



Central Florida Cares  
Health System

**State Mental Health Treatment Facility Discharges:  
Plan for Reintegration of Individuals to the Community**

*FY 2017-2018*

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**CENTRAL FLORIDA CARES HEALTH SYSTEM**  
**State Mental Health Treatment Facility Discharges:**  
**Plan for Reintegration of Individuals to the Community**

## **INTRODUCTION**

Central Florida Cares Health System, Inc. (CFCHS) oversees state-funded mental health and substance abuse treatment services in Circuits 9 and 18 (Brevard, Orange, Osceola, and Seminole counties). As a managing entity, CFCHS' vision is to achieve a comprehensive and seamless behavioral health system promoting recovery and resiliency for individuals in our community. In an effort to improve coordination of services, CFCHS has implemented procedures for the continuity of care for individuals discharged from State Mental Health Treatment Facilities (SMHTF) through the oversight of 1 full-time employee (FTE), the System of Care Specialist. The Specialist is primarily responsible for the implementation of this plan, along with the coordination and oversight of network service providers that serve individuals with severe and persistent mental illness who have been committed to a SMHTF.

CFCHS contracts with Community Mental Health Treatment Centers in each of its covered counties to provide a Community Case Manager and/or Forensic Specialist for individuals residing in SMHTF. The Community Case Manager and/or Forensic Specialist coordinates admission and discharge planning for the civil and forensic systems. They track individuals during their state mental health treatment stay and post-discharge to ensure treatment engagement, stable housing, resumption or acquisition of benefits, and meaningful involvement in the community.

## **PURPOSE AND SCOPE**

The purpose of this plan is to provide an overview of the coordination of services for individuals in SMHTF who are ready to be re-integrated into the community. In collaboration with subcontracted provider agencies, the Department of Children and Families (DCF), SMHTFs, judiciary system and other local stakeholders, the goal is to ensure that services and placement options meet the individual's needs upon release from the SMHTF.

CFCHS adheres to the continuity of care guidelines in accordance with the following state requirements:

- Chapter 394, Florida Statutes
- CFOP 155-17, Guidelines for Discharge of Residents from a State Civil Mental Health Facility to the community.
- CFOP 155-18, Guidelines for Conditional Release Planning for Individuals Found Not Guilty by Reason of Insanity or Incompetent to Proceed Due to Mental Illness
- Program Guidance for Managing Entity Contracts- Guidance 7: Forensic and Civil Treatment Facility Admission and Discharge Processes

## RESPONSIBILITIES OF CFCHS AND NETWORK PROVIDERS

### Central Florida Cares Health System <sup>1</sup>

CFCHS recognizes that continuity of care is a key factor in successfully re-integrating individuals ready for discharge from SMHTF to a less restrictive setting in the community. CFCHS responsibilities in management of SMHTF discharges includes:

- Monitoring the discharge responsibilities of the Community Mental Health Treatment Centers and assure that all requirements and duties as expressed and referenced in Florida Statutes and Florida Administrative Codes are being satisfied prior to discharge from the SMHTF.
- Work with DCF and SMHTF to engage in appropriate protocols for the placement of persons involved in the civil and forensic systems when discharge-ready. The goal of these efforts will be to ensure that placements occur in accordance with the time frames specified in the Seeking Placement List (SPL) process: 30 days after placement on the SPL for Chapter 394 F.S., civil residents; and 90 days after placement on the SPL for Chapter 916 F.S., forensic residents.
- Collaborate with DCF, SMHTF and Community Case Manager/Forensic Specialist in finding solutions to resolve community issues related to discharging individuals from SMHTF.
- Assist in the implementation of the Continuity of Care Guidelines as agreed upon by DCF and the SMHTF.
- Ensure that monthly recovery plan meeting schedules are disseminated to the Community Case Managers/Forensic Specialist to participate in those meetings.
- Manage the efficiencies of CFCHS network providers for discharging individuals placed on the Integrated Seeking Placement List (SPL).
- Coordinate monthly conference calls to review civil clients awaiting discharge past 30 days.
- Coordinate monthly conference calls to review forensic clients awaiting discharge past 90 days.

### Community Case Manager<sup>2</sup>

In compliance with 394, F.S., CFCHS contracts with three Community Mental Health Treatment Centers to provide case management services for each civil resident of a SMHTF whose home county is within CFCHS geographic area. It is the responsibility of the Community Case Manager for persons committed pursuant to Ch. 394, F.S. to participate in the development of the discharge plan and identify services and supports needed for the individual's discharge. The Community Case Manager is responsible for providing the following services:

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<sup>1</sup> Reference- CFCHS policy: Adult Mental Health- State Mental Health Treatment Facilities

<sup>2</sup> Reference- CFOP 155-17 and ME Guidance Document 7

- Participate in recovery team meetings when possible to anticipate and remedy possible barriers to community placement during discharge planning;
- Participate in the discharge planning meeting and assist in the development of a discharge plan which addresses the needs of the client in the community. The purpose of this meeting is to initiate activities and planning which will result in the provision of community services which will most appropriately address the resident's needs upon discharge, and:
  - Assure a common understanding of the resident's clinical conditions;
  - Assure a common understanding of needed services and supports for discharge;
  - Identify any other necessary information; and,
  - Agree on responsibility for obtaining the necessary information.
- Secure placement and needed services and supports;
- Notify the SMHTF once placement and services have been secured;
- The Community Case Manager will also work to ensure possession of current and valid identification cards and retain copies of those documents in the individual's community files to facilitate access to benefits upon return to the community.
- Maintain at least monthly contact with the SMHTF staff concerning the status of the individual.
- Maintain contact with the individual's family consistent with *Chapter 394, F.S.*
- Share relevant information with the SMHTF staff.
- Participate in the discharge planning meeting and assist in the development of a service plan which addresses the individual's needs in the community.
- Actively carry out linkage and brokerage activities in the community prior to the individual's discharge in order to implement the service plan. Secure community placement and services in cooperation with State Mental Health Treatment Facilities social worker and discharge planner.
- Have a face-to-face contact with the individual in the community within 2 working days of discharge from the SMHTF; and
- Maintain progress notes in the client record reflecting all meetings and communications with SMHTF staff, the client, the family or significant others.
- Ensure recommended services are received after the client's discharge.

### **Forensic Specialist<sup>3</sup>**

Each Community Mental Health Treatment Center will have a Forensic Specialist who will provide an array of services to individuals with felony charges who have been Court ordered for a mental competency or sanity evaluation or have been committed to the Department of

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<sup>3</sup> References- CFOP 155-18 and ME Guidance Document 7



Children and Families under the provisions of Chapter 916, F.S. The Forensic Specialist will be involved in discharge planning as specified in CFOP 155-18. Services related to discharge planning will include:

- Participate in recovery team meetings when possible to anticipate and remedy possible barriers to community placement during discharge planning;
- Participate in the discharge planning meeting and assist the treatment facilities and appropriate court personnel in the development of conditional release plans.
- Work consistently with the SMHTF staff to ensure an individual with forensic involvement is placed in the least restrictive environment in a timely manner.
- Attend quarterly meetings with individuals at SMHTF and assist with discharge planning.
- Locate appropriate community placements and arrange for needed aftercare services for individuals determined appropriate for discharge.
- Provide or ensure the provision of information to the Courts and the attorneys pertaining to the individual's treatment in the state treatment facilities as requested. Attend all scheduled court hearings involving individuals with mental illnesses who are adjudicated or at risk of being adjudicated, Incompetent to Proceed or not Guilty by Reason of Insanity, including the determination of competency hearings.
- The Forensic Specialist will work to ensure possession of current and valid identification cards and retain copies of those documents in the individual's community files to facilitate access to benefits upon return to the community
- The Forensic Specialists will work with the hospital discharge planner to identify appropriate, available services. Forensic specialist coordinates any treatment services, including case management and any other services as identified in the discharge plan.

## **REINTEGRATION OF INDIVIDUALS DISCHARGED FROM SMHTF**

Practices for reintegrating individuals back into the community, at a minimum, includes the following:

1. Upon email notification from the SMHTF staff that an individual has been placed on the SPL, CFCHS will forward the information to the Community Case Manager/Forensic Specialist to develop discharge plans for those individuals on the SPL awaiting community placement.
2. Behavioral health services shall be provided to persons pursuant to s. 394.674, F.S., including those individuals who have been identified as requiring priority by state or federal law. These identified priorities include individuals who reside in civil and forensic SMHTFs<sup>4</sup>. Depending on client needs and program eligibility criteria, services within CFCHS' network will be made available to individuals being discharged from SMHTF for continuity of care. These services may include FACT, Care Coordination,

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<sup>4</sup> Reference- ME Contract GHME1

residential treatment, outpatient services, medication management, and Forensic Multidisciplinary Team.

3. The Community Case Manager/Forensic Specialist will work towards engaging clients in treatment, locate stable housing, resumption or acquisition of benefits and linkages to available services that may meet the needs of the clients.
4. Community Case Manager/Forensic Specialist will maintain contact with the SMHTF discharge planners on community placements options to include barriers on placements. The Community Case Manager/Forensic Specialist will notify the SMHTF when placement is located and arrange for needed aftercare services for individuals determined appropriate for discharge. This includes a referral to Care Coordination. The Care Coordinator will take over once the client has been discharged and is residing in their community placement.
5. CFCHS will obtain updates on efforts made to locate appropriate placement for individuals on discharge status from the Community Case Manager/Forensic Specialist and provide technical assistance with placement options, when necessary. Information on barriers for re-integration into the community is shared with CFCHS management to review current system of care and make possible changes to address the barriers.
6. The Community Case Manager/Forensic Specialist will ensure that aftercare services will be in place upon discharge when clients are placed outside the CFCHS geographic area. The Forensic Specialists and Forensic Coordinators from both circuits will work cooperatively to develop and review the conditional release plan prior to submission to the court. Mental health services will be provided by the circuit in which the individual will reside, unless alternative arrangements have been made. All reports to the court will be provided by the circuit providing services with copies provided to the other circuit.