
Division of MH/DD/SAS
“Stopping the Revolving Door”
Discharge Planning from the State Psychiatric Hospitals
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State Operated Services

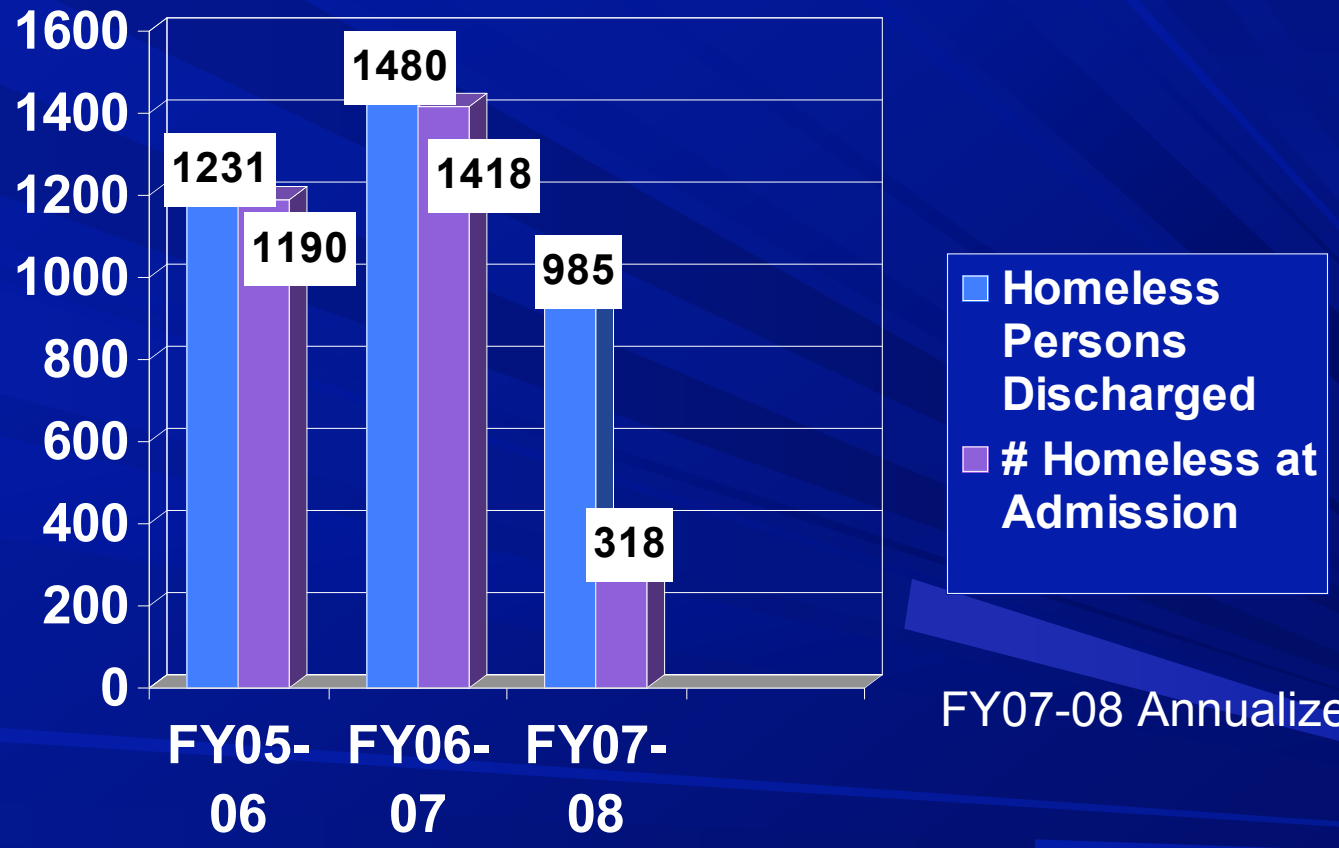
State Psychiatric Hospital Statistics

- Total State Psychiatric Hospital Admissions:
  - FY2005-2006: 17,046
  - FY2006-2007: 17,419
  - Current: 13,804*
- Total State Psychiatric Hospital Discharges:
  - FY2005-2006: 19,951
  - FY2006-2007: 17,546
  - Current: 15,399*

*=Annualized

- Homeless Persons Admitted:
  - FY2005-2006: 1190
  - FY2006-2007: 1418
  - Current: 239 (318*)
- Homeless Persons Discharged:
  - FY2005-2006: 1231
  - FY2006-2007: 1480
  - Current: 739 (985*)

Discharge Destinations from State Psychiatric Hospitals



FY07-08 Annualized

Mental Health Statutes

- 122c-201. Declaration of Policy.
  - …All admissions and commitment shall be accomplished under conditions that protect the dignity and constitutional rights of the individual...
  - …Individuals who have been voluntarily admitted shall be discharged upon application and that involuntarily committed individuals shall be discharged as soon as a less restrictive mode of treatment is appropriate.

Mental Health Statutes Continued…

- 122c-211(e): Admissions:
  - When an individual from a single portal area seeks admission to an area or State 24 hour facility, the admission shall follow the procedures as prescribed in the area plan. When an individual from a single portal area presents himself for an admission to the facility directly and is in need of an emergency admission, the individual may be accepted for admission. The facility shall notify the area authority within 24 hours of the admission. Further planning of treatment for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.

Mental Health Statutes Continued…

- 122c-212: Discharges.
  - (a)…an individual who has been voluntarily admitted to a facility shall be discharged upon his request. A request for discharge from a 24 hour facility shall be in writing.
  - (b) An individual who has been voluntarily admitted to a 24 hour facility may be held for 72 hours after his written application for discharge is submitted.
  - When an individual from a single portal area who has been voluntarily admitted to an area or State 24 hour facility is discharged, the discharge shall follow the procedures as prescribed in the area plan.

Mental Health Statutes Continued…

- 10A NCAC 28F Section .0200
  - Voluntary Admissions, Involuntary Commitments and Discharges of Adults from Regional Psychiatric Hospitals…
- .0203: Authorization of Hospitalization by Area Program:
  - The designated area program staff shall authorize all hospitalizations for individuals residing in an area program's catchment area…
- .0208: General Criteria for Admission.

Rules

- .0209: Coordination and Continuity of Care:
  - (a) Each hospital in conjunction with each area program shall develop a process to assure ongoing communication between the hospital and area program regarding clients in treatment at the hospital….the process shall include but is not limited to the following:

Rules Continued…

- Specifically designated staff at both the hospital and area program to facilitate communication
- Routinely scheduled case management contact at hospital site
- Hospital staff visitation to area program
- Telephone conferences, and
- A discharge plan developed in collaboration among hospital and area program staff and client.

(b) The process for ongoing communication shall be incorporated into each area program's written agreement with the state hospital.

Contracts

- DHHS has a contract with the LMEs and DMH/DD/SAS
- DMH/DD/SAS-State Operated Services has a contract with the LMEs

Policies

- Short-Term and Long-Term Care
  - Short-Term is under 30 days—the average length of stay is about 7 days.
  - Long-Term is for people staying in the hospital more than 30 days. Typically, these individuals have very complex conditions.
  - Anyone being discharged after 30 days and is going to a homeless shelter MUST be approved by State Operated Services.

Discharge Planning Process

- Discharge planning begins at admission
- A psychosocial Assessment is completed:
  - Assess living arrangement prior to admission
  - Social supports the person uses
  - Employed? Other Income? Disabled?
  - Previous admissions?
  - Known to the LME or a provider?

Discharge Planning Process Continued…

- Family and Community Contacts
  - Obtain person's consent to contact family/others
  - If person does not consent, try later…
  - Document efforts to make contact and to get consent
  - If consent, contact the family or others the person has indicated

Discharge Planning Process Continued…

- Case Formulation, Social Work and other Interventions
  - Study strengths and barriers to clinical treatment success
  - Determine what is realistic to be addressed
  - Review and assess prior discharge plans
  - Determine what needs to be changed
  - Treatment plan developed with individual, family, staff, others

Discharge Planning Process Continued…

- Dual Process
  - Compiling assessment data while working on discharge planning
  - Assess relationships and supports
  - Assess housing options
  - Coordinating with the LME, the LME Hospital Liaison, community providers and families
  - Comply with Olmstead requirements
  - Quality improvement reviewed (recidivism, best practices used in treatment, and follow up post discharge is appropriate)

Discharge Planning Process Continued…

- Housing
  - Is person homeless?
  - Was discharge to a shelter upon last or other previous discharge?
  - Analyze continued homelessness
  - Determine what is needed to make this discharge viable
  - What are the resources for homeless persons?
  - Visit shelters; placements, when time allows

Discharge Planning Process Continued…

- Housing Continued…
  - Some people have no alternative to a homeless shelter.
  - In these instances, efforts to locate appropriate placement/referral are pursued and exhausted.
  - State Operated Services is involved (must approve) in discharges to homeless shelters if a person is in the hospital more than 30 days.

Discharge Planning Process Continued…

- Crisis/Safety Plans
  - Must accompany the person at discharge
  - Crisis plan includes information about community connections, or lack of and alternatives for contact in a crisis.
  - A provider should be identified as a first responder if the person is in crisis.
  - Should be very concrete: who and how to contact; contact responsibilities.
  - LME should be involved in this process or ensure a provider is involved.

Barriers and Challenges

- Too many rapid admissions
- Often not enough time to fully coordinate discharge planning
- Not enough housing or other living arrangement options
- Many individuals have “worn out” their supports
- Lack of outpatient intensive case management
- Lack of communication between partner agencies
- Confusion about roles and responsibilities

Case Scenario

- 37 y.o. man. Was living with a friend.
  - Became assaultive, wasn't taking prescribed medications.
  - Started having hallucinations and was abusing alcohol
  - Diagnosis or paranoid schizophrenia
  - Hospitalized several times in the past 2 years

Case Scenario Continued…

- Family was involved, but was “tired,” “frustrated,” that individual was not in recovery mode
  - Family would not take person back to live with them
  - Family offered an alternative (a trailer) but the person refused
  - No resources—does not have Medicaid/Medicare, no SSI/SSDI. Refuses to sign application.
  - Hospital social workers attempt many times to engage the individual, but he refuses
  - Individual was told the only option now is a shelter or ADATC (ADATC is voluntary). Person refuses ADATC.
  - Individual decides to go to homeless shelter after being told this was a final option.

Case Scenario Continued…

- LME Involved
  - LME Hospital Liaison contacts provider
  - Provider does come to one treatment team meeting two weeks prior
  - Provider refuses to come back to the hospital to meet with the person—says he must come to them

Case Scenario Continued…

- SOS will not approve D/C plan until:
  - A Community Support provider is assigned and meets with the individual.
  - The provider confirms a face-to-face contact is made with the consumer at the shelter within 48 hours of discharge.
  - A medical appointment for medication assessment is made.
  - Other housing options are pursued via the local housing team.
  - An appropriate PCP and Crisis Plan are developed with the person's involvement and approval.
  - Evidence that the Hospital has discussed person's needs if accepted into the homeless shelter.
  - Informing law enforcement or the transporting entity about taking the person directly to the shelter.
  - Family is involved as can be allowed (because sometimes the consumer does not want their family involved).

Case Outcome

- After further investigation and involvement of the LME Care Coordinator:
  - Located transitional housing
  - Discharge was delayed until consumer could visit the transitional housing location
  - Consumer was more amenable to signing consents and consented to be a volunteer for the ADATC
  - LME involvement was key in preventing this person from going to a homeless shelter

Conclusions

- Imperative that all professionals involved work together to appropriately transition individuals from the hospitals to the community (homeless shelters being the last option).
- The family should always be encouraged to be involved, even if there were historical issues.
- Consumers change their minds when they have calmed down and are more stable about choices. They have the right to be told many times about their choices and how a shelter is not always a solution.
- Recidivism is high among the homeless population, re: hospitalizations and the need for crisis intervention. This should be a priority for all human service areas—prevention and stabilization.
- We all want to do what's right for all individuals entering and leaving State psychiatric hospitals.

Contact Information

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