

- How will they access treatment after being discharged?
  - What is the process if they need to come back?
  - Can they use this service again? When? Who do we contact?
- Re: Accessing the Service**
- How do I provide support? What happens if they don't go?
  - Do I need to do anything to support this referral?
  - Can you tell me about the services you have referred them to?
  - Have they met the new clinician/GP/support worker?
  - Have they agreed to this?
  - Does everyone know what they are meant to be doing – is there a shared plan between all services referred to?
  - Do they need to go to a GP for another referral?
  - How long will the referral last?
  - Have they been accepted?
  - Who have you made referrals to?

### Referrals

- Are there any physical health issues needing to be addressed?
- Has an ECG (heart monitor) been completed?
- Have there been blood tests undertaken to check physical health issues (also known as 'metabolic screening')?
- Is a brain MRI required?
- How, if at all, will the treatment impact on their physical health?
- Do you have any recommendations/suggestions for me as a carer as to how I can support this person's physical health?

### Physical Health

- Can you explain how the medication works, any side effects and any interactions it may have with alcohol or other drugs?
- What should I do if they seem to be having a bad reaction?
- What should I do if they don't take their medication?
- Is there a record of what medications have been tried? Has this been shared to avoid any mistakes?
- Is there a record of his/her reactions to past medications?

### Medications

## Carer Supports

- Who can I contact if I need help myself or if things go wrong?
- What sort of support can I have?(eg respite, counselling, peer support, advocacy) Do I need a referral?
- Am I able to speak with a carer consultant/peer worker?
- Am I able to access any financial support?

## Relevant Emergency Contacts

- Can you give me emergency contact numbers for my area?
- How do I know which one to call?
- When is it the right time to call?
- What do I do if we are not at home in an emergency?

## After Discharge

- If they don't follow the plan, what will you do?
- Will I be able to contact you or ask for advice after they're discharged?
- If not you, who or what service should I speak with?
- What psychosocial supports are available? e.g. education, employment, recreation, community managed mental health services, housing, legal, financial, National Disability Insurance Scheme (NDIS) etc.

## Risk

- Have they been educated about possible risk issues? Eg. mental health and substance use, housing, legal etc
- Is there a risk of them overdosing?
- What is the likelihood that their mental health condition will relapse?
- What is the likelihood that they will relapse in relation to alcohol or other drug use?
- Has a risk assessment been recently completed? What were the results? What self harm or suicide risk exists?
- Who can I contact if I feel I can't manage the risk issues?

## Anything Else?

- Is there anything else I need to know?
- Can you tell me where to get more information about the illness?
- How else can I help once they leave here?
- Where can I find out more?

- How can I be involved in treatment planning?
- Can you explain the diagnosis and prognosis?
- How might the treatment they are receiving affect their behaviour?
- Has an assessment of the interaction between their substance use and their mental health (dual diagnosis assessment) been done?
- What treatment have they received for both their substance use and their mental health issues? How does it work?
- How do we know if the treatment is working?
- Have they agreed to the treatment plan?
- Is this treatment compulsory? If yes, what is the process and review date?
- Will treatment be in the public or private system? How much will it cost? i.e. Medications, services etc

### Treatment

- How will I know if they are relapsing?
- What might the early warning signs be?
- Do they know what they are?
- What do I do if I notice these early warning signs?
- Who should I contact?
- Is there a written relapse plan?
- Have they made a written plan about what they want to happen if they become unwell? (e.g. advance statements)

### Relapse

- Am I part of the discharge plan?
- What am I expected to do? (eg medication, relapse, transport, making appointments etc)
- Can we talk about it?
- Have they agreed to me doing those things?
- What happens if I can't do those things?
- Can I have help to support them? What sort of help can I get?

### Carer's Role in Discharge



## Consent/Information Sharing

- Has the person receiving care identified me as a carer?
- Are there any consent issues I need to be aware of?
- What are my rights if they don't provide consent?
- Have they been asked how they would like me to be involved?
- Have they agreed to sharing information with me?
- What information am I entitled to?
- How do I share information that I believe is relevant with the treating team?
- Will information I share with the treating team be shared with others? Who?

## Discharge Planning

- Have they been asked if they are ready to be discharged?
- Can I be included in the discharge planning?
- Can you explain why they are being discharged?
- Who has been involved in making the decision?
- Are both mental illness and drug and alcohol issues being addressed in an integrated manner?
- Has the person's culture and background been taken into consideration?

## Strengths

- Can we talk about their strengths? I'd like to support them.
- What decisions and choices have they made about their illness?
- Can we talk about how they're understanding and feeling about the experiences that have led them to being in this situation?
- What goals have they been pursuing through this service?

## Discharge Summary

- Is it possible to receive a draft of the discharge plan prior to discharge so I can have further input if need be?
- Is there a written discharge summary?
- Who will receive it? Will I get a copy?
- Does everyone know what they need to do next?