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Accelerated Evidence Snapshot and Desktop Review

Emerging evidence for mental health discharge planning and transfer of care

An Accelerated Evidence Snapshot and Desktop Review
produced by the Sax Institute for the Mental Health Branch, NSW Ministry of Health
March 2025

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This report was prepared by: Cat van Kemenade[a], Alexandra Schiavuzzi[a], Meron Lewis[b], Nick Petrunoff[a,c], Eileen Goldberg[a]. March 2025

a Sax Institute

b School of Human Movement and Nutrition Science, Faculty of Health Medicine and Behavioural Sciences, The University of Queensland

c Prevention Research Collaboration, Sydney School of Public Health, Faculty of Medicine and Health, the University of Sydney

Enquiries regarding this report may be directed to the:

Director
Evidence and Evaluation Services
Sax Institute
www.saxinstitute.org.au
evidence@saxinstitute.org.au

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This Accelerated Evidence Snapshot and Desktop Review was produced using a rapid evidence review methodology in response to specific questions from the commissioning agency.

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Introduction

The Mental Health Branch (MHB), NSW Ministry of Health, commissioned the Sax Institute to prepare this Accelerated Evidence Snapshot and Desktop Review to inform a review being undertaken by the MHB of the *Discharge Planning and Transfer of Care for Consumers in Mental Health Services in NSW* Policy Directive (PD2019_045) (the Policy Directive).

The Policy Directive establishes minimum standards to support effective and safe discharge planning and transfer of care for consumers of NSW Health mental health services. The update to the Policy Directive aims to reflect current evidence and contemporary thinking on best practices to ensure a high standard of patient care, efficiency in mental health care delivery, and compliance with regulatory requirements.

The MHB is interested in current evidence on new practices that support effective and safe discharge planning and transfer of care, and existing standards of best practice in discharge planning and transfer of care across Australian jurisdictions. To this end, the Sax Institute undertook two discrete components of work to address the following **research question**:

> **What is the emerging evidence on best practice interventions that support safe and effective discharge planning and transfer of care for consumers of inpatient mental health services and/or their carers?**

This report details the methods and key findings from the two components of work:

Part 1 - An Accelerated Evidence Snapshot of the peer-reviewed literature to identify peer-reviewed evidence that has emerged since 2020 on interventions that support effective and safe discharge planning and transfer of care for consumers of inpatient mental health services and/or their carers.

Part 2 - A Desktop Review of the grey literature relevant to discharge planning and transfer of care sourced from government, professional, and non-governmental mental health organisations.

Part One – Accelerated Evidence Snapshot

Review aim

We aimed to identify and synthesise high-quality evidence on best practice interventions that support safe and effective discharge planning and transfer of care for consumers of inpatient mental health services and/or their carers.

Methods

We employed a systematic approach to guide the review process. Each step is outlined in Table 1, with further details provided below.

Table 1: Approach to ensuring the review captured emerging evidence

Step	Action	Approach	Outcome
Step 1	**Systematic search** for systematic reviews and **screening for relevance**	Conducted structured searches in PubMed, CINAHL, Embase and Cochrane library for systematic reviews published in the last 5 years, ensuring coverage of recent evidence.	Identified high-quality evidence syntheses covering the latest research.

		Selected studies that emphasised emerging evidence.	
Step 2	**Systematic search** for experimental and quasi-experimental studies and **screening for relevance**	Conducted structured searches in PubMed, CINAHL, Embase for studies with experimental or quasi-experimental designs* published in the last 5 years, ensuring coverage of recent emerging evidence.	Captured new primary research on discharge planning and transfer of care.
Step 3	**Quality appraisal**	Assessed studies using a simplified red-amber-green (low-moderate-high) rating system. Applied bespoke criteria to assess the relevance and strength of emerging evidence.	Prioritised high-quality studies and excluded weak evidence. Assessed emerging evidence using tailored criteria.

Systematic search for systematic reviews

We developed a search strategy using the three-step methodological approach originally proposed by Arksey and O'Malley and further refined by the Joanna Briggs Institute (JBI).[1,2] First, we conducted a pilot search in PubMed on 25/02/2025. Second, we reviewed the results to refine search terms and translated the final search strategy for additional databases using validated search automation tools, including the Systematic Review Accelerator (SRA), Polyglot Search Translator, and SearchRefinery.[3–6]

We searched four electronic academic databases: Pubmed, CINAHL, Embase and Cochrane, on 25/02/25. Appendices 1 and 2 provide the full search strategy and search strings. We imported the results into Covidence systematic review workflow management software and removed duplicates.[7] Two reviewers (AS, ML) dual-screened a subset of papers (n=100, 19.6%) to assess inter-rater reliability, with a high level of overall agreement (proportionate agreement = 0.84)†. In total, we screened 510 peer-reviewed papers at the title and abstract level. Appendix 3 shows the inclusion and exclusion criteria.

Following title and abstract screening of the remaining papers, a third reviewer (EG) resolved discrepancies through discussion. Two reviewers (EG, ML) independently screened full texts, with a fourth reviewer (NP) resolving any disagreements. We present the PRISMA flow diagram in Appendix 4. One author (ML) completed the data extraction, which was then checked by two reviewers (CvK, EG).

Systematic search for RCTs and studies with quasi-experimental designs

As a second step in the review process, we conducted a systematic search of three electronic databases, PubMed, CINAHL and EMBASE, on 19/03/25 to identify studies with experimental and quasi-experimental designs published between 1 January 2020 and the search date. This search

* RCTs, interrupted time series, controlled before-and-after studies

† NOTE: The probability of random agreement was also high (0.75), resulting in a Cohen's Kappa value of 0.37. Based on commonly used interpretation guidelines, this represents fair agreement beyond chance. The relatively low prevalence of 'yes' responses (1.76%) and high prevalence of 'no' responses (73%) likely contributed to the moderate Kappa value despite a high raw agreement.

followed the same structured methodology as the previous phase but focused on primary research rather than systematic reviews. Appendices 1 and 2 provide the full search strings.

We imported the search results into Covidence systematic review software and removed duplicates.[7] Appendix 3 details the inclusion and exclusion criteria. Two reviewers (CvK, AS) independently screened the titles and abstracts of 305 peer-reviewed papers, achieving near perfect agreement (proportionate agreement = 0.99)[‡]. They also conducted full-text screening, with any discrepancies resolved through discussion with a third reviewer (EG). The PRISMA flow diagram outlining study inclusion and exclusion is presented in Appendix 4. One author (CvK) carried out data extraction, and a second author (EG) checked the extracted data for accuracy.

Quality appraisal

We designed the quality appraisal process to ensure a rigorous yet efficient assessment of studies within the short timeframe of this rapid review. Drawing on best practice guidance from Cochrane[8], the World Health Organization[9] and other sources that support pragmatic, fit-for-purpose approaches[10–13], we applied a two-stage quality assessment process. In Stage 1, we used a checklist-based assessment to screen studies for inclusion based on essential methodological indicators. In Stage 2, we applied a simplified traffic light system (red, amber, green) to rate study quality as low, moderate, or high based on key indicators (see Appendix 5). This tiered approach aligns with Cochrane Rapid Reviews Methods guidance, which supports structured yet flexible appraisal strategies suitable for expedited evidence synthesis.[8]

Summary of findings

Description of studies

Our searches for studies on emerging evidence in the peer-reviewed literature identified nine eligible publications: eight systematic reviews[14–21] and one primary study using interrupted time series design.[22] The selected studies span a wide range of international contexts, populations, and interventions aimed at improving transitions of care in mental health. Most were conducted in high-income countries, with the USA being the most frequently represented (featured in seven of the reviews), followed by Canada, the UK, Australia, and several countries in Europe, Asia, and the Middle East.

Three reviews, conducted by Austin et al. (2024), McIntyre et al. (2022), and Otis et al. (2023), focused on emergency department (ED) settings.[14,18,19] These studies targeted both adult[14,18] and paediatric[19] populations presenting with mental health concerns, including suicidality. They drew on a variety of designs, RCTs, quasi-experimental, qualitative, and before–after intervention studies, from countries including the USA, Canada, Australia, Japan, and the UK.

[‡] The probability of random agreement was also high (0.99), resulting in a Cohen's Kappa value of 0.37. Based on commonly used interpretation guidelines, this represents moderate-substantial agreement. The relatively low prevalence of 'yes' responses (0.003%) and high prevalence of 'no' responses (98.692%) likely contributed to the moderate Kappa value despite a high raw agreement.

Corrigan et al. (2022), Petkari et al. (2021), Roson Rodriguez et al. (2024), and Lam et al. (2020) examined transitions from hospital to community care in depth.[15,21,22] These studies examined peer support, carer involvement in discharge planning, and transitional discharge models, particularly for adults with serious mental illness or schizophrenia, and also included people experiencing homelessness and substance use. The designs included were predominantly RCTs, alongside controlled trials, retrospective case studies, longitudinal and interrupted time series designs. The studies were conducted in the USA, Canada, the UK, China, Iran, Taiwan, and several European countries.

Reviews by Gaebel et al. (2020) and Manuel et al. (2023) addressed broader frameworks for care coordination and critical time intervention.[16,17] These reviews synthesised systematic reviews, meta-analyses, and quasi-experimental studies to examine the applicability of structured transition models across a range of populations and settings (including homelessness, criminal justice and substance use) with studies originating from the USA, Brazil, the Netherlands, Canada, and the UK.

Table 6.1 in Appendix 6, provides more information on each study.

Quality assessment

Overall, the systematic reviews exhibited robust methodologies and a low risk of bias. Several studies were directly relevant to the current review aim and described discharge planning and care transitions. [17,20–22] Other included studies added indirect evidence to address the aim, focussing on relevant aspects such as care coordination, communication, integrated care or emergency department care. [14–16,18,19] The single primary study included[22] was rated lower in quality by default, see Table 2 below.

Table 2: Quality appraisal of selected studies for review

First author, year	Study design and methodology	Risk of Bias assessment	Applicability*
Austin E, 2024[14]			
Corrigan PW, 2022[15]			
Gaebel W, 2020[16]			
Lam M, 2020[22]			
Manuel JI, 2023[17]			
McIntyre H, 2022[18]			
Otis M, 2023[19]			
Petkari E, 2021[20]			
Roson Rodriguez P, 2024[21]			

*For systematic reviews, applicability relates to the emerging evidence from each SR relevant to the review aim.

Emerging evidence

We found that the strategies for supporting discharge planning and transfer of care fell broadly into five categories: Case management and care coordination; discharge and transfer of care processes; communication and clinical processes; workforce and role management; and family and carer involvement. The evidence supporting each of these categories is described below.

Case management and care coordination

Case management interventions, as explored by Austin et al. (2024), targeted individuals presenting to the ED with mental illness or those who had engaged in self-harm or made a suicide attempt. These interventions involved comprehensive psychosocial assessments and the development of ongoing, collaboratively negotiated care plans, typically delivered by mental health professionals or designated case managers. For individuals who had self-harmed or made a suicide attempt, case management led to notable reductions in subsequent suicide attempts and self-harm behaviours following discharge from hospital. However, the approach did not consistently yield reductions in hospital readmission rates. For patients with broader mental health needs, case management facilitated critical connections with appropriate community-based services, particularly benefiting frequent presenters and those with chronic or complex conditions. System performance outcomes included reduced ED length of stay (LoS), while insights into patient experience highlighted that working relationships and support to transition between services are important, service navigation is not easy, and shame and stigma are barriers to engagement. Staff experience emphasised the importance of rapport-building and acknowledged that effective case management requires sustained engagement rather than short-term interventions. Gaebel et al. (2020) highlighted the effectiveness of intensive case management in improving social functioning and reducing inpatient stays and drop-out rates among individuals with severe mental illness.[16] Integrated care supported by electronic health records enhanced service access and provider communication, though adequate resourcing was essential. Transitional interventions yielded mixed results on readmissions but were preferred by service users for continuity and personalisation of care.

Critical time intervention (CTI), as detailed by Manuel et al. (2023), provided short-term, individual-level, structured support during key life transitions to reduce the risk of homelessness and other adverse outcomes.[17] The model led to a significant five-fold reduction in homelessness and early readmissions post-discharge and improved continuity of care, although evidence for long-term readmission reduction was inconsistent.

Corrigan et al. (2022) examined the role of **peer supporters**, often individuals with lived experience, integrated into assertive case management models.[15] Most studies found peer support effective in reducing readmissions (7/13) and some reported enhanced outcomes such as reduced symptom severity, increased hope and better quality of life. However, no benefits were seen in terms of arrests, crisis stabilisation, or transitions into independent self-management.

Otis et al. (2023) reported that embedding psychiatric consultations and therapies into acute paediatric medical settings (**model of integrated acute care**) reduced ED admissions, LoS, and repeat hospitalisations.[19] Multidisciplinary approaches, including telephone follow-ups and urgent care pathways, were particularly effective, while family-based therapy also prevented repeat admissions among adolescents with eating disorders.

Discharge and transfer of care processes

Austin et al. (2024) detailed structured **discharge and transfer-of-care strategies** designed to improve continuity and efficiency in mental health care within the ED.[14] These included default psychiatric referrals initiated by medical staff, especially when utilising observational beds to allow more time for coordinated planning with post-ED services. Additional components included assigning a primary contact person for both psychiatry staff and patients, implementing discharge checklists, and scheduling discharge appointments prior to ED departure. These initiatives yielded several positive outcomes: they decreased overall ED utilisation and reduced ED LoS, streamlined discharge processes, and increased the proportion of patients discharged earlier in the day, particularly before 11 a.m. By refining workflows and enhancing communication between hospital-based and community-based mental health providers, these structured discharge interventions supported timelier, coordinated, and patient-centred transitions from ED care.

Roson Rodriguez et al. (2024) assessed **transitional discharge models** (TDMs) designed to support individuals with schizophrenia and related disorders during the critical shift from inpatient to community care.[21] These models featured a structured overlap between hospital and community-based mental health teams until a therapeutic alliance was established, as well as peer support from individuals with lived experience who had successfully navigated similar transitions. Although the impact on rehospitalisation rates remained inconclusive, relative risk (RR) of 1.18 with a wide confidence interval, the interventions were associated with notable improvements in patient outcomes, including general functioning (standardised mean difference [SMD] 0.95, a large effect), satisfaction (RR 1.96), and quality of life (SMD 0.24). Similarly, Lam et al. (2020) evaluated a large-scale implementation of TDMs across 13 psychiatric units in nine hospitals, spanning both acute and tertiary care settings.[22] In acute care units, TDMs were linked to a statistically significant reduction in median LoS, alongside an initial spike in 30-day psychiatric readmissions, which declined over time. In contrast, outcomes in tertiary care units were less definitive, showing large but statistically inconclusive changes in readmission rates. These findings suggest that while transitional discharge models hold promise for improving patient experience and reducing acute care burden, their effects may vary depending on the setting and patient population.

Communication and clinical processes

Austin et al. (2024) assessed enhancements to electronic medical records (EMRs) as a form of **decision support** tailored to patients presenting with substance-related disorders and mental health conditions in the ED.[14] For substance-related and addictive disorders, modifications included EMR-integrated prompts and notifications to support universal screening at triage, assess withdrawal severity, and guide next steps such as referral, treatment planning, and discharge instructions. For mental health presentations, enhancements involved automated discharge alerts within a 30-day window, reminders to complete key care tasks, and the inclusion of psychiatric medication charts with “prescribe as required” options and clinical advice. These tools also embedded mental health triage scales and prompts to identify prior unsuccessful care strategies. The implementation of these decision support tools led to improved system performance in substance-use contexts by increasing the identification and treatment of eligible patients, reducing ED visits, lowering prescription rates, and decreasing the number of hospital days per year. Patient outcomes for mental health presentations included decreased ED utilisation, though there was no observed change in ED admission rates, LoS, or acuity recognition. Importantly, staff reported increased confidence in managing these

presentations, highlighting the value of integrated digital tools even amidst mixed effects on traditional performance metrics.

McIntyre et al. (2022) examined interventions aimed at strengthening **communication pathways** between EDs and community mental health services.[18] These included structured support coordination, the use of motivational interviewing, and enhancements to EMRs. Support coordination facilitated smoother transitions by integrating community supports such as primary care, counselling, and peer services over a four- to six-month period. This approach led to a reduction in repeat ED presentations, from 6.5% to 4.3% in the first six months, and significantly increased the proportion of patients linked to primary care at one-year follow-up (62.4% vs. 37.6% with usual care). Motivational interviewing was notably effective for adolescents, particularly when delivered by an ED psychiatrist in combination with outpatient referral, resulting in improvements to both appointment scheduling (73%) and attendance (64%). Additionally, EMR improvements enabled more consistent communication with primary care physicians, increasing documentation from 1% to 40% and follow-up rates from 5% to 67%, while nearly eliminating repeat ED visits (from 4% to 0.5%).

Workforce and role management

Austin et al. (2024) reported that the introduction of **new roles**, such as psychiatric nurses embedded in the ED, mental health consultation-liaison officers, full-time psychiatrists, nurse practitioners, and onsite psychiatric assessment officers, along with adjustments to **rostering models** (e.g., adding 10-hour swing shifts to complement existing 12-hour shifts), significantly improved ED workflow.[14] These changes led to reduced wait times, faster task completion, shorter ED LoS, and decreased admission rates. They also lowered the number of patients leaving without being seen (LWBS) and reduced the demand for standby security staff. Staff experience benefited from improved collaboration, communication, and timely care delivery, though resident wellbeing and burnout levels remained unchanged. Despite these gains, psychiatric nurses reported feeling isolated from the broader mental health team and disconnected from ongoing service developments, highlighting the importance of integration within interdisciplinary teams. Additionally, formal mental health training for triage nurses was found to increase staff confidence and further contribute to reductions in ED LoS.

Family and carer involvement

Petkari et al. (2021) evaluated a spectrum of **carer-focused programs** aimed at supporting individuals transitioning from psychiatric inpatient care to community-based services.[20] Interventions that actively involved carers in discharge planning and post-discharge follow-up demonstrated the most substantial impact. These comprehensive programs were associated with significantly reduced psychiatric readmission and relapse rates, improved treatment adherence and medication compliance, and greater patient and carer satisfaction. They also led to a measurable reduction in carer burden and improvements in carer health status. Programs that extended carer involvement into the aftercare phase further enhanced outcomes, including a lower number of psychiatric readmissions and improved patient functioning, though some effects appeared to be time-limited. In contrast, purely **psychoeducational interventions**, those focused solely on providing information without structured engagement, did not yield statistically significant reductions in relapse or readmission. While simpler models of carer support showed encouraging but less consistent results, the findings underscored the value of structured, ongoing carer engagement in achieving sustained mental health outcomes.

Gaps in evidence noted in the literature

A key gap identified in the peer-reviewed literature was a lack of rigorous research and evaluation methods. Austin et al. (2024) noted that no single study included in their review evaluated system performance, patient outcomes, patient experience, and staff experience together, limiting a comprehensive understanding of impact.[14] Gaebel et al. (2020) reported a lack of robust evidence and called for empirical monitoring and evaluation of care coordination models.[16] Manuel et al. (2023) emphasised the importance of moving beyond average treatment effects, suggesting subgroup analyses based on demographic and clinical characteristics to understand for whom and under what conditions interventions are effective.[17] Similarly, Otis et al. (2023) noted that many studies failed to report on ethnicity or gender and rarely tested intervention effects for individual differences.[19] Lam et al. (2020) recommended that future research stratify participating hospital units by type (e.g., acute vs. tertiary) to better understand variation in outcomes.[22] The evidence for psychoeducation, particularly in acute settings, was found to be limited. Petkari et al. (2021) advocated for factorial trial designs to isolate and evaluate the effects of individual intervention components (e.g., psychoeducation, carer involvement in discharge planning or follow-up).[20] Corrigan et al. (2022) and Otis et al. (2023) both observed that interventions and study samples did not sufficiently account for ethnicity, gender, or other social determinants, limiting the relevance and inclusiveness of findings.[15,19]

Studies often did not incorporate the voices or insights of people with lived experience of mental illness, or could improve on this aspect. McIntyre et al. (2022) noted that although search strategies included terms like “homeless person,” the studies reviewed lacked meaningful inclusion of diverse and marginalised populations.[18] Corrigan et al. (2022) highlighted the need to expand the research definition of "peer" in peer support studies to account for diversity, equity, and inclusion, and recommended using qualitative methods to better capture lived experience.[15]

The transitional phase between inpatient and community care remains under-researched. Roson Rodriguez et al. (2024) stressed the importance of involving service users and carers in evaluating transitional care models, while calling for higher-quality, longer-term studies.[21] Lam et al. (2020) highlighted the need for ongoing support from hospital care teams until a therapeutic relationship with a community provider is established, and emphasised the importance of relational, interpersonal nursing strategies.[22]

Recommendations noted in the literature

Authors from the included peer-reviewed publications identified the following recommendations:

Discharge planning and transitional care

- Refine discharge and transfer procedures and develop capacity in community services.[14]
- Use CTI during transitions to support community reintegration.[17]
- Assess and plan for transitions from psychiatric wards to community care.[21]
- Involve carers in discharge planning and follow-up.[20]

Care coordination and continuity

- Improve case management and coordination, especially post-discharge.[14,16]
- Combine support coordination with counselling, education, and electronic records sharing.[18]

- Nurses should support continuity of care from hospital to community.[18,22]
- Promote carer involvement across inpatient and outpatient services.[20]

Peer support and lived experience involvement

- Tailor peer support strategies to individuals; include diverse voices.[15]
- Encourage people with lived experience to contribute insights.[18]
- Increase patient and carer participation in generating evidence.[21]

Digital and technological interventions

- Use electronic health records, including decision support tools, to enhance care coordination.[14,16]
- Enhance electronic record sharing to improve care continuity.[18]

Nursing roles and therapeutic relationships

- Base nursing strategies on interpersonal and phased therapeutic relationships.[22]
- Mental health nurses should lead communication interventions in ED settings.[18]

Psychosocial and psychotherapeutic approaches

- Co-locate psychiatry and triage services to improve access and reduce over-medicalisation.[19]
- Improve access to psychotherapy during acute mental health crises.[19]

Research and evaluation

- Design studies to evaluate subgroup effects and intervention mechanisms.[17]
- Conduct factorial trials to assess individual psychoeducation components.[20]
- Broaden research definitions and methods for better inclusivity and qualitative insight.[15]
- Encourage higher-quality, long-term studies in transitional care.[21]
- Stratify study units for better comparison across care types.[22]

Tables 6.2 and 6.3 in Appendix 6 provide further detail on the findings from the included studies.

Discussion

Recent peer-reviewed literature offers valuable insights into interventions that support safe and effective discharge and transfer of care for people experiencing mental illness, in ED and inpatient settings. While findings were mixed across studies, several intervention types demonstrated stronger evidence of effectiveness, especially in improving system performance and short-term patient outcomes.

Case management and care coordination interventions were consistently associated with reduced ED length of stay, improved linkage to community-based services, and enhanced continuity of care.[14,16] Intensive case management, in particular, showed positive effects for individuals with severe mental illness, including improved social functioning and reduced inpatient stays. CTIs showed promising

outcomes, especially in reducing early readmissions and homelessness among high-risk groups following discharge.[17]

Structured discharge planning and TDMs demonstrated effectiveness in streamlining care transitions.[14,21,22] These approaches led to earlier discharge times, shorter inpatient stays, and improved satisfaction and general functioning. However, findings on readmission rates were inconclusive and varied across settings.

Digital and clinical decision-support tools, such as enhancements to EMRs, were found to improve identification, treatment planning, and follow-up care, particularly for substance-related and mental health presentations.[14,18] These tools were associated with improved staff confidence and reduced repeat ED visits.

Role innovation and workforce redesign, including the introduction of psychiatric nurses and liaison roles in EDs, yielded operational improvements such as reduced admissions, shorter LoS, and decreased LWBS rates.[14] Staff collaboration also improved, though some professionals reported feeling isolated within broader mental health teams, pointing to the need for better integration.

Carer involvement, especially in discharge and follow-up, led to reduced readmissions and relapse, and improved medication adherence and patient satisfaction.[20] Simpler psychoeducational approaches, by contrast, had limited impact.

Despite these encouraging findings, the literature identified several evidence gaps. There remains a lack of comprehensive evaluations that assess interventions across all domains (system, patient, staff, and experience outcomes). Many studies lacked subgroup analyses, limiting insights into how interventions affect different populations. Diversity and lived experience were often insufficiently considered, and the transitional phase from inpatient to community care remains under-examined, particularly in terms of long-term outcomes. Additionally, in the context of health service research, it is important to understand the context and mechanisms for change, as well as the overall effect. Further research into these implementation factors is warranted to address these gaps. Methodological limitations, including the underuse of factorial trial designs, stratified sampling, and qualitative approaches, were also noted across the literature.

Conclusion

Interventions that promote continuity of care, particularly case management, structured discharge planning, carer involvement, and digital supports, are underpinned by the strongest evidence to date. However, further research using inclusive, high-quality designs is needed to assess long-term impacts and tailor interventions to diverse populations and service contexts.

Part Two – Desktop Review

Review question

What is best practice in contemporary Australian discharge planning and transfer of care policies for consumers of inpatient mental health services and/or their carers?

Methods

We conducted a targeted grey literature scan to identify relevant materials on discharge planning and transfer of care from government bodies, professional associations, and non-governmental mental health organisations. A comprehensive list of sources is provided in Appendix 8. For each selected organisation, we performed manual website searches using internal search functions where available and keyword-based navigation. We also employed Google Advanced Search to enhance coverage to identify relevant grey literature within specified domains. Additionally, we reviewed the reference lists of selected documents to identify further pertinent reports, policies, or guidelines. Documents were screened based on predefined inclusion and exclusion criteria. Relevant materials were catalogued in Excel, and data were systematically extracted using a coding matrix to support consistent analysis across sources.

Summary of findings

The desktop review identified 41 documents published between 2020 and 2024 by Australian organisations, focusing on discharge planning and transfer of care for consumers of mental health inpatient services and their carers. The largest category type included policy and guideline documents (n=27). Other categories included strategic plans (n=3), evaluations (n=2), and a single framework (n=1). An additional eight documents were classified as ‘other’, encompassing submissions, case studies, and priority issue papers.

The documents reflect contributions from a broad range of jurisdictions and organisations, encompassing state, local, and national perspectives. The NSW Ministry of Health emerged as the most prominent source, accounting for 16 documents. Other key contributors included South Eastern Sydney Local Health District, Victoria Health, the Australian Commission on Safety and Quality in Health Care, and the WA Country Health Service. National organisations, such as the Australian Government Department of Health, the National Aboriginal Community Controlled Health Organisation (NACCHO), and the Black Dog Institute provided significant input. This diversity of sources highlights a collaborative and multi-tiered approach to addressing challenges in discharge planning and the transfer of care within mental health services.

Best practice processes and implementation considerations

Findings from the grey literature highlight several key elements that define best practice in discharge planning and transfer of care for consumers of inpatient mental health services and their carers. These elements emphasise person-centred, recovery-oriented approaches and require coordinated implementation across multiple service levels and sectors.

Early initiation of discharge planning

Best practice discharge planning begins early, ideally at the point of admission, to ensure a structured, coordinated process that addresses consumers' medical, psychological, and social needs throughout their inpatient stay. The NSW Ministry of Health underscores early planning as a means of reducing relapse risk and minimising harm,[23] while the WA Country Health Service advocates for discharge planning to commence upon presentation to the emergency department.[24] Effective implementation of early planning requires clearly defined protocols, staff training, and accountability mechanisms to ensure timely and consistent delivery across services.

Multidisciplinary team collaboration

Effective discharge planning is underpinned by collaboration within MDTs. Clearly defined roles and responsibilities across team members, spanning clinical, allied health, and community services, are essential for ensuring seamless transitions of care.[25] Successful implementation also involves external service partners, including guardians, National Disability Insurance Scheme (NDIS) providers, and community health organisations. Appointing a designated key contact within the MDT to oversee and coordinate the discharge process supports continuity, fosters accountability, and helps manage complex care needs across multiple systems.[26]

Trauma-informed and recovery-oriented approaches

Trauma-informed and recovery-oriented care principles are fundamental to best practice and must be embedded throughout discharge planning. These approaches prioritise consumer safety, emotional wellbeing, and autonomy, particularly for individuals with complex needs or heightened risk, such as those experiencing suicidality. For example, the NSW Ministry of Health mandates trauma-informed care in discharge protocols, while standardised tools (e.g. checklists) can assist with consistent and sensitive application.[27] To support implementation, workforce capacity-building and systemic reinforcement of these approaches are essential.

Integration of peer support

Peer support is increasingly recognised as a valuable component of discharge planning. Peer workers with lived experience of mental health recovery provide mentorship, advocacy, and practical support that enhances the transition to community-based care.[28] Programs such as Peer-STOC demonstrate the effectiveness of embedding peer workers in MDTs. Evidence indicates reductions in hospital readmissions and improved consumer engagement with services post-discharge.[28] Successful implementation requires clear role definitions, supervision structures, and integration of peer workers into broader workforce strategies.

Attention to social determinants of health

Addressing social determinants of health, particularly housing and financial stability, is a critical element of safe and sustainable discharge planning. Consumers should not be discharged into homelessness or without access to essential supports. [29] The Victoria Health Transfer of Care and Shared Care Policy (2022) identifies systemic barriers, including delays in NDIS approvals and limited housing access, that impede timely discharge.[30] Programs such as the Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS) demonstrate effective models of integrated housing and psychosocial support that improve post-discharge outcomes.[29,31,32] Implementation requires strong cross-sector collaboration and alignment between health, housing, and disability services.[30]

Workforce development

A skilled and supported workforce is essential to embedding best practice in discharge planning and care transitions. Ongoing training in trauma-informed care, cultural safety, and recovery-oriented practice is necessary to ensure high-quality, person-centred care. The Australian Government Department of Health (2022) emphasises the importance of upskilling staff and expanding peer worker roles to enhance care coordination and improve outcomes for consumers.[33] Effective implementation includes competency-based training programs, supervision models, and mechanisms to support the application of new knowledge in practice.

Continuity of care

Continuity of care is a key element of best practice in discharge planning and plays a vital role in supporting recovery and preventing relapse following inpatient mental health treatment. Findings highlight several components of effective continuity of care, including follow-up arrangements, interagency collaboration, peer support, and care coordination.

Follow-up arrangements

Timely and structured follow-up care is essential to maintaining continuity after discharge. Consumers must leave hospital with clear, individualised post-discharge plans that include scheduled follow-up appointments, crisis contacts, and referrals to appropriate community services. The Australian Commission on Safety and Quality in Health Care (2023) emphasises that no person should be discharged without these arrangements in place.[34] Recommended follow-up strategies include assertive outreach, regular check-ins, and proactive crisis planning, particularly for consumers at higher risk of deterioration.[34,35]

Best practice standards advise that consumers receive follow-up contact within seven days of discharge, and for high-risk individuals, within 24 to 72 hours. Implementation requires systems to support timely communication between inpatient units and community services, including processes for confirming appointments and conducting welfare checks where appropriate.[26,34,36]

Early engagement and transition planning

Initiating discharge planning early, ideally at admission, is critical for facilitating seamless transitions. This includes identifying the service responsible for ongoing care within two working days of admission and ensuring timely referrals to support continuity. Early engagement with external service

providers reduces the risk of service gaps and supports smoother transitions to community-based care.[25,37]

Role of peer support

Peer workers contribute significantly to continuity of care by engaging with consumers during hospital stays and maintaining support during the transition to the community. Drawing on their lived experience, peer workers help build trust, identify individual needs, and assist consumers in navigating mental health and social support systems. They play an active role in ensuring discharge plans are actioned and linkages to community services are maintained.[26,28]

Structured transition pathways

Structured and flexible transition models, such as step-up/step-down care, enable services to adjust care intensity in line with individual needs. These models help bridge the gap between inpatient and community care by providing short-term, supportive environments during periods of transition. In addition, 'warm transfers', which involve direct communication and handover between referring and receiving services, are encouraged to enhance continuity, improve information exchange, and reduce consumer anxiety during transitions.[23,38]

Care coordination

Assigning a dedicated care coordinator or case manager is a cornerstone of effective continuity of care. This individual acts as a single point of contact throughout the discharge and transition process, ensuring oversight and consistency in care. The care coordinator supports the consumer and their carers, liaises with community services and general practitioners, and monitors the implementation of post-discharge plans. Establishing clear care coordination roles is essential for maintaining accountability and avoiding fragmentation across service systems.[39,40]

Communication

Effective communication is a foundational element of best practice in discharge planning and transfer of care. The grey literature consistently emphasises the need for structured, consistent, and person-centred communication strategies to ensure safe, coordinated transitions from inpatient mental health services to community or support settings.

Structured communication frameworks

Structured handover tools are widely recommended to promote accurate and reliable information exchange. Frameworks such as ISBAR (Introduction, Situation, Background, Assessment, Recommendation) and ISOBAR (Identify, Situation, Observations, Background, Agreed plan, Read back) provide standardised formats for clinical communication, reducing the risk of omissions or misinterpretation during care transitions. Their use supports consistency across MDTs and service boundaries.[23,41,42]

Warm handovers, where verbal communication complements written documentation, enable continuity and clarity during transitions. These approaches facilitate two-way communication, allowing questions, clarifications, and shared understanding of discharge plans.[26,27] Regular team meetings,

including MDT huddles, also play a key role in fostering ongoing communication, strengthening collaboration, and aligning care priorities.[43,44]

Accessible and inclusive communication

Equity in communication is essential. Best practice requires that information be accessible to all consumers, including those with disabilities or from culturally and linguistically diverse (CALD) backgrounds. This includes providing discharge materials and care plans in Easy Read, large print, braille, or translated formats, depending on the individual's needs. Inclusive communication enhances understanding, supports engagement, and promotes informed participation in care planning and decision-making.[25,30]

Trauma-informed and person-centred approaches

Communication must be trauma-informed and person-centred, particularly for individuals with a history of mental health crises, suicidality, or past service-related trauma.[33,45] This involves using respectful, non-judgmental language, allowing space for consumer voice and choice, and recognising the emotional impact of care transitions. Families and carers also play a vital role in supporting recovery and should be actively engaged in the discharge process. They should receive clear information about their role, how to access support services, and how to assist the consumer post-discharge.[23,26]

Culturally safe communication

For Aboriginal and Torres Strait Islander consumers, culturally safe communication is critical. Service providers must engage with respect for Indigenous worldviews, which emphasise holistic, family- and community-oriented approaches to health and wellbeing.[46,47] This includes recognising the role of kinship, spirituality, and connection to Country in healing processes. Effective communication in this context requires cultural competence, relational trust-building, and responsiveness to diverse expressions of health and recovery.

Discharge summaries

Discharge summaries are central to ensuring clear and coordinated post-discharge care. These documents should reflect the consumer's goals, preferences, and cultural needs, and position them as active participants in their recovery journey.[34,42] High-quality discharge summaries are comprehensive and should include:

- the reason for admission and treatment provided
- current medications and administration instructions
- follow-up appointments and contacts for ongoing care
- crisis support information
- relevant psychosocial or cultural considerations[23,24,30]

The timely and accurate completion of discharge summaries supports safe transitions, improves continuity of care, and facilitates collaboration between hospital and community-based services.

Consumer and carer involvement

Active involvement of consumers and carers in discharge planning is widely recognised as a key element of best practice. Engaging consumers and carers from the outset ensures that discharge plans are responsive, person-centred, and better aligned with the supports required for sustained recovery.

Early involvement in discharge planning

Consumer and carer involvement should commence at the point of admission, allowing sufficient time for shared planning and preparation.[26,43] Early engagement facilitates open communication, enables informed decision-making, and helps ensure that discharge plans reflect the lived experiences, preferences, and needs of those receiving care. Carers play a vital role in supporting consumers during the transition from inpatient to community-based care. Their involvement in discharge planning has been shown to improve treatment adherence, reduce relapse risk, and support overall wellbeing.

Effective implementation includes providing carers with clear information about their roles and responsibilities following discharge. This may involve guidance on recognising early signs of deterioration, managing medication regimens, accessing community support services, and responding to crisis situations.[27,42] Resources must be accessible and tailored to carers' needs to ensure they feel confident and supported in their roles.

Co-design and service development

Co-design is increasingly recognised as a best practice model that extends beyond care planning to include consumer and carer involvement in the design, implementation, and evaluation of services.[35,48] It acknowledges the value of lived experience in shaping responsive, equitable, and effective mental health systems. Embedding co-design in practice requires appropriate structures for engagement, such as advisory groups, feedback mechanisms, and shared decision-making forums.

Cultural and developmental considerations

For Aboriginal and Torres Strait Islander consumers, involvement in discharge planning must reflect holistic and culturally grounded understandings of health. This includes integrating both clinical and cultural dimensions into care plans and recognising the role of community, spirituality, and connection to Country. Engagement should be culturally safe, relationship-based, and led where possible by Aboriginal and Torres Strait Islander health professionals or community organisations.[46,49]

Young people and their families also require tailored approaches to involvement, particularly during transitions between child and adult mental health services. Best practice transition planning for young people is person-centred, developmentally appropriate, and inclusive of family and caregiver perspectives. It involves early preparation, continuity of support, and attention to the emotional and practical challenges young people may face during this period of change.[44,50]

Digital technology

Digital technology plays an increasingly important role in supporting best practice discharge planning and continuity of care. When effectively implemented, digital tools can enhance communication,

support self-management, and strengthen care coordination between inpatient and community-based services.[40,51]

Supporting transition planning and self-management

Mobile technologies offer consumers timely access to self-management tools, reminders, and personalised information about their care plans.[39,50] These tools can assist in medication adherence, appointment scheduling, and mental health monitoring, thereby supporting consumers' autonomy and engagement in their recovery journey. By making health information more accessible, mobile platforms help bridge the gap between hospital and home environments.[23,33]

Telehealth services further improve access to care, particularly for individuals experiencing geographic isolation, mobility issues, or other barriers to attending in-person appointments. Through telehealth, consumers can access counselling, medication management, and follow-up care, supporting smoother transitions and reducing the risk of disengagement post-discharge.[23,33]

Enhancing care coordination and information sharing

Digital systems such as EMRs are vital for documenting discharge plans and ensuring seamless information sharing between service providers.[26,31,37] These systems support care continuity by allowing clinicians, community workers, and other stakeholders to access up-to-date information on treatment history, medications, and post-discharge arrangements. Improved interoperability and real-time data access enhance the responsiveness and efficiency of discharge processes.[26,31,37]

Digital tools also empower consumers and carers by giving them access to care plans and health information. This promotes transparency and enables active participation in recovery planning. When designed effectively, these tools support shared decision-making and reinforce recovery-oriented, person-centred care.[35]

Culturally responsive digital solutions

There is growing recognition of the need for culturally safe digital tools to support Aboriginal and Torres Strait Islander consumers. These tools are being developed to reflect holistic models of health and incorporate Indigenous worldviews, language, and cultural practices. Culturally tailored digital resources can improve engagement, build trust, and enhance service accessibility for Aboriginal and Torres Strait Islander peoples during and after discharge.[46,49]

Performance monitoring

Performance monitoring is a critical component of effective discharge planning and service quality improvement. It ensures that best practice standards are implemented consistently and that services remain responsive to consumer needs.

Monitoring follow-up care

A key focus of performance monitoring is ensuring that consumers receive timely follow-up care after discharge.[26,34,43] This includes verifying whether follow-up contact occurs within recommended timeframes (e.g. within seven days of discharge or within 24–72 hours for high-risk individuals).

Timely follow-up is a key indicator of service quality and continuity, and monitoring these metrics helps identify gaps and target areas for improvement.

Incorporating consumer feedback

Consumer and carer feedback is essential to evaluating the effectiveness and relevance of discharge planning processes.[36,50] Services are encouraged to gather input through structured mechanisms such as surveys, interviews, focus groups, and feedback forms. Regular engagement with lived experience perspectives supports continuous improvement and ensures that care delivery aligns with the needs, expectations, and experiences of service users.[44,52]

Audits and compliance tools

Routine audits are an important mechanism for assessing adherence to discharge planning policies and protocols.[26,37] Compliance checklists, when used consistently, help monitor whether required steps are completed, such as documentation, referral follow-through, and communication with external providers. Governance structures that oversee audit processes and accountability mechanisms further support quality assurance and service consistency.[43,51]

Data systems and dashboards

The integration of data systems and performance dashboards is becoming more common in mental health services to support real-time monitoring and decision-making.[44,51] These tools enable services to track key performance indicators, measure outcomes across different population groups, and identify trends or areas of concern. For example, dashboards can be used to monitor discharge outcomes for individuals at risk of suicide, supporting targeted interventions and timely responses.[45,51]

Risk management

Risk management is a critical element of safe and effective discharge planning. It involves identifying, assessing, and addressing potential risks to ensure consumer safety during and after the transition from inpatient mental health services to community-based care.

Safety planning

Best practice requires that each consumer has an individualised safety plan that includes early warning signs, coping strategies, and contact details for crisis and emergency support.[26,27] These plans support self-management and help consumers and their carers recognise when to seek help. Early identification and assessment of risks, such as suicidality, medication non-adherence, or unstable living situations, are essential to ensure that appropriate strategies are in place before discharge.[24,43]

Multidisciplinary collaboration

Tailored discharge plans must be developed through joint input from clinicians, allied health professionals, peer workers, and other relevant service partners. Effective communication and shared responsibility within the team enhance the ability to respond to complex needs and manage risk in a coordinated and person-centred manner.[37,44]

Medication safety

Medication reconciliation must occur prior to discharge to prevent errors or omissions. Discharge summaries should include detailed and accurate information about medications, including any changes made during admission, prescribed dosages, administration instructions, and potential side effects.[42,43,46] Clear documentation supports continuity of care and enables community providers to manage medication safely.

Follow-up and support access

Consumers should be discharged with clear post-discharge arrangements, including scheduled follow-up appointments, crisis support contacts, and pathways to community-based support services.[42,45] These arrangements are particularly important for individuals at higher risk of relapse, self-harm, or disengagement from care.

Housing stability

Housing insecurity is a well-documented risk factor that must be addressed as part of discharge planning. Consumers should not be discharged into homelessness or unsafe environments, as unstable housing significantly increases the risk of harm and readmission.[24,30] Discharge planning should include referrals to housing support services and collaboration with relevant agencies to ensure accommodation needs are met.

Culturally safe and trauma-informed approaches

Culturally safe and trauma-informed care are essential to effective risk management, particularly for Aboriginal and Torres Strait Islander consumers and others with histories of trauma.[46] These approaches help build trust, reduce the risk of re-traumatisation, and ensure that care plans are responsive to cultural, emotional, and social needs. Risk management practices should reflect a holistic understanding of wellbeing and be adapted to the individual's lived experience and cultural context.

Cultural competence

Culturally competent care is a fundamental component of best practice in mental health service delivery, particularly during discharge and transition planning. For Aboriginal and Torres Strait Islander peoples, culturally responsive approaches are essential to addressing historical and systemic barriers that continue to affect access, trust, and engagement with services.

Addressing cultural safety and historical context

Discharge and transfer planning for Aboriginal and Torres Strait Islander consumers must be grounded in cultural safety. This includes acknowledging the impacts of colonisation, intergenerational trauma, and institutional racism, and ensuring that care is delivered in ways that respect cultural identity, strengths, and community connections. Culturally safe practices are relational, strengths-based, and prioritise trust-building over time, particularly during periods of transition, which can be disruptive and anxiety-inducing.[46,49]

Implementation of culturally competent care requires services to adapt their processes to reflect Indigenous worldviews, which emphasise holistic understandings of health, encompassing physical, emotional, spiritual, and social wellbeing. Care planning should be flexible, person-centred, and informed by the preferences of the individual, their family, and their community.

Building trust and supporting gradual transitions

Engagement with Aboriginal and Torres Strait Islander consumers should be grounded in respectful, sustained relationship-building. Gradual, well-communicated transitions support trust and reduce the risk of disengagement or harm during discharge. Involving Aboriginal health workers or liaison officers throughout the discharge process can help mediate cultural misunderstandings, facilitate communication, and ensure that plans are responsive to cultural needs.[46,49]

Partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs)

Strong partnerships with ACCHOs are essential for ensuring continuity of culturally safe care after discharge. ACCHOs are trusted service providers that deliver holistic, culturally informed care aligned with community needs and priorities. Formal referral pathways, shared care arrangements, and co-developed discharge plans with ACCHOs can enhance access, improve outcomes, and build trust between consumers and the broader health system.[46,49]

Discussion

Limitations

The desktop review has several limitations that may influence the scope, depth, and applicability of the findings. One notable limitation is the predominant focus of reviewed documents on risk management at the individual or clinical level, such as preventing relapse or disengagement from care, rather than at the organisational or system level. While outcomes like hospital readmission rates may serve as proxies for organisational performance, broader risks such as governance challenges, workforce capacity, and resource constraints are largely underexplored. As a result, the review offers limited insight into how discharge planning influences organisational sustainability, accountability, or service resilience.

Another limitation relates to the scope of consumer and carer involvement. While many documents emphasise the importance of involving consumers and carers in individual discharge planning, fewer reflect their engagement in the co-design or development of the policies and guidelines themselves. This limits the extent to which these documents incorporate lived experience perspectives, which may affect their relevance, acceptability, and responsiveness to diverse consumer and carer needs.

The review also reflects variability in jurisdictional and organisational approaches to discharge planning and relies exclusively on publicly available grey literature. Internal or unpublished materials, such as local protocols, internal audits, or implementation evaluations, were not captured, which may lead to incomplete coverage of current practices. As a result, findings may not be generalisable across all service contexts, particularly where local innovation or informal practices play a significant role.

Moreover, the review focused on the content and stated intent of policy and guideline documents, rather than their implementation or real-world impact. This limits the ability to assess the degree to which recommended practices are embedded in routine care or their effect on consumer outcomes. While some documents address key social determinants of health, such as housing and financial insecurity, there is limited attention to the structural barriers and intersectoral mechanisms needed to address these factors comprehensively. Similarly, although digital tools are frequently mentioned, the rapid pace of technological change and the uneven adoption of digital solutions across services and regions may affect the future relevance and applicability of current guidance.

Taken together, these limitations highlight the need for future research and stakeholder engagement to explore underrepresented areas, including organisational risk management, the co-design of policy frameworks, and the real-world implementation and impact of best practice models in diverse service settings.

Conclusion

Contemporary best practice in discharge planning and transfer of care for consumers of inpatient mental health services in Australia is underpinned by person-centred, trauma-informed, and culturally safe approaches. This review of grey literature identified several core principles that support safe, effective, and recovery-oriented transitions from inpatient to community care.

Key elements of best practice include the early initiation of discharge planning, strong multidisciplinary team collaboration, and attention to social determinants of health, such as housing stability and financial security, to support smooth transitions and continuity of care. Effective communication strategies, active consumer and carer involvement, and the use of digital technologies further enhance care coordination, engagement, and self-management.

Performance monitoring and risk management play critical roles in maintaining service quality, accountability, and safety during transitions. Culturally competent care, particularly for Aboriginal and Torres Strait Islander peoples, is essential for ensuring that discharge practices are responsive, inclusive, and respectful of diverse cultural needs and lived experiences.

Together, these elements represent a comprehensive and evidence-informed approach to discharge planning and transfer of care. When implemented effectively, they can help reduce avoidable readmissions, strengthen continuity between services, and improve outcomes for consumers and their carers. Ongoing efforts to embed these practices in policy, workforce development, and service delivery will be essential to realising their full impact across diverse mental health settings.

Appendices

Appendix 1: Part One – Accelerated Evidence Snapshot – Search Terms

Concept	Search terms	
Population	*Not limited*	
Intervention	discharge or discharge plan* or hospital discharge or patient discharge or post-discharge or continuity of care or transfer of care or care transition or patient handoff or aftercare or follow-up or transition* or transition care or care transition OR *Continuity of patient care/* AND mental illness or mental health or mental disorder or psychiatric inpatient or psychiatric hospitalization or psychosis or bipolar disorder or schizophrenia or depression or substance use disorder OR *Mental health/*	
Comparison	Not required	
Outcomes	transitional care model or critical time intervention or peer support or care coordination or psychoeducation or role-based intervention or contact-based intervention or care pathways	
Study types	**Step 1** systematic review or meta-analysis or evidence synthesis or critical appraisal	**Step 2** RCTs or quasi-experimental studies

Appendix 2: Part One – Accelerated Evidence Snapshot – Search Strings

Step 1

PubMed

(discharge[Title/Abstract] OR discharge plan*[Title/Abstract] OR hospital discharge[Title/Abstract] OR patient discharge[Title/Abstract] OR post-discharge[Title/Abstract] OR continuity of care[Title/Abstract] OR transfer of care[Title/Abstract] OR care transition[Title/Abstract] OR patient handoff[Title/Abstract] OR aftercare[Title/Abstract] OR follow-up[Title/Abstract] OR transition*[Title/Abstract] OR transition care[Title/Abstract] OR care transition[Title/Abstract] OR Continuity of patient care [MeSH Terms]) AND (mental illness[Title/Abstract] OR mental health[Title/Abstract] OR mental disorder[Title/Abstract] OR psychiatric inpatient[Title/Abstract] OR psychiatric hospitalization[Title/Abstract] OR psychosis[Title/Abstract] OR bipolar disorder[Title/Abstract] OR schizophrenia[Title/Abstract] OR depression[Title/Abstract] OR substance use disorder[Title/Abstract] OR Mental health [MeSH Terms]) AND (transitional care model OR critical time intervention OR peer support OR lived experience* OR care coordination OR psychoeducation OR role-based intervention OR contact-based intervention OR care pathways) AND (systematic review OR meta-analysis OR evidence synthesis OR critical appraisal) AND (high-income countries OR Australia OR United Kingdom OR Canada OR United States OR New Zealand)

CINAHL

(((TI discharge OR AB discharge) OR (TI "discharge plan*" OR AB "discharge plan*") OR (TI "hospital discharge" OR AB "hospital discharge") OR (TI "patient discharge" OR AB "patient discharge") OR (TI post-discharge OR AB post-discharge) OR (TI "continuity of care" OR AB "continuity of care") OR (TI "transfer of care" OR AB "transfer of care") OR (TI "care transition" OR AB "care transition") OR (TI "patient handoff" OR AB "patient handoff") OR (TI aftercare OR AB aftercare) OR (TI follow-up OR AB follow-up) OR (TI transition* OR AB transition*) OR (TI "transition care" OR AB "transition care") OR (TI "care transition" OR AB "care transition") OR (MH "Continuity of patient care+"))) AND (((TI "mental illness" OR AB "mental illness") OR (TI "mental health" OR AB "mental health") OR (TI "mental disorder" OR AB "mental disorder") OR (TI "psychiatric inpatient" OR AB "psychiatric inpatient") OR (TI "psychiatric hospitalization" OR AB "psychiatric hospitalization") OR (TI psychosis OR AB psychosis) OR (TI "bipolar disorder" OR AB "bipolar disorder") OR (TI schizophrenia OR AB schizophrenia) OR (TI depression OR AB depression) OR (TI "substance use disorder" OR AB "substance use disorder") OR (MH "Mental health+"))) AND (("transitional care model" OR "critical time intervention" OR "peer support" OR “lived experience” OR "care coordination" OR “psychoeducation” OR "role-based intervention" OR "contact-based intervention" OR "care pathways")) AND (("systematic review" OR “meta-analysis” OR "evidence synthesis" OR "critical appraisal"))

Filtered past five years and English

Embase 1

((discharge or "discharge plan*" or "hospital discharge" or "patient discharge" or post-discharge or "continuity of care" or "transfer of care" or "care transition" or "patient handoff" or aftercare or follow-up or transition* or "transition care" or "care transition").tw. or exp "Continuity of patient care"/) and (("mental illness" or "mental health" or "mental disorder" or "psychiatric inpatient" or "psychiatric hospitalization" or psychosis or "bipolar disorder" or schizophrenia or depression or "substance use disorder").tw. or exp "Mental health"/) and ("transitional care model" or "critical time

intervention" or "peer support" or "lived experience*" or "care coordination" or psychoeducation or "role-based intervention" or "contact-based intervention" or "care pathways").mp. and ("systematic review" or meta-analysis or "evidence synthesis" or "critical appraisal").mp. and ("high-income countries" or Australia or "United Kingdom" or Canada or "United States" or "New Zealand").mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
limit (yr="2020 -Current")

Embase 2

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('transitional care model' or 'critical time intervention' or 'peer support' or 'lived experience*' or 'care coordination' or psychoeducation or 'role-based intervention' or 'contact-based intervention' or 'care pathways').mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
('meta analysis' or 'systematic review' or 'evidence synthesis' or 'critical appraisal').mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]
4 and 1 and 2 and 3

Cochrane Library

#1 discharge OR discharge NEXT plan* OR "hospital discharge" OR "patient discharge" OR post-discharge OR "continuity of care" OR "transfer of care" OR "care transition" OR "patient handoff" OR aftercare OR follow-up OR transition* OR "transition care" OR "care transition" - 381668
#2 MeSH descriptor: [Continuity of Patient Care] explode all trees 39784
#3 "mental illness" OR "mental health" OR "mental disorder" OR "psychiatric inpatient" OR (psychiatric hospitali*ation) OR psychosis OR "bipolar disorder" OR schizophrenia OR depression OR "substance use disorder" 160780*
#4 MeSH descriptor: [Mental Health] explode all trees 3387
#5 "transitional care model" OR "critical time intervention" OR "peer support" OR (lived NEXT experience) OR "care coordination" OR psychoeducation OR "role-based intervention" OR "contact-based intervention" OR "care pathways" 9456
#6 "systematic review" OR meta-analysis OR "evidence synthesis" OR "critical appraisal" 34950
#7 "high-income countries" OR Australia OR "United Kingdom" OR Canada OR "United States" OR "New Zealand" 366031
#8 #1 or #2 407980
#9 #3 or #4 160780
#10 #5 and #6 and #7 and #8 and #9 392
Applying limits Jan 2020 – Dec 2025

Step 2

PubMed

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Embase

((discharge or "discharge plan*" or "hospital discharge" or "patient discharge" or post-discharge or "continuity of care" or "transfer of care" or "care transition" or "patient handoff" or aftercare or follow-up or transition* or "transition care" or "care transition").tw. or exp "Continuity of patient care"/) and (("mental illness" or "mental health" or "mental disorder" or "psychiatric inpatient" or "psychiatric hospitalization" or psychosis or "bipolar disorder" or schizophrenia or depression or "substance use disorder").tw. or exp "Mental health"/) and ("transitional care model" or "critical time intervention" or "peer support" or "lived experience" or "care coordination" or psychoeducation or "role-based intervention" or "contact-based intervention" or "care pathways").mp. and (exp "Randomized Controlled Trial"/ or RCT.mp. or "Cluster RCT".mp. or exp "Quasi-Experimental Studies"/ or exp "Interrupted Time Series"/ or exp "Controlled Before-After Studies"/) and ("high-income countries" or Australia or "United Kingdom" or Canada or "United States" or "New Zealand").mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]Limited 2020-current = 127 results

CINAHL

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"bipolar disorder") OR (TI schizophrenia OR AB schizophrenia) OR (TI depression OR AB depression) OR (TI "substance use disorder" OR AB "substance use disorder") OR (MH "Mental health+")))) AND (("transitional care model" OR "critical time intervention" OR "peer support" OR "lived experience" OR "care coordination" OR psychoeducation OR "role-based intervention" OR "contact-based intervention" OR "care pathways"))) AND (((MH "Randomized Controlled Trial+") OR RCT OR "Cluster RCT" OR (MH "Quasi-Experimental Studies+") OR (MH "Interrupted Time Series+") OR (MH "Controlled Before-After Studies+")))) AND (("high-income countries" OR Australia OR "United Kingdom" OR Canada OR "United States" OR "New Zealand"))

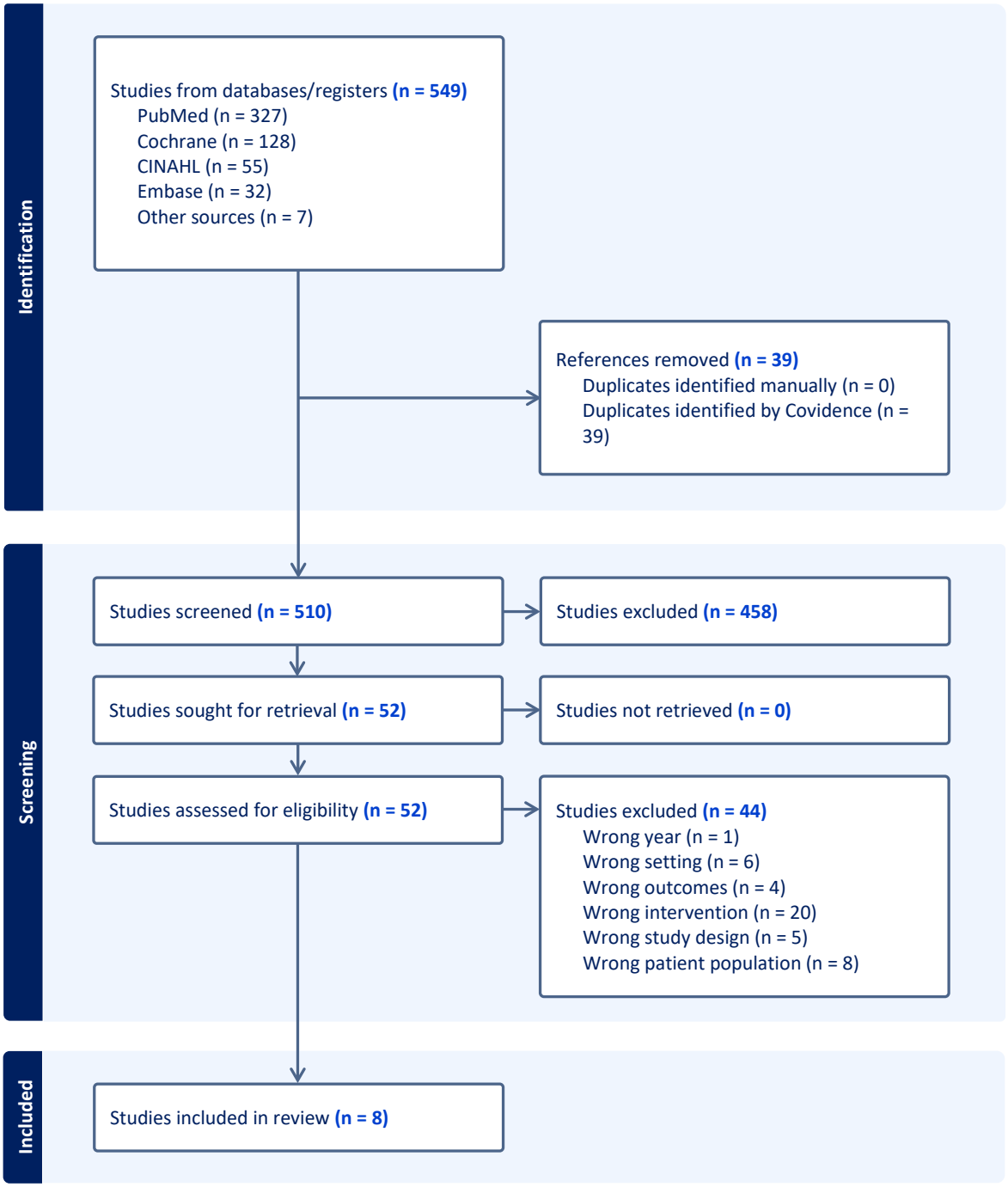
Appendix 3: Part One – Accelerated Evidence Snapshot – Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Study Type	
• Systematic reviews reporting findings of intervention and/or evaluative studies (e.g. studies that use either an experimental or quasi-experimental design) • Randomised controlled trials (RCTs) • Quasi-experimental studies (e.g., controlled before-and-after studies, interrupted time series, propensity score-matching studies)	• Observational studies • Qualitative studies • Narrative studies and other non-systematic reviews • Grey literature
Interventions of interest	
• Interventions that cover the period immediately prior, or within the first 28 days, of discharge from an inpatient facility, such as those listed above.	• Clinical interventions • Pharmacotherapy
Language	
• English	• Languages other than English
Country*	
• High-income countries according to the World Bank classification system, particularly countries particularly comparable to Australia in social and economic characteristics: New Zealand, Canada, United Kingdom, United States, and Nordic countries (e.g. Norway, Sweden).	• Countries other than those listed
Population	
• Mental health service consumers and/or their carers	• Cohorts who are not mental health service consumers and/or their carers
Year of publication	
• 2020 onwards	• 2019 and earlier

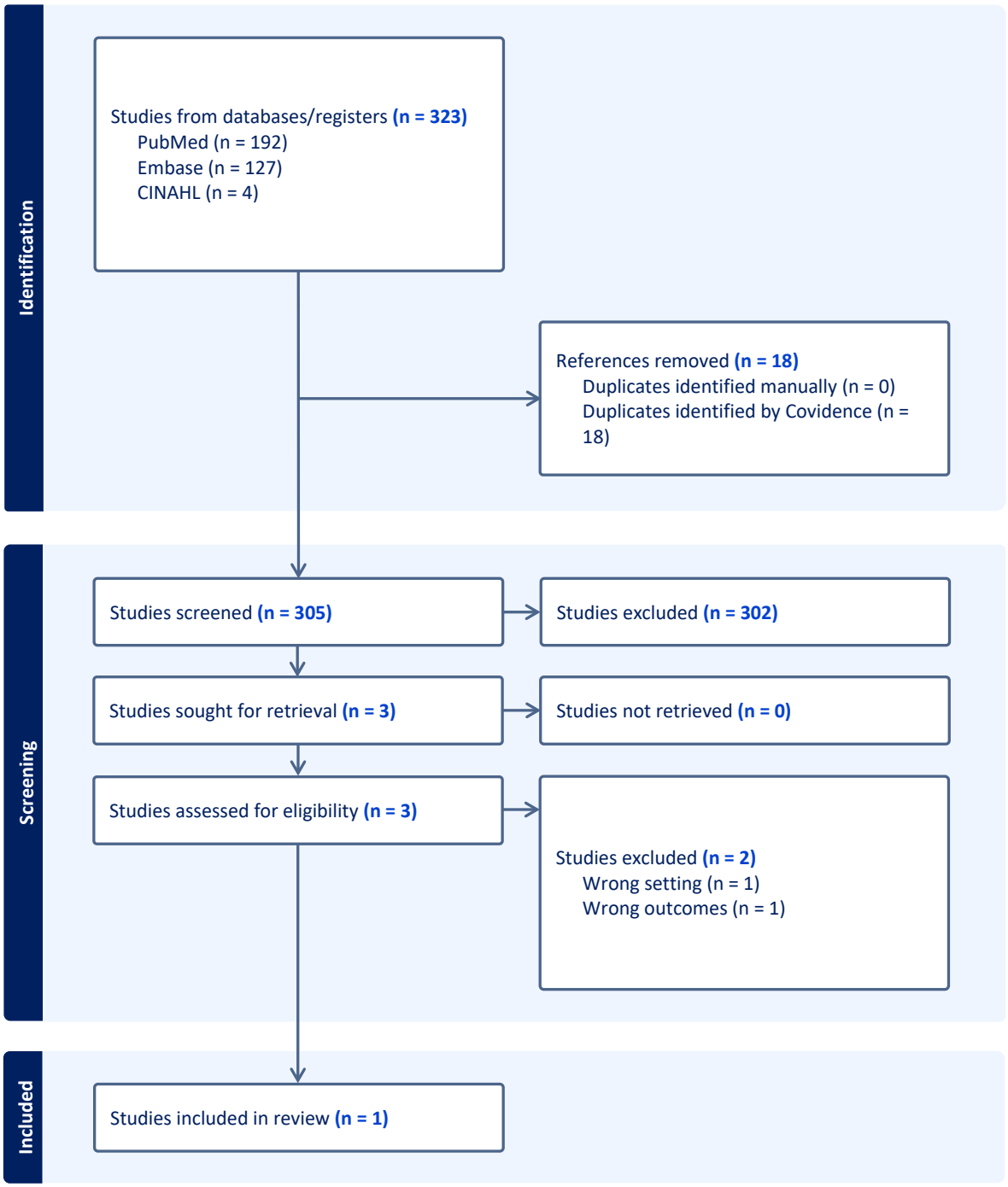
*The following countries within the OECD are particularly comparable to Australia in social and economic characteristics: New Zealand, Canada, United Kingdom, United States, Nordic countries (e.g. Norway, Sweden). Should the yield of relevant papers be over 1500, studies from these countries may be prioritised, and/or the year of publication may be adjusted.

Appendix 4: Part One – Accelerated Evidence Snapshot – PRISMA flow diagrams

Systematic Reviews



Observational studies



Appendix 5: Part One – Accelerated Evidence Snapshot – Quality Appraisal

A two-stage quality assessment process was applied, which aligns with Cochrane Rapid Reviews Methods Guidance[8], which recommends a tiered approach to quality appraisal in expedited evidence reviews.

Stage 1: Basic screening for minimum quality standards

A rapid checklist-based assessment, using essential methodological indicators outlined in Table 5.1 below, was applied to screen studies for inclusion.

Table 5.1: Minimum quality screening criteria

Criterion	Screening Question	Inclusion Decision
Study design	Is the study a systematic review or a high-quality observational study (cohort, case-control, longitudinal)?	Exclude if NOT a systematic review or observational study
Peer review	Was the study published in a peer-reviewed journal?	Exclude if not peer-reviewed
Relevance	Does the study examine emerging risk factors rather than well-established ones?	Exclude if focused on well-established risk factors (>10 years)
Recency	Was the study published in the last 10 years (for systematic reviews) or after the latest systematic review date (for observational studies)?	Exclude if outside the date range

Stage 2: Traffic light rating system for study quality

Studies that pass Stage 1 screening will undergo rapid quality assessment using a simplified traffic light rating system, adapted from Hartling et al. (2015)[10] and AMSTAR2 (Shea 2017).[53] Each study was assigned a quality rating using a simplified traffic light system, focusing on core criteria relevant to rapid review methodology, outlined in Table 5.2 below.

Table 5.2: Traffic light rating system for quality appraisal

Quality indicator	✅ High Quality (Green)	⚠️ Moderate Quality (Amber)	❌ Low Quality (Red)
Study Design & Methodology	Clear, transparent methodology (systematic review with robust search strategy, observational study with appropriate controls)	Some methodological limitations, but findings are still likely valid	Poor methodological clarity, no clear control for confounders

Risk of Bias Assessment	Systematic review includes a **formal risk of bias assessment** (e.g., ROBIS, GRADE); observational study adjusts for key confounders	Risk of bias assessment is unclear or limited	No risk of bias assessment; observational study lacks control for confounders
Applicability to Emerging Risk Factors	Explicit focus on new/emerging risk factors relevant to early-onset cancers	Some discussion of emerging risk factors but not primary focus	Study focuses primarily on well-established risk factors
Inclusion Decision	**Include** in synthesis	**Include with caution**, flag for interpretation limitations	**Exclude**

Appendix 6: Part One – Accelerated Evidence Snapshot – Data Extraction Tables

Table 6.1: Characteristics of selected peer-reviewed studies

First author, year, country	Title	Aim	Characteristics of setting and population*	Characteristics of included studies
Systematic reviews				
Austin E, 2024, Australia[14]	Improving emergency department care for adults presenting with mental illness: a systematic review of strategies and their impact on outcomes, experience, and performance.	To examine the research evidence provided in the peer-reviewed literature to identify the relationship between the strategies used to improve Emergency Department care delivery for adult mental illness presentations and measures of (1) system performance, (2) patient outcomes, (3) patient experience, and (4) staff experience.	*Setting:* Emergency Department *Demographic*: Adult mental health presentations [SU] *Countries*: USA (4), UK (2), Japan (1), Canada (1), Australia (1)	*Most recent:* 2023 *Design:* RCT (1), quasi-experimental (6), qualitative (1)
Corrigan PW, 2022, USA[15]	Formal peer-support services that address priorities of people with psychiatric disabilities: A systematic review.	Review peer support services for mental illness with outcomes of (a) Transitioning from a hospital back into the community (b) Helping people learn self-management skills or to better engage with existing health care services (c) Helping people to better manage symptoms and dysfunctions of their mental illness (d) Other goals including employment, criminal justice involvement, and parenting.	*Setting:* Transition from hospital *Demographic*: Adults with serious mental illness, sometimes further defined as below 150% of the poverty line, on crisis resolution teams, with co-occurring substance use disorder, and/or previously homelessness [SU, CD, EH] *Countries*: USA (10), UK (1), Canada (1), Netherlands (1)	*Most recent*: 2020 *Design:* RCT/quasi-experimental (9), literature review (1), cohort (1), longitudinal (1), model (1)
Gaebel W, 2020, Germany[16]	EPA guidance on the quality of mental health services: A systematic meta-review and update of recommendations focusing on care coordination.	To develop recommendations for care coordination in mental healthcare based on a systematic literature review of systematic reviews, meta-analyses and evidence-based clinical guidelines on care coordination.	*Setting:* Mental health services *Demographic*: Adults with mental illness [SU] *Countries*: Not reported	*Most recent:* 2020 *Design:* Rapid review (1), systematic review (1), scoping review (1), systematic review with meta-analysis (1)
Manuel JI, 2023, USA[17]	Supporting Vulnerable People During Challenging Transitions: A Systematic Review of Critical Time Intervention.	To summarise and examine the consistency of findings across the critical time intervention studies and their applicability in a variety of populations and transition types.	*Setting:* Life course transitions including hospitalisation *Demographic*: Not specified [SU, EH, CJ]	*Most recent:* 2017 *Design:* RCT (3), quasi-experimental (3)

			Countries: USA (8), Brazil (1), the Netherlands (2), UK (1), Canada (1)	
McIntyre H, 2022, Australia[18]	Communication pathways from the emergency department to community mental health services: A systematic review.	To synthesise all existing international literature regarding communication pathways for continuity of care from the ED to community mental health services, outpatients and/or general practitioners for people presenting to the ED with mental health concerns or suicidal crisis. (Specifically focused on service users being discharged from the ED without having any inpatient care, and pathways and procedures of transfer of care from the ED to community mental health care, outpatients, or general practitioners).	*Setting:* Emergency Department *Demographic*: All age patients presenting to ED with mental health concerns or suicidality [NR] *Countries*: USA (5), Australia (1), Canada (4)	*Most recent:* 2019 *Design:* RCT (4), quasi-experimental (3), qualitative (3)
Otis M, 2023, UK[19]	Models of integrated care for young people experiencing medical emergencies related to mental illness: a realist systematic review.	To determine whether embedding psychiatry within paediatric emergency settings improves health maintenance to stay out of hospital.	*Setting:* Paediatric Emergency Department *Demographic*: Children (<18 years) presenting with mental health related emergencies [NR] *Countries*: USA (15), Canada (6), Australia (10)	*Most recent:* 2021 *Design:* before-after intervention design (16), non-RCT (3), retrospective observational design (3)
Petkari E, 2021, UK[20]	Involvement of informal carers in discharge planning and transition between hospital and community mental health care: A systematic review.	To identify and synthesise research evidence on described interventions that include carers in discharge planning, and/or transitions between hospital and community mental health care.	*Setting:* Hospital *Demographic*: Carers of inpatient/outpatient mental health patients [NR] *Countries*: USA (7), Australia (1), Taiwan (1), Iran (2), UK (3)	*Most recent:* 2015 *Design:* RCT (8), controlled trial (2), case (2), retrospective case-control (1), qualitative (1)
Roson Rodriguez 2024, Global Consortium[21]	Transitional discharge interventions for people with schizophrenia.	To assess the effects of transitional discharge interventions for people with schizophrenia.	*Setting:* Hospital *Demographic*: Adults with schizophrenia or schizophrenia-related disorders [CD] *Countries*: China (8), Europe (1), North America (2), Iran (1)	*Most recent:* 2021 *Design:* RCT (12)
Primary study				
Lam M, 2020[22]	Evaluation of the transitional discharge model on use of psychiatric health services: An interrupted time series analysis	To compare temporal trends in psychiatric health services use before and after TDM implementation within acute and tertiary care psychiatric units in Ontario, Canada.	*Setting:* Hospital psychiatric units *Demographic*: Patients [CD] *Country*: Canada	*Design:* Interrupted time series

Table 6.2: Intervention types and outcomes reported in selected peer-reviewed studies

First author, year	Intervention type	Characteristics	Findings
Systematic reviews			
Austin E, 2024[14]	Decision support tools	*1. Substance-related and addictive disorders:* Modifications to EMR to include prompts and notifications related to universal screening at triage, patient arrival in the ED, measure withdrawal and guide next steps such as referral, management plan, and instructions *2. Mental health:* Modifications to EMR systems to include notification of discharge within the last 30 days, prompts to attest to completion of tasks, add assessment questions to identify previously used or failed care plan strategies, psychiatric medication chart to include "prescribe as required" and provide advice, or a mental health triage scale	*1. Substance-related and addictive disorders* *System Performance:* increased the number of eligible patients identified and treatments delivered, decreased ED visits, prescriptions, and pathology tests *Patient Outcomes:* decreased hospitalisations and the number of hospital days per year *2. Mental health* *System Performance*: no change in admission rates, ED LoS, recognition of patient acuity *Patient Outcomes:* decreased ED utilisation *Staff Experience*: increased confidence
	Discharge and transfer of care	*1. Substance-related and addictive disorders:* Collaboration and communication with community providers and referrals to clinics *2. Mental health:* Refinement of discharge processes including default referral to psychiatry by medical staff using observational beds to allow more time to collaborate with post-ED services and communication processes such as allocating a primary contact for psychiatry staff and patients, discharge checklists, and discharge appointments	*1. Substance-related and addictive disorders* *System Performance:* decreased ED visits, prescriptions, and pathology tests, increased the number of eligible patients identified and treatments delivered *Patient Outcomes:* decreased hospitalisations and the number of hospital days per year *2. Mental health* *System Performance:* decreased wait time, increased proportion discharged by 11 am, reduced ED LoS *Patient Outcomes:* reduced ED utilisation
	Case management	*Mental health:* Case management and care planning facilitates connections with appropriate community-based services, sometimes targeting frequent presenters and chronic and complex patients at risk of extended LoS *Suicide or deliberate self-harm:* Case management consists of psychosocial assessment and continuous negotiated care	*Mental Health* *System Performance:* reduced ED LoS *Patient Experience:* working relationships are important, service navigation is not easy, transition between service support is important, shame and stigma are barriers to engagement *Staff Experience:* rapport is critical, case management is not a short-term relationship, service users have multiple existing connections that require significant coordination *Suicide or deliberate self-harm*

First author, year	Intervention type	Characteristics	Findings
		plan provided by a mental health professional or case manager	*Patient Outcomes:* decrease in suicide attempts, decrease in self-harm, no reduction in readmission rate
	Role changes and rostering	*Mental health:* Role changes in the ED include clarification on legal obligations and safeguards regarding restraint and detention, the addition of psychiatric nurses in the ED, a full-time psychiatrist and nurse practitioner employed in the ED, an onsite psychiatric assessment officer (to assess, brief intervention, and coordinate care), or a mental health consultation liaison role. Rostering changes include the addition of a 10-h swing shift for ED residents with a later start time during the day to complement the 12-h regular shifts	*Mental Health* *System Performance:* reduced wait time, reduced time to complete tasks, reduced ED LoS, reduced admissions, reduced security staff standby hours, role utilised *Patient Outcomes:* reduced ED utilisation, reduced LWBS *Patient Experience:* no change in patient satisfaction *Staff Experience:* no effect on resident wellbeing or burnout, improvements in communication, collaboration, and timely care delivery, personalities were the main reason for success, though the psychiatric nurses felt isolated from the mental health team and out of touch with developments, role provides a resource to support better care delivery
	Education and training	*Mental health:* Formal training for triage nurses on mental health and illness	*Mental Health* *System Performance:* reduced ED LoS *Staff Experience:* increased nurse confidence
Corrigan PW, 2022[15]	Peer support	Adaptations of standard case management services including assertive community treatment with peer supporters as providers. Peer support provided via a 'welcome basket'. Among other things, welcome basket seeks to “normalise” inpatient transition; peer supporters meeting with service recipients while still in the hospital and then coming to their home soon after discharge with baskets of food, plants, and discount coupons from local retailers. Program participants generally adults with serious mental illness.	- One study found significant negative effects of peer support related to psychiatric hospitalisation and one with negative effects on crisis stabilisation. - Seven studies reported significant positive impact on various measures of hospital readmission. - Two studies assessed the impact of peer support on arrests and incarcerations: neither found positive benefits. - Three studies examined housing stability and homelessness: One yielded positive findings for peer support. Symptoms were assessed as self-report measures in four studies. Two of these reported positive benefits of peer services on symptoms. - Two studies examined the degree to which peer-supported self-management is relevant to transitioning from the hospital; neither of these found significant effects. - Four studies examined impact on recovery and hope; one showed positive benefits. - Three studies examined effects on quality of life; two found positive outcomes on subscales of quality of life.
Gaebel W, 2020[16]	Care coordination/Integrated care; Intensive case management; transitional interventions	Management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system	- Intensive case management may lead to shorter inpatient treatment, lower drop-out rates, and improved social functioning in severely mentally ill persons compared to standard care (i.e., simple outpatient appointments). - Care coordination with electronic health records provides easier patient access to healthcare and improves communication between the caregiver and patient. Sufficient funding, reimbursement, and access to technologies must be secured - No positive effect of transitional interventions on readmission rates compared to treatment as usual. Some limited evidence that elements of case management

First author, year	Intervention type	Characteristics	Findings
			(e.g., transition managers and timely communication between inpatient staff and outpatient care) may have positive effects on health-related and social outcomes (e.g., symptom severity, quality of life). Additionally, service users prefer transitional interventions.
Manuel JI, 2023[17]	Critical time intervention	A time-limited individual-level intervention designed to reduce the risk of homelessness and other adverse outcomes by providing support to individuals during challenging life course transitions.	- Five-fold reduction in the prevalence of homelessness among participants assigned to CTI compared to those assigned to usual services among individuals with serious mental illness and chronic homelessness following psychiatric hospital discharge. - Significantly greater continuity of care in post-discharge mental health and substance use services for 3-month CTI compared with usual discharge planning with veterans following inpatient psychiatric hospitalisation. - No significant group differences were found in post-discharge hospitalisation and emergency room visit outcomes in a randomised study of a Brief CTI model with veterans. - Lower early psychiatric readmission rate within 30 days of discharge among participants in the CTI group versus comparison group, but the groups did not differ significantly with respect to long-term readmission rates (31-180 days).
McIntyre H, 2022[18]	Communication pathways	Pathways and procedures at transfer of care from the ED to community mental health care, outpatients, or general practitioners.	- Support coordination decreased ED psychiatric repeat presentations for people seeking help from 6.51% to 4.3% during the first six months. - At one-year follow up a higher number of participants were linked to primary care with the support coordination intervention group n = 63 (62.40%), compared to usual care n = 38 (37.6%). - An intervention incorporating support coordination aspects, including community supports such as primary care, peer support, counselling and other services as needed, over four to six months, reduced people repeating presentations to ED by 14%, however, this was not considered statistically significant. - Motivational interviewing for adolescents with an ED psychiatrist and outpatient referral increased scheduling (73%) and attendance (64%) at a follow-up appointment. -Improved electronic records increased communication to primary care physicians from 1% to 40%, increased follow up from 5% to 67%, and reduced repeat ED presentations from 4% to 0.5%.
Otis M, 2023[19]	Models of integrated acute care	Embedding psychiatric consultations to improve triage into acute hospitalisation and embedding psychological therapies into typically medical services to improve integrated pathways within inpatient services.	- Multidisciplinary staffing for medical and psychiatric assessments supported a new referral pathway to an urgent care team, which reduced admissions from the emergency department from 6.3 to 2.3% ($F(3,42)=4.6$, $P<0.05$). - A multidisciplinary telephone follow-up service from the emergency department for patients and caregivers of MHR emergencies, consisting mainly of suicide-related emergencies, reduced admissions by 16% (OR=0.45, 95% CI 0.33-0.60, $P<0.001$).

First author, year	Intervention type	Characteristics	Findings
			- For LOS, another telephone follow-up study reported a monthly total LOS reduction from 315 to 298h. - Family-based therapy delivered as aftercare from acute settings (i.e. partial hospitalisation) for adolescents with eating disorders consistently reduced “the revolving door” of repeat admissions. - Innovations for integrated care (embedding psychiatric consultations to improve triage into acute hospitalisation and embedding psychological therapies into typically medical services) show promising evidence for reducing the rate of emergency admissions to an acute ward, the LOS in both the emergency department and inpatient setting, and the rehospitalisation rate after discharge.
Petkari E, 2021[20]	Carer programs	1. Purely psychoeducational programs, which focused on providing psychoeducation to patients and their carers and prepare discharge planning 2. Programs that involved carers in planning the transition from the psychiatric inpatient treatment to community mental health services 3. Programs that bridged into the aftercare involving carers in follow-up after the patient had been discharged from hospital	- Psychoeducation program to patients and carers: no statistically significant effect of the intervention on relapse, defined as readmission rates. - Programs involving carers in planning inpatient-outpatient transition: reduction in re-admissions, improved treatment adherance, compliance & satisfaction, less medication side effects. Decreased carer burden and improved carer health status. - Programs focused on involving carers in aftercare follow-up: number of psychiatric readmissions significantly lower, but may be short effect. Positive effect on severity of psychopathology and length of hospital stay. After one year, family treatment combined with social skills training for patients produced 0% relapse rate measured as symptoms exacerbation, as opposed to 38% in the control group. The comprehensive programs which included discharge planning and explicit involvement of carers with dedicated contacts after discharge had an effect in reducing relapse. Other, simpler models of interventions showed promising effects but have been assessed less systematically.
Roson Rodriguez P, 2024[21]	Transitional discharge	1. An overlap of hospital and community staff until a therapeutic relationship is established with the community care provider 2. Peer support from someone with the lived experience of mental illness who has successfully transitioned to the community	- Proportion of participants with hospitalisation after discharge: RR 1.18 (0.55-2.50) - Clinically important change in general functioning: SMD 0.95 (a large effect) - Clinically important change in satisfaction: RR 1.96 (1.37-2.80) - Clinically important change in quality of life: SMD 0.24 (small difference effect) No clear evidence for or against implementing transitional discharge interventions for people with schizophrenia and schizophrenia-related disorders. These interventions may improve patient satisfaction and functionality, but this evidence is very uncertain.
Primary study			
Lam M, 2020[22]	Transitional discharge model	A TDM, designed to facilitate a smooth return to community living for patients discharged from	*Acute care units:* TDM was associated with a statistically significant decrease in median LOS (trend change = −0.2 days, 95% CI = −0.2 to −0.1). There was also a

First author, year	Intervention type	Characteristics	Findings
		psychiatric units was implemented at 9 hospitals, spanning 13 psychiatric units, including 6 acute and 7 tertiary care units.	significant level increase in the 30-day rate of psychiatric readmissions (level change = 20.0 readmissions/1,000 discharges, 95% CI = 1.5– 38.5) with a significant decrease in trend (trend change = −1.3 read- missions/1,000 discharges, 95% CI = −2.4 to −0.2) following TDM . There were no significant changes in level or trend for the 1-year rate of psychiatric readmissions or 30-day rate of mental health ED visits for acute care units. *Tertiary care units:* no statistically significant changes in level or trend for any of the outcomes were detected. However, a large drop after TDM for both the 30-day rate of psychiatric readmissions (level change = −52.0 readmissions/1,000 discharges, 95% CI = −111.7 to 7.7) and 1-year readmissions (level change = −214.5 readmissions/1,000 discharges, 95% CI = −461.7 to 32.7) was observed. There were also indications of an increase in trends after TDM implementation for the 30-day rate of psychiatric readmissions (trend change = 3.4 readmissions/1,000 dis- charges, 95% CI = −0.4 to 7.1) and 1-year psychiatric readmissions (trend change = 13.6 readmissions/1,000 discharges, 95% CI = −1.7 to 28.8). Among acute care units, median LOS decreased significantly below the projected historical trend following TDM implementation, while readmissions increased significantly and declined thereafter. No significant changes were found for tertiary care units.

Table 6.3: Implications and recommendations reported in selected peer-reviewed studies

First author, year	Evidence gaps	Recommendations
Systematic reviews		
Austin E, 2024[14]	No studies evaluated all areas of system performance, patient outcomes, patient experience, and staff experience.	Strategies for improving ED care delivery for mental illness presentations can include refinements to discharge and transfer procedures and case management. However, need to develop capacity in community services to support the ED role of delivering safe and timely urgent care.
Corrigan PW, 2022[15]	Need to expand research definition of 'peer' to consider diversity, equity and inclusion.	Tailored strategies are needed to guide ongoing adaptations of peer support to better individualise goals and strategies. Future research evaluating adaptations should include design and measures that help unpack effects. Qualitative methods should also be used to engage with service recipients on broad perceptions about interventions and impact.
Gaebel W, 2020[16]	Lack of robust evidence and a need for empirical monitoring and evaluation of care coordination projects.	1. Implement Intensive Case Management for people with severe mental illness who are high users of inpatient care and difficult to engage or recurrently disengage. 2. Use digital technology such as electronic health records to enhance care coordination. 3. Provide elements of case management to persons with mental illness after discharge from inpatient treatment.
Manuel JI, 2023[17]	Research is needed that moves beyond examining the average treatment effects by identifying the intervention effects across sub-groups with respect to demographic (i.e., age, gender, race/ethnicity) and clinical (i.e., symptom severity) characteristics, and for whom might varying durations and intensity work best. Limited evidence that addresses how CTI achieves its positive impacts.	Mitigating the challenges of community reintegration and coordinating continuing care during service transitions is essential for persons with mental health, housing, and other needs. CTI can serve as a bridge during periods of transition when existing service systems are unable to provide the level of support ideally needed.
McIntyre H, 2022[18]	Although the term “homeless person” was used in the search strategy research papers included in this review did not address a variety of diverse populations. People with lived experience have	Combining strategies of support coordination, counselling initiatives such as motivational interviewing, education or enhanced electronic records sharing may improve continuity of care and service user engagement (along with secondary outcomes) for people

	had limited input in this area of research, and could provide insights.	presenting at the ED with mental health concerns or suicidal crisis, and reduce the need to re-present. Mental health nurses can advance and advocate communication pathway interventions to help improve continuity of care for individuals presenting to the ED with mental health and/or suicide related distress. This can improve quality of nursing practice linked to service outcomes within the health care system with the aim to mitigate further distress, returning to the ED, as well as follow up care and support in a timely and personalised manner.
Otis M, 2023[19]	Robust evidence of psychoeducation for acute inpatients with anxiety-related and eating disorders was limited. Few studies reported ethnicity characteristics of the sample, nor tested intervention effects for individual differences such as ethnicity and gender.	The co-location of psychiatry space as well as expertise, alongside acuity risk triage were key components of reducing over-medicalisation of MHR emergencies and improving access to psychotherapies.
Petkari E, 2021[20]	Further trials in this area may consider a factorial design in order to assess the effects of individual components (psychoeducation in hospital, carer inclusion in discharge planning and in follow-up community appointments) and estimate the relative benefits of each of them in order to promote flexible implementation strategies.	Services should strive to promote a comprehensive approach to family/significant other involvement that works across different services (inpatient wards and outpatient services). There is a need for services to adopt strategies to facilitate implementation of carer involvement across hospital and community services.
Roson Rodriguez P, 2024[21]	Not reported	We believe it is important to encourage the active participation of patients and their carers in producing evidence related to this key component in their care, such as transitional care. It is also important for clinicians to assess the transitional period from the psychiatric ward to the community, considering an adequate discharge plan and coordinating with outpatient care, taking into account this vulnerable phase. Policymakers should commit to promoting higher quality and longer studies in the field.
Primary study		
Lam M, 2020[22]	Future studies should recruit more units and further stratify them based on differentiating characteristics. It would be interesting to	Nursing strategies need to be based on interpersonal approaches. Specifically, support from the hospital care provider does not end until there is a working relationship with a

	explore whether this stratification could provide insight into the differences in outcomes for acute and tertiary care units.	community care provider. Nurses need to understand the phases of therapeutic relationships to identify when a relationship is in the working phase. Awareness of hospital and community resources is important to facilitate referrals to peer support.

Appendix 7: Part One – Accelerated Evidence Snapshot – Additional Papers of Interest

The papers below did not meet the inclusion criteria for this review but may be of interest.

Title	Author	Year	Journal	DOI	Source
Mindfulness-based crisis interventions (MBCI) for psychosis within acute inpatient psychiatric settings; a feasibility randomised controlled trial	Jacobsen, P. et al.	2020	BMC Psychiatry (2020) 20:193	10.1186/s12888-020-02608-x	Systematic search
Impact of Integrated Care Pathways Within the Framework of Collaborative Care on Older Adults With Anxiety, Depression, or Mild Cognitive Impairment	Dham, P. et al.	2022	The American Journal of Geriatric Psychiatry, Volume 30, Issue 7, 834 - 847	10.1016/j.jagp.2022.01.010	Systematic search

Appendix 8: Part Two – Desktop Review – Search Strategy

Website search

Grey literature from official government, professional, and non-governmental mental health organisations relevant to discharge planning and transfer of care includes:

Government Agencies and Health Networks

- NSW Health and Pillars (including all 15 Local Health Districts, specialty mental health services)
- All other Australian state and territory health agencies
- Commonwealth Department of Health and Aged Care (mental health policy sections)
- The NSW Justice Health and Forensic Mental Health Network
- The 31 Primary Health Networks (PHNs) across Australia
- Australian Healthcare Quality and Safety Commission

Professional and Regulatory Bodies

- Royal Australian College of General Practitioners (RACGP)
- Royal Australian College of Psychiatrists (RANZCP)
- National Aboriginal Community Controlled Health Organisation (NACCHO)

Non-Government and Community-Based Mental Health Organisations

- Mental Health Coordinating Council
- Beyond Blue, Headspace, Mental Health Carers Australia
- Mental Health Australia
- Mental Health Commission of NSW
- National Mental Health Commission

Inclusion and Exclusion Criteria

Document Type	
• Evaluations (e.g. impact assessments of discharge planning policies) • Policies and strategies (government, professional, or NGO-developed frameworks) • Clinical guidelines (e.g. best practice recommendations for mental health discharge processes)	• Peer-reviewed literature • Opinion pieces • Media articles • Non-evidence based commentaries
Policy settings of interest	
• Public mental health inpatient units • Emergency Departments and general medical wards • Community mental health services • Private psychiatric hospitals • General practice • Community-managed organisations (CMOs) • Drug and alcohol inpatient units • Government agencies involved in mental health services (e.g. NDIS, Housing and Accommodation Support Initiatives) • Correctional facilities • Aboriginal Community-Controlled Health Services (ACCHS) • Residential aged care facilities	
Interventions of interest (must occur before or within 28-days post-discharge)	
• Critical Time Intervention (CTI) • Transitional Discharge Models (TDM) • Peer Support • Contact-Based Interventions • Role-based interventions (e.g. case managers, discharge coordinators) • Education/Psychoeducation • Care Pathways/Service Care Pathways • Other emerging non-clinical interventions	• Clinical interventions e.g. inpatient psychiatric treatments without a discharge focus • Pharmacotherapy-focused interventions (unless tied to a discharge planning framework) • General mental health policies that do not address discharge planning or transition of care
Population of interest	
Mental health service consumers and/or their carers	Cohorts who are not mental health service consumers and/or their carers
Country	
• Australia	• Countries other than Australia
Year of publication	
• 2020 onwards	• 2019 and earlier

Search Strategy Implementation

A. Direct website searching

Each target organisation's searched using:

- Internal search engines (where available)
- Publications or Resources sections
- Policies and Guidelines sections
- Programs and Initiatives pages
- Evaluation Reports archives

Example Keywords for Site Search:

- "Discharge Planning"
- "Transfer of Care"
- "Continuity of Care"
- "Mental Health Transition Support"
- "Best Practice in Mental Health Discharge"
- “Case management”
- “Care coordination”

B. Google Advanced Search Strategy

Google Search Syntax

("discharge planning" OR "transfer of care" OR "hospital discharge" OR "care transition" OR "continuity of care" OR “care coordination” OR “case management”)

AND

("mental health" OR "psychiatry" OR "psychosocial support")

AND

("policy" OR "strategy" OR "guideline" OR "evaluation" OR "framework")

site:health.nsw.gov.au OR site:health.gov.au OR site:racgp.org.au OR site:ranzcp.org OR site:beyondblue.org.au OR site:headspace.org.au OR site:mentalhealthcommission.gov.au OR site:safetyandquality.gov.au

Alternative Google Search Terms

- **For Evaluations**: "mental health discharge evaluation" site:health.gov.au
- **For Policies**: "mental health discharge policy site:nsw.gov.au"
- **For Guidelines**: "discharge planning guideline site:mentalhealthcommission.gov.au"

C. Citation Chaining

- Checking of reference lists of retrieved grey literature for additional relevant reports, policies, or guidelines.

Data Extraction and Coding

A coding matrix will be used to systematically extract information from retrieved documents, including:

1. Organisation Name and Website
2. Document Title and Type (e.g. policy, strategy, evaluation)
3. Publication Date
4. Policy Setting (e.g., inpatient units, community mental health)
5. Interventions Addressed (e.g. CTI, peer support)
6. Involvement of Consumers and Carers (e.g. consultation, co-design)
7. Best Practice Elements (e.g. governance, digital health solutions)
8. Implementation and Risk Management (e.g. KPIs, service level agreements)

Appendix 9: Part Two – Desktop Review – Data Extraction Table

Author	Year	Document title	Continuity of care	Communication	Consumer and carer involvement/co-design	Best practice processes/ implementation factors	Digital technologies	Performance monitoring	Risk management
NSW Ministry of Health[23]	2023	Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines	Post-treatment support (e.g., case management, support groups, accommodation) sustains engagement. Regular contact with medical professionals, case managers, and outreach services aids long-term recovery. Step-up/step-down approaches adjust care based on client needs. Young people benefit from structured continuing care programs. Establish formal connections with ongoing care providers (referrals, appointments, contacts).	Use the ISBAR framework (Introduction, Situation, Background, Assessment, Recommendation) for effective handovers. Provide a written discharge summary to the client, support services, and records, including: - Reason for engagement - Treatment details & timeframes - Medication information - Client progress & response - Risks, strengths, protective factors - Recommendations for ongoing care	Treatment should be person-centred with regular assessments and feedback shaping interventions.	Best practices blend therapies (e.g., CBT + Motivational Interviewing) and include: - Assessment, feedback, psychoeducation, and goal setting - Intensive engagement, structured progression, and assignments Strong partnerships between government & non-government sectors improve care. Address gaps beyond AOD treatment (e.g., mental health, welfare, childcare). Early planning ensures smooth transitions, relapse prevention, and harm reduction.	Virtual interventions (phone/video) enhance access for remote clients & those with disabilities. Supplementing—not replacing—in-person care		
NSW Ministry of Health[54]	2022	Drug and Alcohol Withdrawal Clinical Practice Guidelines	Active referrals to mental health services, rehabilitation, and peer support.	Family/carer involvement enhances treatment adherence and recovery.		Early discharge planning starts at admission to ensure smooth transitions.	Telehealth for counselling and medication management, especially in rural areas.		Harm reduction education, coping strategies, crisis contacts and strategies for

Author	Year	Document title	Continuity of care	Communication	Consumer and carer involvement/co-design	Best practice processes/ implementation factors	Digital technologies	Performance monitoring	Risk management
			Regular check-ins to prevent relapse and ensure continuity of care.	Use ISBAR for effective information transfer at handovers.		Promote trauma-informed, non-judgmental care. Invest in community & peer-led services for long-term support. Individualised care addressing medical, psychological, and social needs. Collaboration between mental health, drug & alcohol, housing, and welfare services. Comprehensive assessment of substance use, mental health, risk factors, and social support.			managing distress.
NSW Ministry of Health [55]	2020	Seclusion and Restraint in NSW Health Settings	Link to community mental health teams, peer support, and follow-ups within 24-72 hours	Strong coordination between mental health services, primary care, and community supports	Begin discharge planning early, involving patients, families, and multidisciplinary teams	Address needs of Aboriginal, CALD, and LGBTQ+ communities	Telehealth supports rural/remote patients	Track discharge outcomes and document restrictive interventions for service improvement	Assess self-harm, relapse risk, and develop crisis prevention plans
NSW Ministry of Health [56]	2022	Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies, June 2013	Discharge planning must incorporate ongoing risk assessments, particularly for patients with histories of aggression or acute behavioural disturbances	Clear, structured handovers ensure smooth transitions between healthcare teams and services Receiving services must have access to all relevant patient information, including risk assessments	Carers, families, and guardians should be actively involved in discharge planning to ensure personalised support Pre-admission planning for patients with disabilities				Behavioural risks should be flagged in patient records and shared with relevant teams, including security Escalation protocols should be in place for high-risk cases

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				Patients and carers should be kept informed of waiting times, delays, and behavioural expectations	should include carer input				Discharges must comply with the NSW Mental Health Act, ensuring legal and risk management requirements are met Security teams should be briefed on high-risk patients and involved in discharge planning as required Specific procedures apply to forensic and custodial patients
NSW Ministry of Health [25]	2024	Responding to the health care needs of people with disability	Early engagement with relevant service providers is essential to ensure seamless transfer Referral structures must be developed for easy access to service providers Consideration should be given to community-based services (e.g., Hospital in the Home) to maintain patient routines and ensure continuity of care	Information must be provided in an accessible format, including Easy Read, braille, large print, or translated materials Proper handovers and follow-ups must be ensured, with clear communication to patients, carers, and service providers The Estimated Date of Discharge (EDD) must be established early, agreed upon by the treating team, and regularly reviewed. It must be communicated clearly to patients, families, carers, and relevant	Carers play a crucial role in the discharge process and must be involved where appropriate Health services must support and recognise the contributions of carers in planning and implementing discharge plans Support should be offered for patients with disabilities to make informed decisions about their care Factors such as decision-making capacity, NDIS	Trauma-Informed & Recovery-Oriented Approach The Discharge Risk Assessment and Transfer of Care Readiness Checklist must be completed MDT members must work collaboratively, ensuring defined roles and responsibilities to support the patient's transition NSW Health is responsible for coordinating a collaborative discharge/transfer process			Education and training should be provided to patients and carers, covering changes in medications, treatments, and use of new equipment

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				community service providers	status, mobility, and transport requirements should be considered	A key contact or coordinator from the Multi-Disciplinary Team (MDT) must oversee the discharge planning process NSW Health Policy Directive PD2019_045 mandates that discharge planning for mental health consumers is guided by trauma-informed and recovery-oriented principles Care planning should involve service partners such as guardians, NDIS agencies, disability advocates, and healthcare providers			
NSW Ministry of Health [27]	2022	Clinical care of people who may be suicidal	Follow-up care must be scheduled within 24-48 hours of discharge and ideally within 72 hours Services must have strategies for ongoing suicidality, including case conferencing and review meetings	'Warm handovers' (written + verbal communication) must be used for smooth care transitions	Carers and peer workers should be integrated into discharge planning and post-discharge support Families must be given information on recognising deterioration and escalating concerns	All health staff must identify suicide risk early, using structured screening and direct questioning Mental health assessments must include psychosocial history, risk factors, strengths, and available support Clinicians must be trained in suicide risk assessment, safety planning, and			A safety plan should be developed, outlining coping strategies, social supports, and emergency contacts Ensure access to lethal means (e.g., medications, weapons) is minimised Crisis plans should include emergency contact pathways, non-clinical

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						culturally responsive care Compliance with NSW Health's Discharge Planning & Transfer of Care Policy (PD2019_045) is required The discharge plan must specify community support services, general practitioners, and crisis contacts Clinicians must consider cultural and social factors that influence suicidality and recovery			supports, and follow-up care coordination
NSW Ministry of Health [57]	2022	The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities	Services must ensure well-coordinated transition of care, avoiding disruptions to treatment Discharge plans should integrate primary care providers, outpatient services, and community supports Adolescents transitioning to adult services require structured transition plans and designated coordinators		Discharge planning must be tailored to the child's developmental stage, abilities, and needs The family's role is central in planning and decision-making Carers should receive education on the child's condition, medication, and warning signs of deterioration Facilities must provide appropriate spaces for carers to stay with children when needed	Culturally appropriate supports must be available for Aboriginal and CALD communities Care must align with trauma-informed principles and support the child's emotional wellbeing Mental health discharges must follow least restrictive care principles, prioritising patient rights and safety Seclusion and restraint should only be last-resort			Facilities must have safe assessment areas for high-risk mental health patients Patients must only be discharged when safe and appropriate support systems are in place High-risk patients (e.g., those with acute mental health concerns) require enhanced monitoring and follow-up Children and adolescents should

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						measures, and alternative de-escalation strategies must be prioritised			always be accompanied by a responsible carer upon discharge
NSW Ministry of Health [50]	2023	Supporting Young People During Transition to Adult Mental Health Services	Joint planning between the treating and receiving teams ensures uninterrupted and coordinated care. A period of parallel care or joint working between services is recommended to maintain relational continuity during the transition process. Peer support, including mentors and peer support workers, is highlighted as a valuable component of the transition process to enhance engagement and motivation.	Clear, effective, and timely communication between all stakeholders is critical. This includes verbal and written information provided to the young person and their family/carers. Documentation of the transition process, including an individualised transition plan, is essential. This plan should be shared with the young person, their family/carers, and the receiving service. Communication should address cultural and linguistic needs, ensuring sensitivity and responsiveness to diverse populations	Young people and their families/carers are to be actively engaged in and guide the transition process. Their preferences and choices should be considered in decision-making. Transition planning should use person-centred approaches, including individualised plans that involve family/carers, general practitioners, and other relevant stakeholders. Consumers and carers should be involved in service design, delivery, and evaluation, as well as in co-producing transition policies, materials, and tools.	Services are encouraged to develop local transition protocols that outline shared expectations and responsibilities. However, protocols alone are insufficient without proper implementation. Training for clinicians in developmentally appropriate and person-centred practices is recommended to improve front-line practice. The guideline references resources like the NICE Baseline Assessment Tool and the MILESTONE Project for supporting implementation and improving transition outcomes. It is important to address the needs of vulnerable populations, such as Aboriginal and Torres Strait Islander young people, those from culturally and	Mobile technology can support transition planning, such as providing information, reminders, and tools for self-management. Digital tools like the Transition Readiness Assessment Questionnaire (TRAQ) are suggested to assess a young person's readiness for transition, though clinical judgement is advised in their application.	Monitoring outcomes of the transition process, both for individual consumers and for service improvement, using tools like the Your Experience of Service (YES) survey, is recommended.	A safety plan is needed to mitigate risks during the transition, with combined reviews by both the referring and receiving teams.

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						linguistically diverse backgrounds, and those with chronic illnesses or disabilities.			
NSW Ministry of Health [36]	2022	Accessing inpatient mental health care for children and adolescents	Discharge planning should start at admission to ensure continuity of care and minimise disruptions Early engagement with community-based services (e.g., CAMHS, school supports) is essential for smooth transitions Multidisciplinary teams should integrate educational, vocational, housing, and family support into discharge planning	Multi-agency collaboration is key, ensuring seamless referrals to education, housing, and specialist mental health services post-discharge	Families/carers must be involved in referral, admission, and discharge processes Communication with carers should be ongoing, ensuring they understand the child's treatment plan and post-discharge support	Care should be tailored to the child's developmental stage, cultural background, and individual needs The least restrictive model of care should be used to support autonomy, minimise trauma, and maintain community connections Services should provide peer support, family-based treatment, and community mental health follow-up after discharge A structured follow-up plan should be in place to monitor the child's wellbeing and prevent readmission		Health services must track key performance indicators (KPIs), such as engagement with post-discharge services and patient-reported outcomes Success should be measured through patient experience surveys, follow-up care adherence, and service accessibility	Local services must have protocols for escalating care when needed, particularly if the most appropriate services are not available locally
South Eastern Sydney Local Health District [26]	2024	Admission and Discharge/Transfer of Care Processes for Acute Mental Health Inpatient Units (including Direct Admissions for Consumers linked with	Discharge planning starts at admission to ensure a smooth transition to community or support services Follow-up contact within 7 days of discharge is	Consumers should receive a written and verbal summary of their care plan, including safety plans for suicide prevention if required Clear communication between inpatient	Consumers and carers are partners in care planning, with the right to be informed and involved	Care must prioritise least restrictive, person-centred approaches, ensuring safety and continuity post-discharge A key contact from the multidisciplinary		The Mental Health Transfer & Discharge Checklist ensures completion of all discharge requirements Performance monitoring includes	Assess and document risks such as suicide, self-harm, housing instability, and medication non-adherence

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		Community Mental Health)	required, with a priority for high-risk consumers to be seen within 48-72 hours	teams, community mental health services, GPs, and other providers is essential Comprehensive discharge summaries must be provided to consumers, carers, and receiving providers		team should coordinate discharge planning Peer support and Aboriginal or culturally diverse workers should be engaged as needed to support transitions		tracking follow-up rates, consumer engagement, and risk outcomes	
NSW Health [28]	2020	Peer supported transfer of care (Peer-STOC) evaluation report	Peer workers provide continuity of care by linking consumers with community-based services and ensuring that discharge plans are actioned Peer workers help consumers navigate post-discharge care, empowering them to access necessary supports Peer workers begin engaging with consumers while they are still in hospital to build trust and collaboratively identify post-discharge needs Most LHDs implemented six weeks of peer support, but some allowed flexibility based on consumer needs e.g. Some LHDs extended peer support beyond six			Peer-STOC resulted in the following benefits for consumers: - Increased engagement with outpatient services and reduced service disengagement - Enhanced self-efficacy, empowerment, and hope through peer mentorship - Support in navigating practical challenges such as housing, employment, and substance use services Embedding peer workers in multidisciplinary teams ensures structured collaboration with clinicians Expanding peer worker training is recommended to strengthen skills in			

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			weeks if required, ensuring individualised and consumer-led care transitions Peer workers ensure consumers are linked to ongoing mental health services, social support programs, and housing assistance			care coordination and consumer advocacy Flexible peer support timelines, allow for individualised, needs-based discharge planning Increased systemic recognition of peer work, with clearer career pathways and equitable pay structures is recommended The program (peer-STOC) aims to lower hospital readmission rates (which are currently 14.6% within 28 days of discharge) by strengthening community connections. System-level benefits of Peer-STOC: - Enhanced communication between inpatient and community teams, ensuring coordinated care - Reduced pressure on clinical teams, as peer workers support follow-up care coordination - Peer-STOC workers are seen as "bridges" between services, helping to			

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						integrate inpatient and outpatient care			
NSW Ministry of Health [43]	2022	Admission to Discharge Care Coordination	Early referrals to community-based support services (e.g., GPs, Aboriginal Community Controlled Health Services) must be arranged Service providers must be engaged early, and liaison with community-based organisations should be completed before discharge	Regular team meetings (huddles) ensure coordinated care and discharge planning The EDD must be documented and communicated to patients and carers throughout their hospital stay and should be updated in the Patient Flow Portal (PFP) and reviewed daily Patients must receive a plain-language discharge summary, including medication instructions and follow-up appointments	Carers should be included in discussions where appropriate	The Multidisciplinary Team (MDT) must establish clear roles and responsibilities for care coordination Discharge Checklists must be completed to ensure all follow-up care, medication plans, and referrals are in place Health services have a duty of care to ensure no patient is discharged into homelessness			A Discharge Risk Assessment must be completed upon admission to identify potential barriers to safe discharge (e.g., homelessness, carer responsibilities, complex psychosocial needs)
Victoria Health [30]	2022	Transfer of care and shared care	Peer support workers should be engaged to assist consumers in navigating mental health services Follow-up contact within seven days post-discharge is required, with 48-hour follow-up for high-risk consumers	Written and verbal communication should be provided in accessible formats, including translations and easy-read materials Comprehensive discharge summaries should be provided within 48 hours of transfer Transfer of Care Plans must include: - Medication details and rationale for changes	Transfer of care planning must begin at admission and involve consumers, families, carers, and support networks Consumers' choices, rights, and autonomy must guide discharge planning Families, carers, and supporters must be included in discharge planning where the consumer consents	The referring service retains clinical responsibility until the receiving service formally accepts the transfer Transfers should be seamless, reducing gaps in service access and minimising risks such as relapse and readmission Culturally safe care should be prioritised, particularly for Aboriginal and			Medication reconciliation must occur before discharge to prevent omissions or errors Link to housing services before discharge to prevent hospital exits into homelessness Coordinate referrals to family violence support services and

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				- Follow-up appointment schedules - Safety and crisis support contacts		Torres Strait Islander consumers			ensure safety planning
Australian Commission on Safety and Quality in Health Care [34]	2023	User guide for health services providing care for people with mental health issues	Post-discharge care often requires coordination across multiple services, including mental health teams, general practitioners, and community support groups It is essential that no person leaves the hospital without follow-up arrangements in place Health service organisations should establish agreements with external agencies to facilitate smoother transitions of care	The person and their carers should receive clear information on what steps to take in case of a crisis, including contact details for support services Use structured handover processes to ensure that responsibility and accountability for care are effectively transferred The discharge plan should be communicated through verbal, written, and electronic means to all important participants Partnerships between healthcare providers should ensure critical information is shared responsibly, avoiding breaches of privacy while preventing care gaps	Discharge planning should be collaborative, involving the person, their carers, and any relevant support networks. The Partnering with Consumers Standard underscores the need for engaging patients in their own care, meeting their information needs, and ensuring their involvement in decision-making. The person's family and carers should be actively involved where appropriate, ensuring that they understand the discharge plan and can support its implementation	Discharge planning should begin at the start of an episode of care, rather than as a last-minute process Examples of Successful Models and Initiatives: - The Way Back Support Service (developed by Beyond Blue):- Provides non-clinical support for up to three months following a suicide attempt, demonstrating reduced rates of subsequent suicide attempts in trial regions - The Living is for Everyone Framework:- Highlights the importance of continuous, unbroken care for individuals at risk, given the rapid changes in risk levels post-discharge		A key indicator of best practice is the rate of post-discharge community care within seven days, which is a nationally agreed benchmark	

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SA Health [37]	2023	Managing Transfer or Discharge of Patients	It is important to connect patients with community-based services, such as Rehabilitation in the Home (RITH), Geriatrics in the Home (GITH), and My Home Hospital (MyHH). These services ensure patients receive appropriate care after discharge. For patients unable to return to their pre-hospital accommodation, interim care options (e.g., transitional accommodation, respite care) are provided to maintain continuity of care while awaiting permanent solutions.	For patients with complex needs, case conferences involving the patient, substitute decision-makers, and multidisciplinary teams are required to ensure tailored discharge plans. Patients and substitute decision-makers must receive comprehensive information, including: - Rights and responsibilities. - Post-discharge care options and community supports. - Contact details for hospital teams and relevant support services (e.g., ACAT, NDIS). - Circumstances requiring emergency department visits post-discharge.	Patients and/or their substitute decision-makers must be involved in discussions about discharge planning, care pathways, and post-discharge support. This includes providing clear information about their rights, responsibilities, and available options.	Discharge planning must begin within 24 hours of hospital admission or as soon as practicable. This includes identifying clinical requirements, patient goals, and likely discharge pathways. The Criteria Led Discharge (CLD) pathway is recommended to ensure efficient patient flow and timely discharge. It uses discharge criteria determined by the multidisciplinary care team to support clinical decisions. Culturally appropriate discharge plans are needed, particularly for Aboriginal and Torres Strait Islander patients and those with diverse cultural needs. The policy identifies common barriers, such as housing issues, delays in NDIS approvals, and guardianship challenges. It provides management options, including collaboration with	The use of Sunrise EMR & PAS or other relevant systems is mandatory to document estimated discharge dates (EDD), discharge plans, and patient information. The use of digital tools is encouraged to facilitate communication with General Practitioners (GPs), community services, and other stakeholders to support continuity of care	Compliance with the policy is subject to audits to ensure effective implementation and adherence to discharge planning requirements.	Clear escalation pathways are outlined for addressing significant delays or barriers to discharge, ensuring accountability and timely resolution. Patients with complex needs, including those with psychosocial factors or behaviours and psychological symptoms of dementia (BPSD), require tailored discharge plans involving multidisciplinary teams and external stakeholders. If patients or substitute decision-makers refuse discharge, the policy outlines steps for escalation, including case conferences, legal advice, and, as a last resort, invoking trespass laws.

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						relevant agencies (e.g., SACAT, SA Housing Authority) to expedite processes.			
South Eastern Sydney Local Health District [26]	2024	Admission and Discharge/Transfer of Care Processes for Acute Mental Health Inpatient Units	Community mental health teams must contact the consumer within seven days of discharge. For consumers with limited social supports, follow-up should occur within 48–72 hours. If the consumer cannot be reached, family/carers should be contacted to assess how the consumer is settling and identify any concerns.	Effective coordination with community mental health teams, general practitioners (GPs), private psychiatrists, and other support services is essential. This includes verbal and written communication of the consumer's needs, risks, and follow-up plans. The ISBAR framework is recommended for standardised, person-centred communication during handovers. The Discharge/Transfer Summary must be explained to the consumer and their family/carers, with questions answered to ensure understanding. Verbal and written communication with receiving services and support providers is prioritised to ensure a smooth transition of care.	Consumers are partners in care planning, including discharge planning. Their right to choice, self-determination, and involvement in decision-making is emphasised. Carers have the right to be involved in discharge planning, notified of transfers, and provided with adequate notice and information. Their concerns must be considered in planning. All carers, regardless of consent, should be offered support through referral to family and carer support programs. General mental health information can be shared with carers even without consumer consent.	Discharge planning must consider the consumer's language, culture, diversity (e.g., Aboriginal and Torres Strait Islander background), gender, and sexual orientation. Care planning, including discharge planning and transfer of care practices, are based on trauma-informed and recovery-oriented principles and practices. The use of standardised checklists (e.g., Mental Health Admission Checklist, Transfer and Discharge Checklist) ensures that all necessary steps are completed and documented. A designated contact from the multidisciplinary team is responsible for ensuring all steps of the discharge planning process are completed.	Documentation such as the Mental Health Current Assessment, Physical Health Examination, and Discharge/Transfer Summary, is completed and stored in the eMR. The Discharge/Transfer Summary is a critical document provided to the consumer, their family/carers, and the receiving service. It includes diagnosis, medications, care plans, identified risks, and follow-up arrangements. The Mental Health Transfer and Discharge Checklist ensures all steps are completed and documented in the eMR.	Monthly audits of inpatient and community files, as well as electronic discharge summaries, are conducted to monitor compliance and improve processes.	For consumers with suicidal ideation or self-harm risks, discharge planning includes a detailed suicide safety plan, lethal means counselling, and contingency planning Discharge planning includes identifying and managing risks such as harm to self or others, substance use, and physical health concerns. Contingency plans and relapse prevention strategies are developed and documented. Consumers are supported to develop or update their Wellness Plan and suicide safety plan, which include early warning signs, coping strategies, and emergency contacts. Consumers are not discharged without addressing

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									homelessness, with active support for finding accommodation documented as part of the discharge plan.
National Aboriginal Community Controlled Health Organisation (NACCHO) [46]	2022	Draft National Safety and Quality Mental Health Standards for Community Managed Organisations - Submission to the Australian Commission on Safety and Quality in Health Care	Continuity of culturally competent care is crucial, especially given the historical lack of cultural safety in mainstream services, which may cause trepidation for some individuals. Transfers of care should be gradual and considerate, allowing time for consumers, families, and carers to build trust and rapport with new service providers. This ensures engagement, participation, and continuity of care. The Standards must explicitly address the sensitivities of care transitions, ensuring cultural competence is maintained throughout referral pathways. Discharge and transfer planning must acknowledge the ongoing impacts of colonization, past	Effective communication is critical and requires service providers to understand and respect Aboriginal and Torres Strait Islander worldviews, which emphasize holistic and collective approaches to health. The Standards must embed Aboriginal and Torres Strait Islander mental health experiences into care models, ensuring culturally appropriate ways to "hear the story," listen, and provide meaningful validation.	Consumers, families, and carers should be actively involved in discharge and transfer planning, including co-designing care plans to meet their needs and preferences. Aboriginal and Torres Strait Islander people must be included in the design and implementation of culturally safe care models, particularly under the "Establishing the model of care" criterion. Individualized, culturally safe care plans should be developed, documented, and shared to ensure continuity of care. These plans must integrate clinical and cultural aspects of health, reflecting the holistic view of health held by Aboriginal and Torres Strait Islander people.	Workforce training must focus on cultural safety and understanding the Social and Emotional Wellbeing (SEWB) framework, particularly for mainstream mental health workers. Multidisciplinary teams should include clinical, non-clinical, and cultural expertise, involving Aboriginal Mental Health Workers and Traditional Healers where appropriate. The Standards should align with the National Agreement on Closing the Gap, emphasizing shared decision-making, strengthening community-controlled sectors, and transforming government organizations to better serve Aboriginal and Torres Strait Islander people.	Digital tools could support culturally safe communication, care planning, and medication management if they are designed with input from Aboriginal and Torres Strait Islander people and consider cultural needs.		Enhanced medication safety standards are essential to prevent misuse or overdose, particularly given the higher incidence of substance use in these communities. Strategies like limited medication supply, webster packs, and Dose Administration Aids (DAAs) can improve medication management. Community-managed organizations should utilize programs like Home Medicine Reviews to help consumers and carers manage medications safely. Collaboration with local community support services, including

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			government policies, and intergenerational trauma, which shape the unique challenges faced by Aboriginal and Torres Strait Islander people. Trust-building is essential, and transitions must respect the cultural and social context of Aboriginal and Torres Strait Islander people to provide effective and respectful care.			Discharge and transfer processes must be culturally safe, addressing power imbalances and respecting cultural identities as a fundamental human right. Services must consider historical, political, and social determinants of health, including colonization, intergenerational trauma, and past policies, which impact mental health and wellbeing. Care plans should integrate clinical and cultural aspects of health, reflecting the holistic SEWB framework that connects health to family, community, culture, spirituality, and ancestry. Mental health services must understand Aboriginal and Torres Strait Islander worldviews to provide appropriate care, including recognizing cultural factors to avoid misdiagnosis (e.g., interpreting cultural experiences like			pharmacists and prescribers, is crucial for ensuring safe medication management during care transitions..

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						hearing relatives' voices).			
Australian Commission on Safety and Quality in Health Care [52]	2021	Partnering with consumers case study: South Western Sydney LHD			Consumer feedback has driven service redesign, such as recruiting an aged care clinical nurse consultant to address specific care needs during transitions. Carers are actively included in bedside handovers, which now occur at the patient's bedside rather than nurses' stations. A handover support document clarifies carers' roles in this process. Camden Hospital's patient-voiced handover initiative empowers patients, particularly mental health consumers, to lead discussions with clinical staff about their healthcare journey, fostering engagement and addressing their concerns.	The TOP 5 initiative engages carers of patients with impaired memory and thinking to gather information that personalizes care and improves communication between staff and patients. The District Transfer of Care Committee focuses on improving care consistency and access during transitions, introducing consumer-suggested measures like patient care boards and follow-up calls after discharge to keep patients and carers informed and supported. A carer information tab was added to the patient administration system in 2020, enabling staff to record carer details and collaborate with them to personalize care, especially during hospital stays and discharge planning.			

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						The LHD's Carers Program provides professional support to carers, helping them navigate the healthcare system and understand illnesses. In mental health services, a dedicated carer peer worker assists carers with referrals and system navigation.			
Western Sydney Local Health District [51]	2020	Western Sydney Suicide Prevention Joint Regional Plan 2024-2025	A "whole-of-system" approach integrates services across primary, community, and acute sectors to ensure seamless care transitions. Collaborative commissioning arrangements aim to shift care from acute settings to primary or community-based services where appropriate. Strengthening models like the Patient Centred Medical Home (PCMH) and Health Care Neighbourhood supports prevention, early intervention, and care coordination. Partnerships are forged within and beyond the health and social care sectors, including	A Communication Action Plan (CAP) ensures clear and consistent communication about the Plan and mental health reforms to the community and health professionals. Multi-stakeholder communication is facilitated through the collaboration action tracker, ensuring transparency and alignment on actions and progress. Community awareness efforts ensure the public is informed about mental health reforms and available services. Specific Suicide Prevention and Crisis Interventions. Pathways are developed to improve follow-up care for	People with lived experience of mental illness and/or suicide, as well as their carers, play a central role in planning and governance. A Youth Advisory Council is being formed to include young people with lived experience, ensuring their voices shape youth mental health programs. Outcome measures are collected from at least 70% of mental health patients to evaluate service effectiveness and ensure consumer needs are met.	Evidence-based aftercare strategies are implemented for individuals discharged following a suicide attempt, reducing risks of further harm. Clear timelines, deliverables, and measures of success are outlined for each action, ensuring accountability and progress tracking. Workforce development initiatives focus on upskilling service providers in trauma-informed care, recovery practice, and integrated care. Contracts and procurement documents are updated to include outcome-based language, shifting the focus from	Data sharing across primary, community, and acute sectors is facilitated through a joint mental health data dashboard, enabling better monitoring and evaluation of care transitions. eHealth systems are being developed to improve care coordination, shared care between consumers and providers, and partnerships between service providers. Digital tools empower consumers and carers to self-manage their mental health and access appropriate services. A service directory is being created to enhance consumer access to mental	A KPI ensures 100% of suicide-flagged cases receive services within seven days of referral. Universal aftercare services must respond to all referrals within one business day, ensuring prompt support for individuals post-discharge. Governance structures, such as a reformed governance group and collaboration action tracker, ensure accountability and alignment of efforts. Implementation measures are tracked quarterly, with traffic light status updates to indicate progress.	

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			education, employment, and community organisations, to address root causes of mental distress and improve outcomes.	individuals transitioning to and from emergency departments, particularly those presenting with suicide ideation or self-harm. Targeted Regional Initiatives for Suicide Prevention (TRISP) are implemented to reduce and prevent suicide and self-harm, with progress tracked through contract management systems.		outputs to meaningful outcomes. Workforce initiatives aim to attract and retain a culturally competent and accredited workforce, with a focus on team-based care and collaborative practice. Training is provided to service providers on universal aftercare guidelines and other best practices to ensure effective discharge planning and care transitions.	health services.	Data sharing and integrated dashboards enable ongoing monitoring, analysis, and insights into service delivery and outcomes.	
South Eastern Sydney Local Health District [44]	2024	Access and Patient Flow Operational Framework for Mental Health Service	Daily transfers of care are coordinated, predicted, and planned to reduce harm and ensure safe and timely admissions and discharges. This includes documenting a clear admission/transfer of care pathway with an estimated date of discharge (EDD).	Regular communication between PFCs, NUMs, ED clinicians, inpatient clinicians, and community mental health teams ensures coordinated care. This includes updates on bed availability, consumer status, and discharge plans. Clinical handover is required at the receiving destination during consumer transfers, ensuring continuity and safety.	The framework highlights the need to include consumers and their families in all decision-making processes regarding transfer of care. This ensures that their preferences and needs are central to planning.	Weekly or fortnightly meetings are held to address barriers to discharge for consumers with extended stays. These meetings involve multidisciplinary teams (MDTs) to ensure holistic care and timely transitions. The "Three Rs" (Right Patient, Right Environment, Right Time) philosophy ensures that decisions about	Patient Flow Coordinators (PFCs) use digital tools such as the Electronic Patient Journey Board and the NSW Health patient flow portal to monitor and manage capacity and demand. These tools support proactive planning and reduce waiting times for consumers. Capacity and demand details are recorded in twice-daily Profile Reports, which are shared with stakeholders to	The framework emphasises the importance of integrated and coordinated services to optimise continuity of care, as outlined in Standard 8.1 of the National Standards for Mental Health Services (2010). This includes collaboration between inpatient and community services to ensure seamless transitions.	Clear communication and escalation processes are outlined for consumers awaiting mental health admission in Emergency Departments (EDs). This includes reporting Emergency Treatment Performance (ETP) breaches to relevant stakeholders to mobilise support.

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						placement consider the consumer's presenting issues, preferences, and safety, as well as the suitability of the environment and timing. The framework defines clear roles for key personnel, such as the Access and Pathway to Care Leads (APCL) and Patient Flow Coordinators (PFCs). These roles are critical for implementing and monitoring discharge planning and transfer processes. Proactive demand planning, including weekend and public holiday planning, ensures sufficient capacity and reduces reliance on neighbouring services. This approach strengthens site self-sufficiency and minimises delays. Policies for obtaining second opinions from Consultant Psychiatrists at specific length-of-stay thresholds ensure that care plans are regularly reviewed and	ensure up-to-date information and effective communication.		

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						optimised.			
Sydney Children's Hospitals Network [58]	2020	Admission to Acute Mental Health Unit	Discharge planning begins at the time of admission, ensuring a seamless transition to community care. The service responsible for ongoing care in the community must be identified within two working days of admission, and appropriate referrals should be made. Community mental health service providers are encouraged to engage throughout the admission process, including attending the hospital to collaborate on planning and ensure continuity of care. Post-discharge, the young person must be reviewed within seven days by the community mental health team or private mental health clinician responsible for follow-up care. The hospital case manager or psychiatric registrar must contact the patient or their parents/guardians	A discharge letter is sent to the young person's local Child and Adolescent Mental Health Service (CAMHS), general practitioner, paediatrician, or private psychiatrist as appropriate. Referrers are responsible for maintaining communication with the patient and their family throughout the referral and admission process. Contact details for support services, including the ward and Acute Care Team (ACT), are provided to the young person and their parents/guardians before leave or discharge.	Parents/guardians are involved in the referral and discharge process, with clear communication about the nature of the unit and admission. Discharge planning includes input and agreement from the young person and their parents/guardians, ensuring a collaborative approach. Feedback from the young person and their family is obtained and documented after leave periods to inform future care planning.	Collaboration with referring agencies is maintained throughout the admission and discharge process. Medium- and long-term management plans, including post-discharge care, are documented within 2–4 working days of admission. The document emphasises the importance of multidisciplinary care planning, involving nursing, psychiatry, psychology, social work, and other relevant fields.			

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			within seven days of discharge to confirm the outpatient appointment and check on the patient's wellbeing.						
Easten Melbourne Public Health Network [38]		HUB model of care	When a consumer requires support from multiple services, a Collaborative Shared Care Plan is developed with the consumer, their family/carers (as appropriate), and all members of the care team. The plan promotes shared understanding of the consumer's recovery goals, consistency in care, and reduced duplication of services. Consent, confidentiality, and appropriate information sharing are central to the process. Discharge planning includes strategies for step up (to higher-intensity services) and step down (to lower-intensity services) care, ensuring consumers receive the appropriate level of support as their needs change.	Regular reviews (at least every three months or as clinically indicated) are conducted to reassess the consumer's needs and recalibrate care levels. Transitions and handovers are discussed with the consumer and care team, ensuring adequate lead time and consideration of the consumer's mental state. A summary of care, including rationale for discharge and ongoing care arrangements, is shared with appropriate parties	Discharge planning is collaborative and involves the consumer, their family/carers, and the care team. Consumers and carers are actively involved in the design, implementation, and evaluation of services, ensuring their needs and preferences are central to discharge planning and care transitions.	The consumer is at the centre of their care, with consideration of their connection to family, friends, peers, and the community. No wrong door approach: Services must accommodate presentations at all stages of illness and for people with comorbidities, ensuring all referrals are supported to engage with appropriate services. Services work in partnership with other services, health professionals, families, and individuals, ensuring integrated care pathways between primary care, specialist services, hospitals, and social/community services (e.g., housing, justice, education, and employment). Plans for discharge are developed in			Formal risk assessments and safety planning are conducted at intake, discharge, and during care reviews. Safety plans are developed collaboratively with the consumer and their carers, ensuring risks are managed effectively during transitions.

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			Warm transfers are used to ensure continuity of care, with active communication between services to provide essential information about the consumer's needs. Partnerships are established with referral agencies, general practice, primary care agencies, mental health services, and social/community services to ensure seamless transitions and integrated care. Warm referrals are facilitated to connect consumers with appropriate services, including physical health, housing, family violence, and other social supports.			consultation with all stakeholders, ensuring smooth transitions and continuity of care. Processes are in place to support consumers to re-enter the service or access alternative supports if needed in the future. The workforce includes a mix of clinical and non-clinical staff, ensuring appropriate expertise to support consumers across the continuum of care. Staff are trained in evidence-based interventions and supported through clinical supervision to ensure high-quality care during transitions.			
Australian Government National Mental Health Commission [35]		Vision 2030	A well-functioning, integrated system is essential to ensure seamless transitions between inpatient and community-based care. This includes: - A single, nationally recognised process for care planning and coordination to ensure continuity of	Clear Pathways and Information Sharing: Vision 2030 highlights the need for clear care pathways and mechanisms for sharing information between services. This reduces confusion and ensures that individuals and carers	Vision 2030 highlights the importance of person-led care, where individuals and their carers are actively involved in care planning, decision-making, and service delivery. This includes individualised care plans that reflect the	A well-trained, multidisciplinary workforce is essential for delivering quality care, including training in trauma-informed care, cultural competence, and collaborative practice. Expanding the roles	Vision 2030 identifies digital solutions as critical for improving access to care, particularly in rural and remote areas. Applications include: Online self-guided programs for psychoeducation, assessment, and low-intensity interventions.	Systematic monitoring and evaluation of outcomes are critical for ensuring the effectiveness of interventions. Key indicators include follow-up care rates, consumer satisfaction, and reductions in readmissions.	Crisis services, including assertive aftercare programs, are essential for supporting individuals post-crisis and reducing the risk of readmission or harm. These services include: - Immediate

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			care across all levels of the system. - Care navigation services to support individuals and carers in accessing the right care at the right time, particularly during transitions. - Mechanisms for real-time information sharing and interoperability of information systems to reduce fragmentation and improve care coordination. The framework advocates for a stepped care model, where individuals can move between different levels of care intensity as their needs change. This ensures that care is tailored and responsive to individual circumstances. Local services are prioritised to ensure that individuals can access care in their communities, reducing the risk of disconnection and improving recovery outcomes. This includes home-based care, community hubs, and assertive outreach programs.	can navigate the system effectively. A consistent, accessible language across jurisdictions and services is essential for improving communication and reducing barriers to care, particularly for culturally and linguistically diverse communities. Public awareness campaigns and education initiatives are recommended to reduce stigma, promote help-seeking behaviours, and improve mental health literacy. Community Hubsprovide integrated mental health and social support services, improving accessibility and coordination of care.	unique needs, preferences, and goals of the person. The framework emphasises the value of co-design, where people with lived experience of mental ill-health, carers, and communities are central to the design, implementation, and evaluation of services. This ensures that services are relevant, effective, and culturally appropriate. For Aboriginal and Torres Strait Islander peoples, co-design must be Indigenous-led, respecting traditional law, customs, and culture.	of peer workers and lived experience professionals. Addressing workforce shortages in rural and remote areas through innovative models and incentives. Vision 2030 calls for funding models that support integrated, person-centred care and incentivise collaboration across sectors. Long-term funding cycles are recommended to ensure sustainability and continuous improvement.	Virtual psychological interventions and telehealth services to provide specialist care remotely. Digital care navigation tools to help individuals and carers access appropriate services. The framework stresses the importance of integrating digital solutions with in-person care to ensure a seamless experience for consumers. Efforts are needed to bridge gaps in digital access, particularly for individuals in remote areas or those without reliable internet or technology.		stabilisation and medical response. - Risk assessment and psychosocial evaluation to determine follow-up and ongoing care needs. - Assertive aftercare programs to ensure safe recovery and reduce the risk of relapse.

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Australian Government Department of Health [33]	2022	National Guidelines to improve coordination of treatment and supports for people with severe and complex mental illness	Develop formal pathways with shared agreements between health and social care services ensures that roles and responsibilities are clearly defined. These agreements should include follow-up processes to confirm that consumers have successfully engaged with receiving services. If engagement fails, escalation pathways should be activated to prevent deterioration. A care coordinator or key person should be identified to oversee transitions and ensure continuity. This individual acts as a single point of contact, supporting the consumer, their carer, and community throughout the transition process. Both the original and receiving services must monitor and evaluate the transition process, using consumer and carer feedback to improve future practices. Examples of	Protocols should be developed to ensure timely and appropriate sharing of information, underpinned by principles of consent and confidentiality. These protocols should be co-designed with consumers, carers, and communities. Services must communicate clearly with consumers, carers, and communities about what information is being shared, why, and with whom. Resources such as pamphlets and web-based tools should be provided in accessible formats and multiple languages. Information sharing should be trauma-informed to avoid retraumatising consumers. Professionals should be trained to communicate sensitively and effectively.	The guidelines strongly advocate for consumer-led, person-centred, and recovery-oriented approaches through: - Care plans developed in partnership with consumers, reflecting their goals, preferences, and cultural needs. Consumers must be active participants in all aspects of the planning and transition process. - Shared agreements and care pathways should be co-designed with consumers, carers, and communities to ensure they are relevant and effective. - Services should invest in building the capacity and confidence of consumers, carers, and communities to take an active role in their health and wellbeing. This includes providing education and resources to help them understand their rights and responsibilities. - Culturally safe practices, particularly for Aboriginal and Torres Strait Islander consumers, who	Governments and organisations must invest in leadership teams that foster collaboration across services and sectors. Leaders should facilitate resource mobilisation and support frontline staff in delivering coordinated care. Staff should receive training on topics such as cultural safety, trauma-informed care, and the value of the peer workforce. Peer workers, in particular, should have access to professional development opportunities and be treated as valued members of the workforce. Adequate funding is essential to support care coordination roles, digital solutions, and capacity-building initiatives. For consumers with NDIS packages, funding should include capacity-building training; alternative funding streams should be available for those not eligible for the	Developing or improving interoperable platforms to facilitate secure and timely information sharing across services and sectors. These platforms should allow consumers to access and update their care plans and provide visibility into the roles of all involved stakeholders. Digital tools, such as telehealth, should supplement face-to-face care, particularly for consumers in regional, rural, and remote areas. These tools can improve access to services and support continuity of care. Digital solutions should be co-designed with consumers, carers, and communities to ensure they are user-friendly and meet their needs. Examples include the iLINKS Information Transformation Strategy in the UK, which facilitates cross-organisational collaboration through a shared information platform, and the		

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			successful initiatives include the Transitional Care Program in New South Wales, where mental health nurses provide up to 12 weeks of post-discharge support, and the Peer Supported Transfer of Care (Peer-STOC) initiative, which uses peer workers to assist consumers during transitions.		should have access to cultural services such as Elders and traditional healers.	NDIS. Examples of best practice: (1) Transitional Care Program (New South Wales, Australia) provides support from a mental health nurse for up to 12 weeks after discharge from hospital. The nurse helps the consumer transition from tertiary care to the community by ensuring access to a general practitioner, psychologist, or other services. (2) Peer Supported Transfer of Care (Peer-STOC) Initiative (New South Wales, Australia). Peer workers with lived experience of recovery support consumers during the transition from inpatient to community-based care. Peer workers help consumers navigate services, connect with resources, and empower them to participate actively in their recovery journey.	Child Information Sharing Scheme in Victoria, which integrates data from multiple services to support holistic care.		
NSW Ministry of Health [43]	2022	Admission to Discharge Care Coordination	Mental health inpatients must undergo a discharge	Daily Multidisciplinary Team (MDT) huddles ensure effective	Mental health consumers and their carers must be	Staff are encouraged to complete the Care Coordination training	The EPJB is a digital tool used to coordinate care for	Facilities must implement compliance	Mental health consumers with medication risks

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			risk assessment to identify needs such as self-care ability, housing stability, responsibilities for dependents, psychosocial factors, and medication changes. This ensures continuity of care from hospital to community settings, with referrals to appropriate services, such as community mental health teams, general practitioners (GPs), and Aboriginal Community Controlled Health Services (ACCHS). Early and ongoing communication with service providers, including mental health-specific organisations, ensures a smooth transition. Referrals are documented in the patient's medical record For mental health consumers, follow-up care may include community mental health services, crisis support, or ongoing therapy. Discharge planning must ensure that no patient is discharged	communication among healthcare providers. These meetings focus on discharge planning, updating the EDD, and addressing patient risks. For mental health inpatients, this includes ensuring that psychosocial and clinical needs are addressed collaboratively. MDT members have defined roles in care coordination, ensuring accountability and efficient communication. This is particularly important for mental health consumers with complex needs. Early discussions with service providers, including community mental health teams, GPs, and ACCHS, ensure that discharge arrangements are in place before the patient leaves the hospital.	actively involved in care planning from admission to discharge. The Estimated Date of Discharge (EDD) is communicated early and updated regularly to align expectations and ensure preparedness. Discharge summaries, care plans, and educational resources must be provided in plain language to ensure mental health consumers and carers understand their post-discharge care requirements. The needs of family members and dependents, particularly in the context of mental health, must be considered. Referrals to family support services, including those addressing the needs of children of mental health consumers, should be made as required.	module available through My-Health Learning. Additional resources, such as the PFP Care Coordination webpage, provide guidance on implementing best practices for mental health discharge planning. Health services must develop local processes to address specific needs, such as rurality, homelessness, or cultural considerations, particularly for mental health consumers. For Aboriginal mental health consumers, referrals to ACCHS and Aboriginal Hospital Liaison Officers are prioritised to address cultural and health-specific needs.	mental health inpatients, track discharge planning, and manage patient flow. It is updated during multidisciplinary team (MDT) huddles and provides a centralised view of patient information. The PFP is used to manage patient flow, including tracking the EDD, identifying delays (via the "Waiting for What" tool), and supporting discharge planning. It also facilitates predictive planning for hospital capacity. Where available, eDS tools ensure accurate and timely communication of discharge information to mental health consumers, carers, and service providers. Implementation Factors	checklists to ensure adherence to discharge planning requirements, such as completing discharge risk assessments, MDT reviews, and discharge checklists.	are prioritised for pharmacist review, and discharge summaries include detailed medication information. The Good to Go (G2G) System ensures that mental health consumers are only discharged when all necessary steps for safe transfer of care have been completed. The "Waiting for What" tool in the PFP identifies and tracks non-clinical delays (e.g., waiting for housing or community mental health services), enabling facilities to address these issues proactively.

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			into homelessness or without appropriate support.						
NSW Ministry of Health [49]	2020	NSW Aboriginal Mental Health and Wellbeing Strategy	Developing formal partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) to ensure culturally safe and coordinated care pathways Strengthening referral pathways to psychosocial support services such as the Housing and Accommodation Support Initiative (HASI), HASI Plus, and the National Disability Insurance Scheme (NDIS) to ensure ongoing support post-discharge Clarifying roles and responsibilities in mental health case management to ensure accountability and continuity of care across service providers Addressing barriers such as stigma, discrimination, geographic isolation, and lack of culturally safe services to improve access to follow-up care	Developing communication plans to improve mental health literacy, reduce stigma, and increase the visibility of mental health care in Aboriginal communities Building partnerships between mental health services, ACCHOs, and other community organisations to ensure culturally safe and connected care Promoting feedback mechanisms for Aboriginal consumers, carers, and communities to improve service planning and delivery	Actively involving Aboriginal consumers, carers, and communities in the co-design of service models and discharge planning processes Ensuring that consumers with lived experience of mental illness are empowered to lead their own care planning and decision-making in culturally appropriate ways Developing localised, co-designed implementation plans with Aboriginal stakeholders, including consumers, carers, and families, to ensure services meet community needs Supporting the inclusion of carers and families in care and treatment planning to ensure a person-centred approach Co-designing healing programs that address intergenerational	Providing access to cultural support during mental health admissions or episodes of care, such as Aboriginal mental health workers, peer workers, or family members Implementing trauma-informed care training for mental health employees to ensure services are sensitive to the experiences of Aboriginal consumers Promoting culturally safe environments through the inclusion of Aboriginal language, artwork, and culturally appropriate service information Incorporating traditional healing methods and cultural practices into care plans to support holistic healing Developing localised implementation plans that reflect the unique needs of Aboriginal	The Maruung Maruung Yarn Up Feel Deadly App, which provides culturally appropriate mental health resources, personal video testimonials, and information about treatments and community events. This app demonstrates how digital solutions can support connected, person-centred, and culturally safe care. Leveraging digital platforms to improve communication and information sharing between service providers, ensuring continuity of care and better outcomes for consumers	Embedding deliverables into local performance planning and ensuring public and community accountability through consultation and reporting Establishing monitoring and reporting frameworks to measure progress and inform future decisions, including the development of key performance indicators (KPIs) to track referrals and follow-up care	

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			Providing services in non-traditional settings to improve access to care without requiring consumers to leave their family, country, or community		trauma and promote cultural, spiritual, and community connections	communities and are co-designed with Aboriginal stakeholders			
NSW Government Agency for Clinical Innovation [39]	2023	Key principles for transition care	A structured and systematic approach ensures seamless care during the transition from paediatric to adult services. Assigning a dedicated individual ensures oversight and continuity throughout the process. GPs, paediatric clinicians, and adult clinicians work together to ensure a smooth handover, including case conferences, joint appointments, and shared documentation. Regular follow-up ensures the transition plan is effective and adjustments can be made as needed. Special attention is given to young people from diverse backgrounds (e.g.,	Collaboration between all stakeholders, including young people, families, GPs, paediatric clinicians, and adult clinicians, is essential for a successful transition. These facilitate effective handover and ensure all parties are aligned on the young person's care plan. Paediatric clinicians provide comprehensive documentation to adult clinicians and GPs, ensuring continuity of care and access to relevant information.	Encouraging young people to take responsibility for their healthcare by promoting self-management skills and involving them in decision-making. Plans are tailored to the specific needs and preferences of the young person, ensuring a person-centred approach. Families are involved in the process, with guidance on their changing roles and how they can support the young person's independence. Adult clinicians are encouraged to empower young people to ask questions and make decisions about their care, while also respecting their identity and independence.	Transition planning begins early, ideally between ages 14-16, to allow sufficient time for preparation and coordination. Coordinators facilitate the process, acting as a central point of contact for young people, families, and clinicians. GPs and adult clinicians are provided with information about rare conditions, treatments, and resources to ensure they are prepared to support the young person. Additional supports are provided for young people from Aboriginal, CALD, or rural backgrounds, as well as those with trauma or mental health conditions. Tools like HEEADSSS are	The MyTransition App helps young people organise their healthcare information, such as medical history, medication lists, and appointment details, fostering independence and self-management. Encouraging young people to use digital resources to stay informed and engaged in their healthcare.		

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			Aboriginal, CALD, rural, or those with trauma or mental health conditions) to ensure their unique needs are met.			used to evaluate the young person's psychosocial needs, informing the transition plan. Special attention is given to young people in out-of-home care, refugees, asylum seekers, and those with disabilities or mental health conditions. Aboriginal health staff and other culturally appropriate services are involved to ensure culturally safe care.			
Australian Government Department of Health and Aged Care [59]	2024	Integrated Team Care Program Implementation Guidelines				Care Coordinators work collaboratively with clients, General Practitioners (GPs), Aboriginal Community Controlled Health Services (ACCHS), and other service providers to assist with care coordination. This includes helping clients understand and manage their conditions, follow care plans, and access multidisciplinary care. Care Coordinators are expected to provide personalised			

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						support, which could be adapted to ensure continuity of care during discharge and transitions. The guidelines emphasise the importance of culturally safe, person-centred care that is responsive to the needs of Aboriginal and Torres Strait Islander people. This includes addressing barriers to accessing services and involving families or carers where appropriate. Improving cultural safety in mainstream services is a priority, which could enhance the experience of care transitions for Aboriginal and Torres Strait Islander clients. Clients with mental health conditions are eligible for care coordination under the program, provided they have a GP care plan. This care coordination could include support for managing mental health needs during transitions between			

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						inpatient and community care. Funding can be used to address urgent needs, such as transport to appointments or access to allied health services, which may support safe transitions from inpatient care to the community. The program encourages collaboration between mainstream and Aboriginal and Torres Strait Islander health sectors, fostering partnerships that could improve discharge planning and continuity of care. The guidelines highlight the importance of identifying and addressing barriers to accessing care, such as transport or affordability, which are critical considerations during discharge planning.			
NSW Ministry of Health [31]	2023	NSW community Mental Health Services priority issues paper	Improved integration and communication between inpatient and community mental health	Better communication between General Practitioners (GPs) and Community Mental Health Teams	Families and carers should be meaningfully included in assessment, care planning, and	Access to high-quality training for staff, including trauma-informed care and de-	Single Digital Patient Record (SDPR) will improve continuity of care, reduce the need for patients and		

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			services are critical. Lack of continuity of care can lead to social isolation, economic hardship, and threats to quality of life. Improved care planning and discharge planning processes that involve both inpatient and community services are essential. Peer-Supported Transfer of Care (Peer-STOC) provides additional person-centred and recovery-focused supports to individuals with complex mental health needs during their transition to home or community after an inpatient admission. It emphasises continuity of care and recovery-oriented approaches.	(CMHTs) is needed. This includes sharing information, developing shared treatment plans, and simplifying referral processes. Improved navigation services, such as peer-led navigation, can help consumers and carers understand and access the services they need post-discharge. This includes connecting them to appropriate community supports and reducing confusion about service pathways.	discharge planning processes, provided the consumer agrees. Their involvement can enhance the consumer's wellbeing and connection to the community. The peer workforce plays a vital role in supporting consumers during transitions. Peer workers use their lived experience to provide guidance and support, which can improve consumer outcomes and reduce stigma.	escalation techniques, is essential for effective discharge planning. Training supports a skilled workforce and aids in retention. Addressing the physical health needs of mental health consumers is critical. Multidisciplinary teams, including dieticians and exercise physiologists, should be involved in discharge planning to ensure holistic care. Programs like the Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS) are critical for recovery and reintegration into the community. These programs provide psychosocial support, which are essential for successful discharge planning. Step-Up Step-Down Services provide sub-acute services in the community, which can support consumers transitioning from	carers to repeat health information, and provide secure access to relevant medical data. This system is expected to enhance discharge planning and care transitions by ensuring all providers have access to accurate and up-to-date information.		

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						inpatient care and prevent readmissions Non-clinical spaces like Safe Havens provide support for individuals in distress, reducing the need for emergency department presentations and offering a smoother transition to community care.			
South Eastern Sydney Local Health District [60]	2022	Community Mental Health Acute Care Teams – Key Practices	Comprehensive verbal and written handovers are essential during the transfer of care. This includes using the ISBAR framework to ensure clear communication between teams. Follow-up within seven days of transfer from an inpatient setting is mandatory. This ensures continuity and monitoring of the consumer's progress post-discharge. The CMH Acute Care Team works closely with other teams, such as Care Coordinators, to ensure seamless transitions. This includes liaising with carers and other	Clinical handovers are structured and occur at the beginning of each shift, with updates on clinical presentation, risk levels, and care plans. A Psychiatry Registrar or Consultant Psychiatrist is present at least once daily during weekdays. Carers are provided with clear instructions regarding their role during the consumer's leave and contact details for mental health services in case of concerns.	Involving consumers and their carers in the development of care plans is important. These plans should reflect the consumer's preferences and strategies identified prior to the crisis period. Consumers' wishes for service provision during times of crisis should be documented in advance (e.g., Consumer Wellness Plans or Advance Directives) and used to guide care during transitions.	Risk Comprehensive risk assessments are conducted at the time of initial contact and during each subsequent contact. These assessments guide the development of management plans and ensure safety during transitions. For consumers on leave from inpatient units, the CMH Acute Care Team provides follow-up support, which may include face-to-face contact or telephone calls, depending on the duration and purpose of the leave. The CMH Acute Care Team works with GPs, private	The use of Electronic Medical Records (eMR) is central to documenting referrals, risk assessments, care plans, and clinical handovers. This ensures that all relevant information is accessible to the teams involved in the consumer's care. The document acknowledges that skill mix deficits within the Acute Care Team (e.g., due to sick leave) can impact the team's capacity to provide timely and comprehensive assessments. Escalation to line managers or on-call executives is required in such cases. The document aligns		

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			stakeholders to develop and document care plans.			psychiatrists, and other community-based services to address the broader needs of consumers.	with several NSW Ministry of Health policies, ensuring that local procedures are consistent with state-wide standards.		
Victoria Health [40]	2024	Care Coordination between acute and community-based services	Care coordination ensures consistency and continuity of care by linking acute and community-based services. This is achieved through clear communication, collaborative integrated care planning, and addressing barriers to engagement. The goal is to establish sustainable, ongoing care plans tailored to individual needs. Care coordination addresses not only medical needs but also complex psychosocial factors, such as social, environmental, financial, and cultural barriers.	Clear communication is a cornerstone of care coordination. It involves liaising with multiple services, linking clients to specialist assessments, and ensuring all parties are informed and aligned in the care process. This reduces fragmentation and supports a seamless transition between care settings.	The care coordination process is guided by the individual care needs of the client. It supports self-management approaches, empowering consumers to take an active role in their care. Carers and families are also involved, ensuring their perspectives and needs are considered in the care plan.	The intensity of care coordination is tailored to the complexity of the consumer's needs and their capacity for self-management. This flexible approach ensures that resources are allocated effectively, with some consumers requiring significant input while others need only short-term assistance.	The Wagner Chronic Care Model, which underpins care coordination, emphasises the use of shared clinical information systems. These systems facilitate communication and collaboration across acute and community services, ensuring all providers have access to up-to-date information about the consumer's care. The Wagner Chronic Care Model promotes a collaborative, system-wide approach, integrating acute, community, and specialist care to meet the needs of individuals with chronic or complex conditions.		
Brisbane North PHN [48]	2021	Integrated Mental Health Service Hubs	The Brisbane North PHN Integrated Mental Health Service Hubs model emphasises the integration of clinical and non-clinical supports, which is critical for continuity of care. This includes	Effective communication between providers and with consumers is a central theme in the hubs model. The use of shared care plans and regular team meetings supports this	The hubs model was developed through a co-design process involving service users, carers, and other stakeholders. This approach ensures that the services are tailored to meet the needs of	The hubs model highlights the importance of a skilled and multidisciplinary workforce, including peer workers, to support the implementation of integrated care.	The document mentions the use of digital tools such as the Primary Mental Health Care Minimum Data Set (PMHC-MDS) and the Recovery Assessment Scale - Domain and Stages		

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			the use of individualised care plans and coordinated service delivery to ensure seamless transitions between services. The hubs aim to reduce duplication of services and improve communication between providers, which are essential for effective discharge planning and transfer of care.	communication, which is vital for safe and effective discharge planning. The document also highlights the need for better communication with external providers to ensure that consumers are connected to appropriate services post-discharge.	consumers and their carers, which is a crucial factor in successful discharge planning. Consumer feedback is actively sought through surveys and focus groups, and this feedback is used to refine service delivery.	This workforce could play a critical role in discharge planning by providing both clinical and psychosocial support. Challenges in implementation, such as data collection and reporting requirements, were noted. Addressing these challenges is essential for ensuring that discharge planning processes are effective and sustainable. The hubs model includes a focus on family-inclusive practice, recognising the role of carers in supporting recovery. This aligns with best practice in discharge planning, which involves engaging carers in the process. The document identifies the need for timely responses to referrals, particularly for consumers at risk of suicide. This highlights the	(RAS-DS) for tracking outcomes and supporting care planning. These tools could be adapted to support discharge planning by providing structured data on consumer needs and progress.		

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						importance of prioritising high-risk consumers in discharge planning			
Black Dog Institute [45]	NR	Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings	First follow-up contact within 7 days (preferably within 24-72 hours for high-risk individuals). Assertive follow-up required for: - Individuals with a diagnosed or suspected mental illness - Those at risk of homelessness - Those in domestic violence situations - Individuals with a history of poor treatment adherence Follow-up can include: - Face-to-face, phone, or telehealth contact - Crisis cards (listing emergency numbers) - Case management to ensure engagement with services - Regular appointment reminders	A written Clinical handover plan (CHP) should be provided before discharge and include: - Personalised treatment and support recommendations - Medication details (frequency, dosage, side effects) - Schedule of follow-up appointments (with contact details) - Emergency contact details (crisis support, after-hours mental health services) - Steps for relapse prevention (early warning signs, coping strategies) - Recommendations for reducing social isolation - Specific guidance for family/carers on supporting the person post-discharge Referral to appropriate aftercare services before discharge, ensuring: - Confirmation that services can accommodate the referral - Documentation of referral outcomes - Contact with GPs		A thorough psychosocial assessment prior to discharge is essential to identify the person's unique needs, risks, and protective factors. Assessment should cover: - Suicidality (lethality of attempt, history, ongoing intent) - Medical and psychiatric history (mental state examination, substance use, trauma exposure) - Psychosocial history and life stressors (family, social support, financial or occupational stress) - Protective factors (coping skills, engagement with help, social connectedness) - Barriers to accessing care (stigma, financial difficulties, reluctance) Peer support workers should: - Offer advocacy and emotional support - Accompany the			

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				and community-based services for continuity of care Hospitals should establish inter-agency protocols with community mental health services, NGOs and outreach programs, housing and social support services A clear communication system for sharing clinical handover information with relevant providers		person while waiting for consultation - Help with communication between the individual and clinical staff - Provide basic comforts (blankets, water, etc.) Ensure private and comfortable waiting areas to reduce distress. Use trauma-informed, compassionate approaches to avoid re-traumatization. Provide structured training for ED staff to improve responses to mental health crises.			
Network of Alcohol and Other Drugs Agencies [61]	2024	A Collaborative Approach to Transfer of Care: Practice Tips	Offer community-based resources such as: - Mental health crisis services - Drop-in clinics and community programs - Non-clinical services to reduce isolation and promote hope Ensure referrals align with the person's preferences (e.g., online or one-on-one support for those	Provide welcome packs that include: Emergency contacts and helplines Harm minimization services Key community support contacts Where possible, facilitate supported introductions to referred services, including: - In-person or virtual meet-and-greet sessions before discharge. - Accompanied visits	Co-design discharge plans with the consumer, ensuring they are actively involved in shaping their care. Peer workers can facilitate the process, making it more meaningful and empowering. Recognize the role of family, chosen family, culture, and community in the person's recovery and transition.	Ensure the plan is flexible, acknowledging that transitions can be difficult and not always linear. Align plans with existing services and supports, ensuring continuity of care. Ensure plans are realistic and achievable, considering the consumer's capacity and needs.		Regularly update welcome and exit packs based on feedback from consumers.	Frame discussions about discharge as a choice while prioritizing safety. Develop simple, personalized safety plans that address: - Steps to reduce risks related to substance use or mental health deterioration. - Emergency accommodation options. Strategies for harm minimization (e.g.,

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			uncomfortable in group settings).	to community services to build familiarity and confidence. Provide clear information about referral pathways and follow-up services. Keep discharge plans simple, practical, and tailored to the individual's needs. Use strength-based language that avoids medical jargon and sector abbreviations. Include at least one emergency or after-hours contact in every discharge plan.	Early engagement in discharge planning ensures clarity and allows for gradual adjustments Initiate discussions about discharge early in treatment, allowing expectations and plans to evolve over time. Ask consumers at the start what they want to happen if they choose to exit early or disengage. Acknowledge that trial and error may be necessary to find the right services for the individual.	Support holistic, long-term wellbeing, incorporating activities that provide social, cultural, faith, or community connections. Ensure discharge planning is trauma-informed and culturally sensitive. Recognize protective factors such as cultural identity and connection. Adapt services to meet the specific needs of diverse populations, including multicultural communities, refugees, Aboriginal and Torres Strait Islander individuals, and people with gambling or substance use issues			naloxone training for overdose prevention).
Australian College of Emergency Medicine [62]	2020	The Australasian College for Emergency Medicine (ACEM) Submission to the Queensland Government (2020)	All discharged mental health patients, particularly those with suicidal ideation or post-attempt care, should receive a follow-up phone call within 24 hours to: - Confirm appointments with GPs or community services.	Develop pre-crisis intervention plans in collaboration with police, ambulance, and community mental health teams.		Increase inpatient psychiatric beds to align with international best practice. Invest in step-up/step-down services, short-stay units, and hospital-in-the-home models to provide alternatives to ED		Implement mandatory reporting and review of any patient who waits longer than 12 hours in ED for mental health care. Conduct audits of restraint and sedation practices	Implement clear governance frameworks for restrictive practices. Train security and ED staff in de-escalation techniques to reduce restrictive interventions.

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			- Provide information on available crisis and aftercare services. - Reduce the risk of disengagement from mental health support.			stays. Expand after-hours mental health services, ensuring accessibility beyond standard business hours. Increase peer worker integration into EDs to provide non-clinical, lived-experience support. ACEM supports diversion models to reduce the burden on EDs and provide more therapeutic environments for individuals in crisis. Successful models include: (1) Psychiatric Alcohol and Non-Prescription Drugs Assessment (PANDA) Unit (St Vincent's Hospital, Sydney): A dedicated short-stay unit for people in mental health crisis with co-occurring substance use. (2) Mental Health Observation Area (MHOA) (Joondalup Health Campus, Perth): A separate ED unit with private interview rooms and overnight beds, providing calm,		in EDs and pre-hospital settings (e.g., ambulance or police custody).	

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						structured environments. (3) Homeless Healthcare Team (Royal Perth Hospital): Outreach support to prevent patients from being discharged into homelessness. (4) Safe Haven Café (St Vincent's Hospital, Melbourne): A non-clinical, peer-led alternative to EDs for individuals needing support rather than medical intervention.			
Australian Institute of Health and Welfare [47]	2021	Improving Indigenous mental health outcomes with an Indigenous mental health workforce	Culturally safe environments are crucial for effective mental health recovery after discharge. Training for non-Indigenous staff on cultural safety improves post-discharge engagement and reduces consumer distress. Embedding Indigenous concepts of social and emotional wellbeing in discharge planning ensures care aligns with cultural beliefs	Community-led mental health services improve continuity of care and discharge planning outcomes. Indigenous leadership in mental health services helps in designing culturally safe discharge plans that consider the person's connection to family, culture, and country. Aboriginal Community Controlled Health Services (ACCHS) improve post-discharge engagement, reducing readmission		Cultural safety and competency are critical in discharge planning, particularly for Indigenous consumers who often feel more comfortable receiving care from Indigenous mental health workers. There is a shortage of Indigenous mental health professionals, limiting access to culturally appropriate post-discharge support. Strengthening the Indigenous workforce increases consumer trust and			

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			and community support systems. Many Indigenous Australians experience distrust in mainstream services, affecting their willingness to engage in aftercare. Language barriers and lack of cultural understanding contribute to poorer discharge outcomes. Community-based and peer-led follow-up programs improve adherence to post-discharge care plans.	rates.		engagement, leading to better adherence to discharge plans. Collaborations between mainstream and Indigenous-led services improve transition-of-care pathways, ensuring continuous support after discharge. Mainstream mental health services should co-design discharge plans with Indigenous organizations to ensure ongoing culturally appropriate support. Coordination with community services (e.g., housing, employment, and social support) is essential to prevent post-discharge disengagement.			
Australian Government Department of Veterans' Affairs [63]	2020	DVA Discharge Planning Resource Guide	Consumers should receive follow-up contact within 24–48 hours post-discharge to monitor wellbeing, medication adherence, and engagement with community services Community nursing, allied health, and home-based services	Ongoing and clear communication between hospitals and community-based services is crucial to ensure continuity of care Consumers and carers should receive education about post-discharge care, including self-management	Where a consumer is too unwell to participate in discharge planning, carers should be actively engaged as primary representatives Carers should be provided with clear expectations regarding their role post-discharge,	Discharge planning should begin before or upon admission and involve all relevant healthcare providers, including medical specialists, nurses, allied health professionals, pharmacists, and community-based service providers Plans should be			Early identification of potential barriers to discharge (e.g., lack of social support, multiple medications, cognitive impairments) helps to prevent readmissions Ensuring appropriate mental health follow-up,

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			should be arranged where necessary Carers should be given post-discharge support, including counselling and peer-support options General practitioners (GPs) should be involved in discharge planning to ensure care continuity Discharge summaries, including medication changes and follow-up plans, should be promptly shared with primary care providers	strategies for medications, diet, and lifestyle adjustments Written information should be provided to assist with navigating community support services	including information about available support networks and respite care options	adaptable, regularly assessed throughout the hospital stay, and developed in collaboration with the consumer, their carer(s), and other support networks Special consideration should be given to consumers with complex health needs, including those at risk of homelessness or those with a history of suicide attempts or self-harm Discharge planning should account for consumers' home environments, ensuring that necessary supports are in place for safe reintegration into the community For those at risk of homelessness, linkages should be made to appropriate housing and accommodation services			especially for those discharged after a suicide attempt, is critical
WA Country Health Service [24]	2020	Admission, Discharge, and Intra-Hospital Transfer Clinical Practice Standard	Follow-up contact within 7 days post-discharge, or within 48 hours for high-risk consumers Community mental health teams must	Discharge summaries must be completed on the day of discharge and sent to GPs and other healthcare providers within 24 hours	Patients and their families must be actively engaged in care planning and decision-making Plans should be tailored to the	Discharge planning should be initiated upon admission to ensure a structured and timely transition Multidisciplinary care teams, including			Comprehensive risk screening for suicide, self-harm, cognitive impairment, substance use, and family violence must be conducted

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			conduct outreach and re-engagement strategies if a consumer disengages from care Peer support services and community-based programs should be integrated into post-discharge care	Verbal and written communication with the patient and carers should include medication instructions, safety plans, and follow-up appointments Electronic messaging should be used where possible to share patient information securely with external services	patient's individual needs, risk factors, and post-discharge environment	medical officers, nurses, allied health professionals, and community-based providers, must coordinate discharge plans Dedicated discharge coordinators or nurse facilitators should oversee care transitions Medical officers (MOs) are responsible for finalising discharge documentation, organising follow-up care, and ensuring clinical handover Allied health professionals play a crucial role in discharge planning, including social workers, physiotherapists, and occupational therapists			as part of the discharge process Blaylock Risk Assessment Screening Score should be used to predict discharge needs and complexity Patients should not be discharged into homelessness, and housing support should be coordinated when needed Medication reconciliation must be completed before discharge to prevent errors Legal requirements must be followed when discharging patients under involuntary care Safety planning and referrals to domestic violence services should be included in discharge planning Patients requiring additional support should have transport arranged to prevent delays in accessing care

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WA Country Health Service [42]	2020	Mental Health Case Management Policy	Consumers are assigned a Case Manager upon entry into mental health services, who remains involved throughout their care, including post-discharge follow-up Case Managers coordinate assessment, care planning, referrals, and ongoing support. They ensure that a crisis plan is in place for high-risk consumers. They maintain regular communication with General Practitioners (GPs), community health services, and carers If a consumer re-enters mental health services, they should be reallocated to their previous case manager when possible Community Case Managers remain involved when consumers are admitted to inpatient psychiatric units to support discharge planning Inpatient teams must work closely with community services	Consumers should receive a written copy of their discharge plan, including medication details, follow-up contacts, and crisis support options	Consumers, carers, and family members should actively participate in planning their discharge and ongoing care Consumers are encouraged to co-design their care plan, using their own language and selecting which supports to involve	Discharge planning must be tailored to individual needs, with specific support for Aboriginal consumers and gender preferences where possible A Recovery-Oriented Management Plan is developed in collaboration with the consumer, specifying treatment goals and post-discharge needs The plan must be reviewed at least every three months to adapt to changing needs Transfer of care procedures must ensure that responsibility is clearly transferred to a receiving provider before discharge			Consumers should not be discharged into homelessness or unsafe environments—linkages to housing services must be arranged where needed Follow-up contact should occur within seven days, and high-risk consumers should be contacted within 48 hours Carers and consumers must be informed of re-entry options and crisis support services

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			to ensure continuity post-discharge						
ACT Health [64]	2021	Emergency department and mental health interface	Consumers discharged from ED should receive follow-up within 24-48 hours, particularly if they are at risk of disengagement Those referred to community mental health teams must have an assigned case manager to ensure continuity of care If a consumer leaves the ED before completing an assessment, efforts should be made to contact them and arrange further support	A discharge summary must be faxed to the consumer's GP and provided to community mental health teams for follow-up	Consumers and carers should actively participate in planning their discharge, ensuring informed decisions and engagement with follow-up care	Discharge planning begins upon presentation to the ED to ensure a structured and coordinated transition ED teams, mental health consultation liaison (MHCL) teams, community mental health teams, and inpatient units must work together to coordinate care transitions Mental Health Consultation Liaison (MHCL) Team provide 24/7 service supporting ED staff in assessing and managing mental health presentations Discharge and Transfer Protocols Comprehensive assessment includes a mental state examination, risk assessment, and treatment history before a discharge decision Consumers discharged from ED should have an interim safety plan and referrals to			Grey Response Team provide rapid-response intervention for escalating aggression or behavioural disturbances in ED Code Black is the emergency response for severe aggression or violence to ensure staff and patient safety Seclusion and restraint should be used only as a last resort and documented according to the Mental Health Act 2015 All mental health consumers in ED must undergo a comprehensive risk assessment before transfer or discharge Consumers with a history of aggression or self-harm require enhanced monitoring, risk assessment, and secure transportation to

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						community services such as the Access Mental Health Team Consumers not admitted post-suicide attempt must be referred to community crisis response teams for continued monitoring			inpatient units if needed For children and adolescents, mental health assessment should be child-centred, involving guardians and youth-specific services (e.g., CAMHS) Patients with co-occurring substance use disorders should be referred to Alcohol and Drug Consultation Liaison Services for coordinated support post-discharge Patients at risk of homelessness should not be discharged without a housing support referral
National Disability Insurance Agency [41]	2023	Mainstream and Community Supports Interface	Timely discharge should be linked to available community-based mental health services to prevent gaps in care	Ongoing communication between hospitals and community providers is crucial for continuity of care A discharge summary must be completed and sent to the general practitioner (GP) and relevant health professionals	The consumer and their carer should be consulted throughout the process, ensuring they have the necessary knowledge and resources to manage post-discharge care Consumers should receive education and self-management tools,	Discharge planning should start at admission and involve a multidisciplinary team, including clinicians, general practitioners, occupational therapists, nurses, pharmacists, and allied health professionals			The responsible medical officer must verify clinical stability before discharge Transport and medication management should be finalised at least 24 hours before discharge, with proper instructions

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				within 24 hours of discharge Clinical handover must use structured frameworks like iSoBAR (Identify, Situation, Observations, Background, Agreed plan, Read back) to ensure information is accurately transferred Secure electronic messaging or fax should be used to transmit discharge summaries to GPs and community health teams	including medication management, lifestyle adjustments, and access to community support Carers play a critical role in post-discharge support, and their ability to provide care should be assessed, with options for respite services and other supports provided	Child and Adolescent Mental Health Services (CAMHS) must be involved for under-18 patients, ensuring specialist follow-up support For patients with substance use concerns, timely referral to Alcohol and Drug Services is recommended			provided to consumers and carers If a consumer discharges against medical advice, procedures must be followed to ensure safety and documentation Patients at risk of homelessness should be linked with housing and social support services

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