

Discharge Planning

The Baker Act ensures that people hospitalized for mental illness must have the opportunity to participate in discharge planning and be notified in writing of his or her right, upon discharge from the facility, to seek treatment from the professional or agency of choice. However, no professional is required to accept persons for psychiatric treatment.

Comprehensive service assessment and treatment planning, including discharge planning, must begin the day of admission and must include the person's case manager if any, the person's family, significant others, or guardian, as desired by the person. Persons must have the opportunity to participate in the preparation of their own treatment and discharge plans. In instances when the person refuses or is unable to participate in such planning, such refusal or inability must be documented in the person's clinical record.

Mental health case managers, when notified by a receiving facility that a client has been admitted, are required to visit that client as soon as possible but no later than two working days after notification to assist with discharge and aftercare planning to the least restrictive, appropriate and available placement. If the client is located in a receiving facility outside of the case manager's district of residence, the mental health case manager may substitute a telephone contact for a face-to-face visit, which must be documented in the case management record and in the client's clinical record at the receiving facility.

Discharge Policies of Receiving and Treatment Facilities

Receiving and treatment facilities are required to have written discharge policies and procedures which contain:

- Agreements or protocols for transfer and transportation arrangements between facilities;
- Protocols for assuring that current medical and legal information, including day of discharge medication administered, is transferred before or with the person to another facility; and
- Policy statements which reflect cooperation with local publicly-funded mental health and substance abuse providers and which will both facilitate access by publicly funded case managers and enhance the continuity of services and access to necessary psychotropic medications.

Discharge from Receiving and Treatment Facilities

A discharge plan is defined in the Baker Act rules to mean the plan developed with the person, which sets forth how the person will meet his or her needs,

including housing, transportation, aftercare, physical health, and securing needed psychotropic medications for the post-discharge period of up to 21 days.

Discharge planning must include and document consideration of the following:

- The person's transportation resources and access to stable housing;
- How assistance in securing needed housing or shelter will be provided to individuals who are at risk of re-admission within the next three weeks due to homelessness or transient status and prior to discharge must request a commitment from a shelter provider that assistance will be rendered;
- Assistance in obtaining a timely aftercare appointment for needed services, including medically appropriate continuation of prescribed psychotropic medications. Aftercare appointments for medication and case management must be requested to occur not later than 7 days after the expected date of discharge; if the discharge is delayed, the facility will notify the aftercare provider. The facility must coordinate with the aftercare service provider and must document the aftercare planning;
- To ensure persons' safety and provide continuity of essential psychotropic medications, such prescribed psychotropic medications, prescriptions, or multiple partial prescriptions for psychotropic medications, or a combination thereof, must be provided to a discharged person to cover the intervening days until the first scheduled medication aftercare appointment, or for a period of up to 21 calendar days, whichever occurs first. Discharge planning must address the availability of and access to prescribed psychotropic medications in the community;
- The person must be given education and written information about their illness and their psychotropic medications including other prescribed and over-the-counter medications, the common side-effects of any medications prescribed and any adverse clinically significant drug-to-drug interactions common between that medication and other commonly available prescribed and over-the-counter medications;
- Information about and referral to any community-based peer support services in the community, to any needed community resources, and referral to substance abuse treatment programs, trauma or abuse recovery focused programs, or other self-help groups, if indicated by assessments.

Discharge from a State Treatment Facility.

When a state treatment facility has established an anticipated discharge date for discharge to the community which is more than seven days in advance of the

person's actual discharge, at least seven days notice must be given to the community agency which has been assigned case management responsibility for the implementation of the person's discharge plan. Use of recommended form CF-MH 7001, Jan 98, "State Mental Health Facility Discharge Form," will be considered by the department to be sufficient.

On the day of discharge from a state treatment facility, the referring physician or, in the absence of the physician, the designated charge nurse, must immediately notify the community aftercare provider or entity responsible for dispensing or administering medications. Use of recommended form CF-MH 7002, "Physician to Physician Transfer," will be considered by the department to be sufficient.

Discharge of Involuntary Persons

A receiving or treatment facility administrator must provide prompt written notice of the discharge of an involuntary person to the person, guardian, guardian advocate, representative, initiating professional, and circuit court, with a copy retained in the person's clinical record. Use of recommended form CF-MH 3038, "Notice of Release or Discharge" will be considered by the department to be sufficient as documentation of such notice. If the discharge occurs while a court hearing for involuntary placement or continued involuntary placement is pending, all parties including the state attorney and attorney representing the person, must be given telephonic notice of the discharge by the facility administrator or his or her designee

Applicants for Receiving Facility Designation

An applicant for designation as a Baker Act receiving facility must, among many other issues, describe local need and accommodation of that need for indigent and low income individuals and families being discharged from the facility in need of continuing psychotropic medications. The applicant must describe how it shall directly provide, or otherwise assist the person in ensuring continuity of availability of necessary psychotropic medications until a scheduled aftercare medication appointment. The applicant must also describe how the facility's discharge planning policies provide for continuity of medication availability until post-discharge follow-up services are scheduled.

Summary

A person cannot be expected to be "compliant" with a discharge plan for which he or she wasn't involved and didn't agree to. Not only must the person be an active participant in developing the discharge plan, the plan must include desirable options for follow-up treatment and supportive care. In every case, the plan must be individualized around the person's preferences and needs.