CF OPERATING PROCEDURE
NO. 155-17

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, April 17, 2020

Mental Health/Substance Abuse

GUIDELINES FOR DISCHARGE OF CIVIL RESIDENTS FROM A STATE MENTAL HEALTH TREATMENT FACILITY TO THE COMMUNITY

1. Purpose. This operating procedure describes processes to be followed when planning for and discharging a civil resident to the community from State Mental Health Treatment Facilities (SMHTF) operated by the state or via a contract with a provider.

2. References.

a. Chapter 394, Florida Statutes (F.S.), Florida Mental Health Act.

b. Chapter 916, F.S., Forensic Client Services Act.

c. Chapter 400, F.S., Licensed Facilities.

d. Chapter 744, F.S., Guardianship.

e. Chapter 65E-5, Florida Administrative Code (F.A.C.), Mental Health Act Regulations.

f. CFOP 155-58, Guidelines for Assisting State Mental Health Treatment Facility Residents Who May Benefit from Appointment of Public Guardianship.

g. CFOP 155-27, Guidelines for Pre-Release Referral of Residents in State Mental Health Treatment Facilities for Social Security Benefits and Insurances and for the Institutional Care Program (ICP) Medicaid.

3. Scope. This operating procedure applies to persons residing in a Civil State Mental Health Treatment Facility committed pursuant to Chapter 394, F.S., due to mental illness. The facilities include West Florida Community Care Center, Florida State Hospital, Northeast Florida State Hospital, and South Florida State Hospital.

4. Definitions. As used in this operating procedure, the following terms shall mean:

a. SMHTF Program Office Benefits Coordinator. An employee with the ACCESS program and consultant to the SAMH SMTHF Policy and Program Office. The Benefits Coordinator provides technical assistance about the eligibility criteria and benefits status to the facility liaison at the State Mental Health Treatment Facility for residents who are being discharged to the community.

b. Community Representative. An individual who works with residents and their families, community service providers, and the recovery team to ensure continuity of care. The Community Representative employed by the Managing Entity or contracted community provider assesses resident needs, plans services, links the resident to services and supports, assists in securing community placement, monitors service delivery and evaluates the effectiveness of service delivery. The

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community liaison, FACT Team leaders/case managers, forensic specialist, forensic case manager, and any other community staff may function as a civil or forensic resident's Community Representative.

c. Direct/Community Discharge. The planned release of a resident to the community under the direction of the mental health treatment facility administrator and/or designee.

d. Discharge Ready. The resident's psychiatric condition has improved so that the resident no longer requires continued inpatient psychiatric treatment in a SMHTF.

e. Express and Informed Consent (hereafter referred to as consent). Permission voluntarily given in writing by a capable person, after sufficient explanation and disclosure of the subject matter involved, to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

f. Facility Benefits Coordinator. Designated staff at each facility who are responsible for the coordination of benefits and liaison to the local social security office. These functions may be coordinated with designated staff within the social services department. Training will be provided to other staff at least annually by the facility benefits coordinator or designated staff on facility specific processes including benefit coordination during admission and discharge. They will also provide any changes to the pre-release agreement as defined in CFOP 155-27.

g. Guardian. A person who has been appointed by the Court to act on behalf of a resident's person, property, or both, pursuant to s. 744.102(9), F.S.

h. Level of Care Utilization Scale (LOCUS). A quantifiable measure used to guide individual assessments resulting in level of care decisions. The LOCUS consists of six clinical and rehabilitative dimensions for composite scoring which corresponds with a particular level of care. Training on the administration and use of the LOCUS is required for all recovery team members providing input into the scoring of the LOCUS.

i. Managing Entity (ME). As defined in s. 394.9082(2)(b), F.S., an entity that manages the delivery of behavioral health services.

j. Mosher v. State. A 2004 1st District Court of Appeals (DCA) ruling (876 So.2d 1230) which requires civil commitment proceedings or release from commitment when a defendant remains without a substantial probability of regaining competency in the foreseeable future, and the defendant has less than five years of involuntary commitment under section 916.13, Florida Statutes.

k. Peer Specialist (PS). Designated staff who provide support services, serve as a peer advocate and provide information and linkage to additional services to meet the needs of the individual and/or family member. PS provides support in a variety of settings and performs a wide range of tasks to support individuals and/or families in directing their own recovery and wellness.

l. Resident. Person who receives mental health treatment services in a civil mental health treatment facility operated by the state or via a contract with a provider. The term is synonymous with "client", "consumer", "individual", "patient", or "person served".

m. Recovery Plan. A written plan developed within 30 calendar days of admission by the resident and his or her recovery team. This plan is based on assessment data, identifying the resident's (individual) clinical, rehabilitative, and quality of life/enrichment service or recovery needs, the strategy for meeting those needs, documented treatment and recovery goals and objectives, criteria for terminating the specified interventions, and services and supports needed for discharge. Also referred to as the "plan." The recovery plan is reviewed at least every 30 calendar days.

n. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan, including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), Community Representative, family member and other treatment professionals as determined by the resident's needs, goals, and preferences.

o. Resident Advocate. An individual whose primary job is to assist the resident in meeting the resident's expressed needs separate and apart from the Recovery Team process.

p. State Mental Health Treatment Facility (SMHTF). A facility operated by the Department of Children and Families or by a private provider under contract with the Department to serve individuals committed pursuant to Chapter 394, F.S., or Chapter 916, F.S.

5. Responsibilities.

a. Facilities. It is the responsibility of facilities to accept persons for psychiatric care pursuant to the provisions of Chapter 394, F.S. Facilities will stabilize; provide treatment; provide competency restoration training and evaluation as appropriate; provide rehabilitation and enrichment services; and prepare the person for a successful return to the community. In addition, the facilities will notify the resident's Community Representative of resident's admission within seventy-two hours, provide notification of the Recovery/Discharge Planning meeting and monthly recovery team meetings.

b. Recovery Teams. It is the responsibility of the recovery teams to conduct initial observations and assessments and, in conjunction with the development of the recovery plan, develop a plan of expected services and supports needed upon discharge. The recovery team will update and revise the recovery plan every 30 days as necessary and provide necessary documentation to potential service providers. These responsibilities will be completed in collaboration with the Community Representative.

c. Community Representative. It is the responsibility of the Community Representative to participate in the development of the recovery plan and identify services and supports needed for the resident's return to the community. The Community Representative will research resources for needs identified by the recovery team, participate in the discharge planning meeting, secure community placement and services in cooperation with state treatment facility social worker/discharge planner, maintain contact with the facility discharge planner and social services staff, and ensure recommended services are received after the individual's discharge. The Community Representative will be involved in discharge planning as specified in CFOP 155-18 and CFOP 155-22 for individuals committed pursuant to Chapter 916, F.S.

d. Region Staff. Region staff are responsible for contract management and oversight of the Managing Entity or other contracted provider to ensure continuity of care for individuals returning to the community from the SMHTF. The Managing Entity or other contracted provider will develop needed services/supports not readily available to persons preparing for discharge from the state mental health treatment facilities and monitor provision of all recommended services upon discharge through designated case management providers.

6. Standards.

a. Discharge Planning.

(1) Begins at the time of admission and continues throughout the duration of the hospitalization.

(2) Specifies the supports and services a person will need and want when returning to the community and informs the Recovery Team regarding actions to be taken to address these needs and wants including:

(a) Verification that the resident has sufficient identifying documents to support application for benefits and/or state issued identification card including as appropriate: birth certificate, marriage certificate(s), driver's license, current passport, social security card, or U.S. Military issued photo-ID;

(b) Verification that persons returning to the community are eligible for reinstatement of pay status upon discharge. Evidence of this verification and the eligibility shall be provided to the Community Representative and or ME;

(c) Assistance in developing a social support system in the community;

(d) Preparation for employment upon discharge if appropriate;

(e) Preparing the resident to take as much responsibility as possible for addressing their medical and psychiatric needs upon discharge; and,

(f) Determine need for guardianship as outlined in CFOP 155-58; Guidelines for Assisting State Mental Health Treatment Facility Residents Who May Benefit from Appointment of Public Guardianship, if applicable.

(3) Allows the resident to make an informed choice for placement and services if not mandated by the Court.

(4) Includes determination as to whether the resident is under a criminal charge or court hold, and notification of the appropriate law enforcement agency of the resident's expected discharge date if the resident is under a criminal charge, to facilitate transfer of custody of the resident to the appropriate law enforcement officer upon discharge.

(5) Requires participation of the following people:

(a) Resident and/or legal guardian;

(b) Recovery/treatment team members; and,

(c) Community Representative.

b. Discharge Criteria.

(1) Discharge criteria for residents committed pursuant to Chapter 394, F.S., are met when the Recovery Team determines that the resident's psychiatric condition has improved so that the resident no longer:

(a) Is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services;

(b) Is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and,

(c) Is likely to inflict serious bodily harm to him/herself or another person in the near future, as evidenced by recent behavior causing, attempting, or threatening such harm, as specified in Chapter 394, F.S.

(2) The discharge criteria for residents committed pursuant to Chapter 394, F.S., as a result of Mosher vs. State, 876 So.2d 1230 (Fla. 1st DCA 2004) are outlined in CFOP 155-13.

c. Discharging Voluntary Residents Committed Pursuant To Chapter 394, F.S.

(1) A facility will discharge a voluntary resident who has sufficiently improved so that placement in the facility is no longer desirable or when a voluntary resident revokes consent to admission or requests discharge.

(a) A voluntary resident who revokes consent to admission or requests discharge will be evaluated to determine if the resident meets criteria for involuntary commitment. Discharge planning will continue when involuntary commitment is not warranted based upon evaluation outcomes.

(b) A voluntary resident or relative, friend or attorney of the resident may request discharge either orally or in writing at any time following admission to the facility.

(c) The resident must be discharged within 24 hours of the request, unless the request is rescinded, or the resident is changed to involuntary status pursuant to Chapter 394, F.S. The 24-hour time-period may be extended by the facility when necessary for adequate discharge planning, but will not exceed three working days.

(d) The request will be documented in the resident's clinical record.

(e) Express and informed consent must be obtained if a person other than the resident makes the request for discharge.

(2) Recovery teams will develop individual treatment interventions to address voluntary persons who refuse discharge.

d. Discharging Involuntary Residents Committed Pursuant To Chapter 394, F.S.

(1) At any time a resident is found to no longer meet the criteria for involuntary placement, the administrator shall:

(a) Discharge the resident, unless he/she is under court hold or criminal charge; or,

(b) Transfer the resident to voluntary status, unless he/she is under criminal charge or adjudicated incapacitated:

1. Before the transfer to voluntary status is processed, the mandatory initial involuntary examination must have been performed by a physician or clinical psychologist, and a certification of the person's competence to provide express and informed consent to treatment must be completed by a physician;

2. Such a transfer is contingent on the person meeting the criteria for voluntary status, which should be documented by an Application for Voluntary Admission (form CF-MH 3098, available in DCF Forms) and a Certification of Person's Competence to Provide Express and Informed Consent (form CF-MH 3104, available in DCF Forms); and,

3. When transfer to voluntary status occurs, notice must be provided to the person, the person's guardian advocate, attorney, case manager and representative.

(2) At discharge the facility administrator or designee shall provide prompt written notice of the discharge of an involuntary resident in the form of CF-MH 3038, "Notice of Release or Discharge" (available in DCF Forms), to the resident, guardian, guardian advocate, representative, initiating professional, Community Representative, and circuit court, with a copy retained in the resident's clinical record.

e. Discharging Residents with a Previous Commitment Pursuant to Chapter 916, F.S. Residents with a previous commitment pursuant to Chapter 916, F.S., who had their charges dismissed may require a 30-day notification to the state attorney prior to discharge, if required in the order of dismissal. Commitment orders will be reviewed for court notification requirements during initial discharge planning.

f. Pursuant to section 429.075, F.S. an Assisted Living Facility (ALF) that serves one or more mental health residents must obtain a limited mental health license. Residents will not be discharged to an ALF that does not have a limited mental health license.

7. General Procedures.

a. SMHTF Responsibilities.

(1) The facility will provide notification to the Social Security Administration when a resident who has been receiving social security benefits has been admitted to the SMHTF.

(2) The recovery team will develop a recovery/discharge plan within 30 days of admission. This plan addresses discharge barriers, discharge criteria and specific resident-centered goals and objectives related to community placement as well as other clinical, rehabilitative and enrichment interventions. This plan includes input from the resident, Community Representative, family, guardian and others as appropriate.

(3) The LOCUS must be administered for all residents committed pursuant to Chapter 394, F.S. (Baker Act). The LOCUS will be completed using input from the resident's recovery team. Issues identified on the LOCUS shall be provided to the Recovery Plan Coordinator for inclusion in the resident's recovery plan or justification for not addressing identified issues shall be documented in a progress note. The LOCUS will be completed as follows:

(a) Within 14 days of the resident's admission to the facility;

(b) Within 14 days of each six-month anniversary of the resident's admission; and,

(c) Within 14 days of the resident's actual discharge from the facility. If a resident is discharged unexpectedly and the discharge LOCUS has not been completed prior to departure, the LOCUS may be completed by the staff involved in the resident's treatment within five (5) working days of the resident's discharge (in absence of the resident).

(4) A copy of the Recovery plan will be placed in the resident's clinical record. The Recovery plan will address the following issues to meet the resident's needs:

(a) Financial resources;

(b) Employment and education;

(c) Physical and mental health;

(d) Living environment;

(e) Self-care capabilities;

(f) Relationships (i.e., family/guardian, significant other);

(g) Legal status and Competency Restoration Services (as appropriate);

(h) Special needs;

(i) Transportation;

(j) Aftercare and support services including medication management;

(k) Leisure activities;

(l) Non-Citizenship Issues; and,

(m) Public Guardianship (as needed).

(5) The recovery team maintains regular and ongoing reviews of the resident's readiness for discharge and updates the plan as necessary. The Community Representative and the ME are informed regarding resident discharge status.

(6) Designated facility staff should communicate monthly with the Community Representative and provide them with a schedule of the resident's recovery plan meetings.

(7) During the discharge planning process, the resident's recovery team and/or designated state mental health treatment facility staff will:

(a) Review the current commitment order to verify all court notice requirements are met;

(b) Determine the benefits status and submit application. Assist the resident in obtaining financial resources as necessary for funding community placement and services prior to discharge; assist in the initial application for benefits and disability determination and verify that persons returning to the community are eligible for reinstatement of pay status upon discharge. The Benefits Coordinator or identified facility staff should track the status of the resident's application for benefits;

(c) Verify that the resident has sufficient identifying documents to support application for benefits and/or state issued identification card including, as appropriate, birth certificate, marriage certificate(s), driver's license, current passport, social security card, or U.S. military issued photo-ID;

(d) Work in collaboration with the Community Representative by arranging site visits and submitting referral packets to the Community Representative;

(e) Coordinate the documentation and paperwork required for acceptance into community placement/services;

(f) Coordinate the completion of the State Mental Health Facility Discharge (form CF-MH 7001) in conjunction with the recovery team and submit the completed form 7001 to the Community Representative prior to discharge;

(g) Provide the Community Representative with at least seven days' notice of the anticipated discharge date or three days' notice when a resident is court ordered or is voluntary and requests discharge;

(h) In collaboration with the Community Representative, assist in developing a social support system in the community for the resident, prepare resident for employment upon discharge, if appropriate help prepare resident to take as much responsibility as possible for addressing their medical and psychiatric needs upon discharge; and,

(i) If the resident is under a criminal charge at the time of discharge, the administrator shall transfer the resident to the custody of the appropriate law enforcement officer upon discharge.

(8) Once an appropriate placement and all identified necessary services have been secured, the resident will be scheduled for discharge.

(9) On the day of discharge, the referring physician or in absence of the physician, the designated charge nurse, will complete form CF-MH 7002 (Physician to Physician Transfer, available in DCF Forms). The completed form will accompany the resident and be given to the aftercare provider or entity responsible for dispensing or administering medications.

(10) Facility Administration or designee shall be notified in instances where discharge planning is impeded or prevented due to lack of financial resources, community resources, legal barriers, inability to reach consensus by the recovery team, or any other barrier. If matters are still unable to be resolved in a timely manner, the facility will notify the Chief Hospital Administrator or Designee for resolution.

(11) Documentation.

(a) The following documents must be completed, distributed, and maintained in accordance with Rule 65E-5, F.A.C., and as part of the resident's clinical record:

1. Discharge Form – form CF-MH 7001 or equivalent;

2. Notice of Release or Discharge – form CF-MH 3038 (for involuntary residents only); and,

3. Physician to Physician Transfer Form – form CF-MH 7002 or equivalent.

(b) A Circuit Transfer Request (form CF-MH 1072, available in DCF Forms) must be completed and sent to the managing entities involved for signature when a resident is being discharged outside of the resident's home circuit.

(12) Tracking Residents Ready for Community Placement.

(a) The SMHTFs shall develop and document a process to track residents who are expected to be discharge ready within the next 30 days for residents committed pursuant to Chapter 394, F.S. Notification shall be provided to the community within one business day when this determination has been made by the recovery team.

(b) The tracking document shall include the following information:

1. Date of admission;

2. Legal status;

3. Date court order expires;

4. Responsible managing entity;

5. Date community placement readiness was determined;

6. Potential barrier(s) to community placement;

7. Date Community Representative notified;

8. FACT or FMT referral made and date;

9. Date of discharge;

10. Name and type of placement upon discharge;

11. Date of aftercare appointment, and;

12. Level of services upon discharge.

(c) This tracking document should be updated at least monthly and shared with the Community Representative and Managing Entity. Data from this list will be made available upon request from the SMHTF program office.

(13) The facility will develop and document a process to ensure residents are not at the facility without a current court order. This process should include a plan for community placement when a petition to recommit is denied and a judge orders someone must be discharged.

b. Community Representative/Case Manager Responsibilities.

(1) Participate in the development of the recovery/discharge plan within the first 30 days of admission and attend monthly recovery plan review meetings to:

(a) Assure a common understanding of the resident's clinical conditions;

(b) Assure a common understanding of needed services and supports for discharge;

(c) Identify any other necessary information; and,

(d) Agree on responsibility for obtaining the necessary information.

(2) Locate community housing and services to address the resident's needs and address potential community barriers and assist with conditional release planning. Placement and supports should be identified within 30 days of becoming ready for community placement for residents committed under Chapter 394, F.S.

(3) If a resident does not have housing and community services arranged within the above time frames, the facility including Hospital Administrator or designee and Community Representative should be involved in resolving barriers and meet weekly to aggressively pursue resolution of discharge barriers.

(4) The Community Representative shall locate placements and services in the community for the resident in collaboration with facility staff. The facility, Managing Entity, and community should work in collaboration to ensure a "warm hand off" and expedite placement for each resident back into the community.

(5) Notify the mental health treatment facility once placement and services have been secured.

(6) Work with the receiving facilities prior to admission to ensure possession of current and valid identification cards as available and retain copies of those documents in the individual's community files to facilitate access to benefits upon return to the community.

c. The Department's Facility Headquarters Staff Responsibilities.

(1) Monitor and track statewide performance on discharge and length of stay of individuals served in civil and forensic SMHTFs.

(2) Work in collaboration with Mental Health Treatment Facilities, SAMH Regions and Managing Entities to make data driven decisions to improve the statewide admission and discharge process.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JACQUELINE A. YOUNG
Director, State Mental Health Treatment Facilities, Policy and Programs

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

Retitled the operating procedure and revised intent and scope to apply only to civil residents committed pursuant to Chapter 394, F.S. (the Baker Act). Removed all references to residents committed pursuant to Chapter 916, F.S.