agency and crisis service for the period following exit.

[where the CMO provides an inpatient service, or provides participant support directly before and/or following discharge]
[insert organisation name] actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the participant from inpatient care.

4.2 Service Exit

The following situations may lead a participant to exit from **[insert organisation name]** programs/services:

- The participant has achieved, or is working towards achieving, the goals stated in the Recovery plan
- Participant support needs would be best met by another service (eg referral/transfer to an aged care service)
- The participant tells **[insert organisation name]** that he or she no longer needs its services
- There has been no contact between the participant and **[insert organisation name]** over a period of **[insert timeframe]**
- The participant moves out of the **[insert organisation name]** service area
- The participant engages in behaviour which is unacceptable to **[insert organisation name]** such as violence, abuse, aggression, theft, property damage
- If the CMO is providing services, under a strict government contract, when directed by the particular department, to do so.
- **[insert other program specific reasons]**.

On exiting the service the participant and their carers are advised of the processes to follow should re-entry be required.

4.2.1 Completion of the Program

Participants who successfully complete **[name of organisation]** programs will be celebrated/acknowledged by **[insert the appropriate information *e.g. recovery celebration, entry into transition program etc*]**.

4.2.2 Early Exit by Participant Choice

In the event of a participant wishing to withdraw from the program/service, even though the organisation, carer and other stakeholders consider that ongoing support is required, every effort will be made to persuade the participant to accept some form

of service or referral to another service. However, if refused, the right of the participant to choose must be upheld. However, the situation of a participant wishing to withdraw from service, may still be passed on to an alternative party, such as emergency mental health services, if the participant is likely to engage in behaviour that could harm themselves or others.

If participants choose to receive services from another organisation, efforts will be made to locate a service that is better able to meet their needs.

Staff will provide appropriate information, with the permission of the participant, to the new service to ensure optimal support. This may include meeting with the participant, to ensure the participant fully understands the implications of the decision.

For a period of **[insert timeframe]** after formally exiting from the service, the participant reserves the right to return to the organisation and receive a service, without having to go through full assessment processes, provided resources are available. Following this timeframe, the participant file is closed and a new referral/intake assessment will need to be undertaken if the participant requires service at some point in the future.

4.2.3 Exit to Another Organisation

Some participants will decide to leave the organisation, in order to obtain a similar type of support at an alternative organisation.

The **[insert organisation name]** support worker allocated to support the participant will meet with the new service provider to provide referral information and finalise the process for transfer (where appropriate).

Where ongoing liaison is essential to the client receiving adequate and relevant support, **[insert organisation name**] will, where possible, participate in joint care, treatment and support. For example, when age care issues predominate, the mental health issues may continue or indeed increase.

Staff will continue to follow up with the participant and liaise with the new service provider for a **[insert time]** period to facilitate a smooth transition. After this timeframe, if the participant wishes to re-enter **[insert organisation name**], a new intake application will need to be completed.

[where the participant exits to an inpatient service with support from the organisation] When admission to an inpatient psychiatric service is required, **[insert organisation name]** makes every attempt to facilitate voluntary admission for the participant and continue voluntary status for the duration of their stay

4.2.4 Participants who are asked to leave the program

As part of entry into the **[name of organisation]** program, participants are informed of participant rights and responsibilities. Information about reasons for being asked to leave the program will be explained to the participant. These reasons will be included in exit planning, if need be.

[insert the criteria for being asked to leave the program here if desired].

The decision to ask the participant to leave the program must be taken to the **[insert position]** for authorisation. If agreed, staff will follow the processes outlined in the exit plan in full.

Appropriate referrals are made and the participant may continue to receive limited support services, within available resources, for a period determined by **[insert position]**. This provision particularly applies for participants with high risk for self harm.

Participants who wish to lodge a complaint regarding their exit are provided with details on the process of complaints and/or may be given information about the Health Care Complaints Commission. (DEEWR Employment Service Complaints for employment service providers.) Refer to the Feedback and Complaints Policy.

4.3 Exit Interview

Where possible, a participant exit interview is carried out during the exit process, using participant exit summary and participant evaluation and feedback processes.

4.4 Follow-up of participants following discharge from an inpatient unit

[applicable where the community managed organisation provides inpatient services] For the purposes of this criterion, discharge is defined as discharge from an inpatient unit or discharge from an episode of care. The criterion does not apply to final discharge of the participant from the mental health service.

Due to the relatively high risk of suicide in the first four weeks after discharge, and to prevent relapse, **[insert organisation name]**, in conjunction with the treating clinician, is required to follow-up wherever possible within seven days of discharge.

Participants flagged for follow-up are identified by a risk assessment performed before they exit.

[applicable where the community managed organisation provides support services to people following discharge]

[insert organisation name], supports the participant to maintain contact with the inpatient service for follow-up for the period for which it is required.

4.5 Re-entering the service

[Arrangements for re-entry will depend on the type of service that has been provided].

Some participants who leave the **[insert organisation name]** will need to re-enter at some future stage. The process for re-entry is made as simple and as streamlined as possible.

Re-entry strategies include:

- Reviewing previous files/records on re-entry – participants will not have to tell their history/story again if re-entry is within **[insert relevant timeframe]**
- Making contact with any other organisations or other stakeholders, such as advocates or employers, involved (subject to participant consent) to identify the triggers for re-entry
- Reviewing the previous Recovery plan to identify what worked and what didn't
- Where possible, the same worker will be allocated to the participant.

4.6 Notifying Relevant People about Participant Exit

The support worker ensures that the relevant service providers (including referral source) and informal support networks are informed that the participant has exited from **[insert organisation name]**.

4.7 Storing Documents

The support worker ensures all relevant documentation is complete and filed in the participant file.

A Participant Exit Summary is the final document completed to signify closure of the file.

The participant file is retained, secured and stored in accordance with the Personal Records Policy.

5. References + Resources

5.1 Internal

Privacy and Confidentiality Policy

Participant Manual
Personal Records Policy
Participant Support Policy
Feedback and Complaints Policy
Referral Procedure

9.2 External

NADA Client Exit Policy.
http://www.nada.org.au/index.php?option=com_content&task=view&id=236&Itemid=44 accessed 12th May, 2011

Commonwealth of Australia (2010). Implementation Guidelines for Non-government Community
Services http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-i-nongov
accessed 6th May, 2011

Bird V, Leamy M, Le Boutillier C, Williams J, Slade M (2011) *REFOCUS: Promoting recovery in community mental health services*, London:
Rethink. http://www.mentalhealthshop.org/products/rethink_publications/refocus_promoting_re.html accessed 10th May, 2011

9.3 Quality and Accreditation Standards

EQuIP4

Provided by the Australian Council on Healthcare Standards (ACHS)

Standard 1.1: Participants/patients are provided with high quality care throughout the care delivery process.

Criterion 1.1.5: Processes for discharge/ transfer address the needs of the participant/patient for ongoing care.

Criterion 1.1.6: Systems for ongoing care of the participant/patient are coordinated and effective.

EQuIP5

Provided by the Australian Council on Healthcare Standards (ACHS)

Standard 1.1: Participants/patients are provided with high quality care throughout the care delivery process.

Criterion 1.1.5: Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Criterion 1.1.6: Systems for ongoing care of the participant/patient are coordinated and effective.

Health and Community Service Standards (6th edition)

Provided by the Quality Improvement Council (QIC)

Standard 2.2: Services and programs are provided in an effective, safe and responsive way to ensure positive outcomes for participants and communities

Evidence Questions: What is the evidence that:

a) interventions and actions are based on assessment and planning?

b) services and programs are managed to ensure positive outcomes for participants and communities?

c) information about the rationale, risks and effect of services and programs is routinely provided to participants and communities?

p) where appropriate, case closure is planned with the participant?

9.4 National Mental Health Standards

Criterion 2.11: The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and / or are transferred to another service.

Criterion 6.12: Consumers have an individual exit plan with information on how to re-enter the service if needed.

Criterion 7.13: The organisation provides information about and facilitates access to services that maximize the wellbeing of carers.

Criterion 10.3.6: Where admission to an inpatient psychiatric service is required, the organisation makes every attempt to facilitate voluntary admission for the participant and continue voluntary status for the duration of their stay.

Criterion 10.3.7: When the participant requires involuntary admission to the organisation the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state / territory policies and guidelines, including the National Safe Transportation Principles.

Criterion 10.4.4: The organisation actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the participant from inpatient care.

Criterion 10.4.5: The organisation conducts a review of a participant's support, care and recovery plan when the participant:

- requests a review
- declines support and support
- is at significant risk of injury to themself or another person
- receives involuntary support or is removed from an involuntary order
- is transferred between service sites
- is going to exit the organisation
- is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.

Criterion 10.6.1: The organisation ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.

Criterion 10.6.2: The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.

Criterion 10.6.3: The organisation has a process to commence development of an exit plan at the time the consumer enters the service.

Criterion 10.6.4: The consumer and their carer(s) and other service providers are involved in developing the exit plan. Copies of the exit plan are made available to the consumer and with the consumers' informed consent, their carer(s).

Criterion 10.6.5: The organisation provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required.

Criterion 10.6.6: The organisation ensures ease of access for consumers re-entering the MHS.

Criterion 10.6.7: Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the organisation.

Criterion 10.6.8: The organisation, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.

9.5 Recovery Oriented Service Self-Assessment Tool (ROSSAT)

Evidence items are:

Item 1.2f: Policy and procedures are accessible and applied in practice and describe the support, treatment, recovery plans and advance directives which are:

- Developed by the person, in partnership with workers and family and carers (with consent), based on the consumer's strengths, needs, desires and goals
- Reviewed collaboratively on a regular basis
- Owned and approved by the person and are available to them and others (with consent).

Item 1.2h: Policy and procedures are in place that describe how human rights inform service provision and:

- Safeguard all people against abuse and discrimination
- Outline processes for reporting abuse of workers and consumers
- Outline the ethical framework of the organisation
- Identify what language is inappropriate and stigmatising and should not be used in any level of the organisation.

Item 1.2j: Policy and procedures are in place that show how information should be disseminated to:

- Workers
- Consumers, carers and families
- External organisations.

Item 1.4: A complaint process is in place and is promoted and easily accessible. Each complaint is respected, taken seriously and acted upon, and consumers and carers are protected from reprisals.

Item 1.8: The organisation values the consumer's right to independently determine who will represent their views to the service, and links people to peer support, peer workers and other advocates in the area.

Item 1.10: The organisation maintains an information system that facilitates the appropriate collection, use, storage, transmission and analysis of data to enable review of services and outcomes at an individual and service level. This is done in accordance with information management and related Commonwealth, State / Territory legislation and Acts.

Item 2.5: Leaders advocate, champion and model:

- Human rights informing service delivery
- The consumers' voice as central to care and service provision
- The belief that recovery is possible and probable for every person

- Hopeful and optimistic attitudes in dealing with workers, consumers and carers.

Item 2.6: Management:
- Is aware of Commonwealth and State policy directions around recovery orientation and integrates these into practice
- Identifies information relevant to the organisation to increase the knowledge base on recovery and recovery oriented practice, including information for consumers, carers and their families.

Item 3.2: Workers acknowledge their role in supporting a person's recovery rather than doing recovery for them.

Item 3.6: When workers engage with people they:
- Respect them as equals and as experts by experience
- Value their voice and vision in informing their support
- Use strengths based language and everyday language (not clinical jargon).

Item 3.7: Workers recognise that self-direction and self-responsibility are important in a person's recovery journey, and that providing them with choice and information inspires recovery and enhances control over decision-making.

Item 3.8: Workers make information available in different formats to ensure that it is accessible to all people using the services.

Item 3.9: Where required, interpreters and workers are made available to consumers, carers and families to communicate in their preferred language.

Item 3.10: Workers respect a person's decision whether to involve carers and family, and acknowledge and respect carer and family participation and input.

Item 3.11: Support / treatment, recovery plans and advance directives:
a. Are developed by the person, in partnership with workers and family and carers (with consent), based on the consumer's strengths, needs, desires and goals
b. Are reviewed collaboratively on a regular basis
c. Are owned and approved by the person and are available to them and others (with consent).

Item 3.13: A person's own interpretation of his or her illness is not used as a basis for discrimination or dismissed as untrue.

Item 3.14: The person, their family and carers are provided with their rights and responsibilities in both written and verbal formats upon contact with the service.

Item 3.15: Workers understand, and also support the person to understand, that recovery is not always linear and that:
- The person may need different levels of support at different points in time

- Relapse is an opportunity to develop resilience and insight and does not mean that a person is no longer on their recovery journey.

Item 3.16: Workers support the person to reflect on times when they have been unwell, and what steps have helped in their experience each time.

Item 3.17: Workers support the person, their family and carers to make informed decisions by:

- Sharing information on services, therapies and supports
- Supporting them to find information from other sources.

Item 3.20: Workers seek to exchange information with other organisations and agencies to ensure continuity of care (with consent).

Item 3.21: Where a person is not able to access the organisation's services (e.g. not eligible), a reason is provided along with supported referrals to other services.

Item 3.22: Workers are aware of a person's physical health and are able to provide referrals to appropriate health care professionals.

Item 3.23: Workers consider the whole context of a person, and support the person to develop and enhance links in their community (e.g. social networks, peer support groups, education/training, employment, community and rehabilitation services, physical activities, a person's hobbies).

Item 4.2a: Policies and procedures are in place that relate to privacy and confidentiality, the obtaining of consumer consent to share their information and communication techniques available.

Item 4.5: Consumers, their families and carers are supported to access education and training on mental health, recovery and wellness.

Item 5.3: Consumers are provided with the regular opportunity to evaluate relationships, respectful practice, perceptions of stigma and discrimination experienced from workers within the organisation, the consumer self-directed focus, the belief in consumer's recovery, the obtaining and sharing of knowledge and information, the quality and relevance of information provided and participation and social inclusion.

Item 5.3e: Consumers are provided with the regular opportunity to evaluate the obtaining and sharing of knowledge and information, the quality and relevance of information provided, the appropriateness of the format information is provided in and the ability to understand information that is provided.

9.6 NSW Disability Services Standards (DSS)

1.3: The service provider implements its own written entry and exit policies and procedures.

1.4: The service provider's entry and exit policies are reviewed regularly with service users.