



**STATE MENTAL HEALTH HOSPITAL TREATMENT FACILITY (SMHTF)
PLAN FOR REINTEGRATION OF INDIVIDUALS TO THE COMMUNITY**

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

INTRODUCTION

Central Florida Cares, Inc. (CFC) 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, CFC's vision is to achieve a comprehensive and seamless behavioral health system promoting recovery and resiliency for individuals in our community. To improve coordination of services, CFC has implemented procedures for the continuity of care for individuals discharged from State Mental Health Treatment Facilities (SMHTF) through the oversight of two full-time employees, the Civil Care Coordinator and Forensic Coordinator. These positions are Managing Entity level positions that are 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.

CFC contracts with Community Mental Health Treatment Centers in each of its covered counties to provide both a Community Case Manager and a Forensic Specialist for individuals residing in SMHTF. The Community Case Manager and 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 network service provider agencies, the Florida Department of Children and Families (Department), SMHTFs, judiciary systems and other local stakeholders, the goal is to ensure that services and placement options meet the individual's needs upon release from the SMHTF.

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

- Chapter 394, Florida Statutes
- Chapter 916, Florida Statutes
- CFOP 155-13, Incompetence to Proceed and Non-Restorable Status
- CFOP 155-17, Guidelines for Discharge of Residents from a State Civil Mental Health Facility to the Community
- CFOP 155-22, Leave of Absence and Discharge of Residents Committed to a State Mental Health Treatment Facility Pursuant to Chapter 916, Florida Statutes
- Program Guidance for Managing Entity Contracts- Guidance 7: State Mental Health Treatment Facility Admission and Discharge Processes

RESPONSIBILITIES OF CFC AND NETWORK PROVIDERS

Central Florida Cares ¹

CFC 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. CFC's 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, Florida Administrative Codes and CF Operating Procedures are being satisfied prior to discharge from the SMHTF.
- Work with the Department 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 following time frames: 30 days after being identified as discharge ready for Chapter 394 Florida Statutes (F.S.), civil residents; and 90 days after being identified as discharge ready for Chapter 916, F.S., forensic residents.
- Collaborate with the Department, SMHTF and Community Case Manager/Forensic Specialist in finding solutions to resolve community issues related to discharging individuals from SMHTF. This includes facilitating conference calls for complicated cases to ensure coordination of care.
- Ensure that monthly recovery plan and discharge plan meeting schedules are disseminated to the Community Case Managers and Forensic Specialists to participate in those meetings.
- Participate in recovery team meetings and discharge planning meetings when possible, to assist Community Case Managers and Forensic Specialists with barriers to community placements.
- 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.
- Work in collaboration with the SMHTF social services staff or discharge planner to identify independent living or supportive housing resources or to the identified level of care that best meets the treatment needs of the individual.
- Ensure coordination between the Community Case Manager/Forensic Specialist and the Social Security office occurs within five business days of discharge from the SMHTF for individuals who are discharged with benefits in pending status to ensure their benefits are activated.
- Ensure services recommended by the Community Case Manager/Forensic Specialist and SMHTF Recovery Team are available and accessible when resident is returned to the community by way of direct discharge from the SMHTF or release from jail.

¹ Reference- CFC policy: Adult Mental Health- State Mental Health Treatment Facilities

- Meet individually with Community Case Manager/Forensic Specialist on an as needed basis to review all individuals served, discuss appropriate housing options and efforts made in securing housing.
- Coordinate annual Network Provider Meeting to review fiscal year data, best practices, updates to guidelines and challenges to discharging residents.

Community Case Manager²

In compliance with Chapter 394, F.S., CFC 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 CFC geographic area. It is the responsibility of the Community Case Manager for persons committed pursuant to Chapter 394, F.S. to participate in the development of the discharge plan and identify services and support needed for the individual's discharge. The Community Case Manager is responsible for providing the following services:

- Participate in the development of the SMHTF recovery plan within the first 30 days of admission.
- Participate in monthly reviews of the recovery plan.
- 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.
- Actively carry out linkage and brokerage activities in the community prior to the individual's discharge to implement the service plan.
- Secure community placement and services in cooperation with SMHTF social worker and discharge planner.
- 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. This contact can be via email or during the virtual treatment team meetings.
- Maintain contact with the individual's family consistent with Chapter 394, F.S.
- Share relevant information with the SMHTF staff.

² Reference- CFOP 155-17 and ME Guidance Document 7

- Ensure recommended services are received after the client's discharge.
- Coordinate Social Security office visits within five business days of discharge from the SMHTF for individuals who are discharged with benefits in pending status to ensure their benefits are activated.
- Maintain progress notes in the client record reflecting all meetings and communications with SMHTF staff, the client, the family or significant others.

Forensic Specialist³

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 Children and Families under the provisions of Chapter 916, F.S. The Forensic Specialist will be involved in discharge planning as specified in CFOP 155-22. Services related to discharge planning will include:

- Collaborate with the Forensic SMHTF facility staff to develop the recovery plan.
- Participate in monthly reviews of the recovery plan.
- Maintain at least monthly contact with the SMHTF staff concerning the status of the individual. This contact can be via email or during the virtual treatment team meetings
- Provide the SMHTF recovery teams with all available community information required to assist with the individual's treatment.
- Participate in the discharge planning meeting and assist the Forensic SMHTF 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.
- Advocate for individuals with non-violent offenses to prioritize their discharge from SMHTF's despite their restoration status.
- 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.
- Work to identify and coordinate appropriate treatment services including case management, residential treatment, and any other services as identified in the discharge plan.
- 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.

³ References- CFOP 155-18 and ME Guidance Document 7

- Work closely with the individual, interested family members when authorized, the treatment facility recovery team, and placement sites to locate appropriate community placements and arrange as needed aftercare services for individuals determined appropriate for discharge.
- Perform home visits, as requested, by SMHTF or CFC.
- Monitor individuals on Leave of Absence (LOA) status, attend any court hearings and report status changes to the SMHTF recovery team and forensic coordinator. The community representative must ensure that residents released by order of the court while on LOA status are assigned to a community representative and linked to appropriate community-based services upon release from jail.
- 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.
- Ensure continuity of care by assisting with the coordination of transportation of the individual from the jail or treatment facility to the placement identified in the conditional release order on the date prearranged with the placement site.
- Check the resident's status while in jail, arrange competency restoration services to assist the resident in maintaining competency, assist to assure needed psychiatric treatment (medication) is continued while in jail, attend court hearings, and follow the resident's case through to disposition. If the resident is released from jail to the community, the Forensic Specialist must make sure the resident is linked to appropriate community-based services and recommended services are received after discharge; and
- Should the court unexpectedly release the resident to the community, the Forensic Specialist must be prepared to assist the individual secure housing, aftercare services and benefits, as well as set up an appointment with a medical/psychiatric provider to ensure the resident can receive prescriptions to remain on his/her medications.
- Participate in forensic mental health treatment facility or Mental Health Program Office initiated discharge status telephone and video conference calls.
- If an alternative circuit placement is sought, the Forensic Specialists from both circuits must work cooperatively to develop the conditional release plan prior to submission to the court.

REINTEGRATION OF INDIVIDUALS DISCHARGED FROM SMHTF

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

1. When a resident is identified as discharge ready, CFC will work with the SMHTF staff to develop a transition plan. CFC will ensure a Community Case Manager/Forensic Specialist participates in the development of the transition plan identifying services and supports needed for the resident's discharge. In collaboration with the SMHTF, the Community Case Manager/Forensic Specialist will coordinate discharge plans for those individuals awaiting community placement.

2. Behavioral health services shall be provided to persons pursuant to section 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 SMHTFs⁴. Depending on client needs and program eligibility criteria, services within CFC' network will be made available to individuals being discharged from SMHTF for continuity of care. These services may include FACT, Care Coordination, 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. CFC 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, CFC' Community Care Coordinator will assist with locating appropriate placement. Information on barriers for re-integration into the community is shared with CFC 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 CFC 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.

⁴ Reference- ME Contract GHME2