PURPOSE

Michigan Department of Health and Human Services (MDHHS) hospitals must ensure that all adult patients who no longer require inpatient psychiatric hospital level of care are discharged timely to an appropriate level of care in the community.

See Administrative Policy Hospitals and Facilities (APF) 106 for pre-release planning for patients adjudicated Not Guilty by Reason of Insanity.

See APF-163 for pre-release planning for minor patients.

DEFINITIONS

Assisted Outpatient Treatment (AOT)

Services ordered by a probate court under §468 or 469a of the Michigan Mental Health Code (MMHC). Assisted outpatient treatment may include a case management plan and case management services to provide care coordination under the supervision of a psychiatrist and developed in accordance with person-centered planning under §712 of the MMHC. This definition also may include one or more of the following:

- Medication.
- Periodic blood tests or urinalysis to determine compliance with prescribed medications.
- Individual or group therapy.
- Day or partial day programming activities.
- Vocational, educational, or self-help training or activities.
- Assertive community treatment team services.
- Alcohol or substance use disorder treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for an individual with a history of alcohol abuse or substance use disorder.
- Supervision of living arrangements.
- Any other services within a local or unified services plan developed under the MMHC that are prescribed to treat the individual's mental illness and to assist the individual in living

and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide, the need for hospitalization, or serious violent behavior.

The medical review and direction included in AOT must be provided under the supervision of a psychiatrist.

Assisted Outpatient Treatment (AOT) Order

A directive issued by a probate court requiring a person to undergo AOT consistent with §468(2)(c) and (d) of the MMHC. Assisted outpatient treatment can be an order to adhere to outpatient services or it may incorporate both outpatient and admission to a hospital.

Discharge

An absolute, unconditional release of patient from a hospital by action of the hospital or a court. Discharge decisions must be based on each patient's actual, real, and individualized risk mitigation and behavioral health treatment needs.

Evidence-Based Practice (EBP)

A clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting individuals achieve their desired outcomes when implemented to fidelity. An EBP is comprised of the:

- Highest level of scientific evidence.
- Clinical expertise of the practitioner.
- Choices, values, and goals of the individual.

Hospital

An inpatient program operated by the MDHHS for the treatment of individuals with serious mental illness, serious emotional disturbance, or intellectual/developmental disability.

Individual Plan of Service (IPOS)

The fundamental document in the person’s record, developed in partnership with the person using a person-centered planning process that establishes meaningful goals and measurable objectives including risk mitigation strategies overseen by the NGRI Committee. The plan must identify services (including discharge

planning), supports and treatment as desired or required by the person.

Legal Representative

A guardian, parent with legal custody of a minor or a patient advocate designated by the patient to make mental health treatment decisions

Person-Centered Planning (PCP)

A process for developing treatment and supports for a patient receiving services that builds upon the patient's capacity to engage in activities that promote community life and that honors their preferences, choices and abilities. The person-centered planning process involves families, friends and professionals as the patient desires or requires

Plan Coordinator

A licensed social worker or psychologist who integrates, coordinates, monitors and assures implementation of each person's IPOS. Monitoring includes ongoing review of the IPOS, recording progress and changes, and initiating modification of the IPOS as necessary. A member of the treatment team will be designated as the plan coordinator for the hospital treatment team or community treatment team where indicated.

Pre-release Plan

A proposal developed by the applicable Community Mental Health (CMH) agency with the assistance from the hospital that provides a plan for appropriate community placement and aftercare services.

Risk Mitigation Strategies

Strategies in a person's IPOS designed to reduce a person's risk of harming themselves or others. Risk mitigation strategies must be tied to the person's behavioral health treatment needs.

Treatment Team

Individuals who work together to develop and implement an IPOS. A treatment team includes the person, the person's guardian, a multidisciplinary team of mental health care professionals, including the plan coordinator, and involved direct care staff. A treatment

team may either be a hospital treatment team or community treatment team.

POLICY

All adult patients who are probate court ordered for treatment are entitled to treatment, care, and services in the least restrictive setting that is appropriate and available. Decisions regarding treatment will be made to promote safely supporting a patient in the least restrictive setting with community-integrated services and ongoing outpatient treatment as clinically indicated.

STANDARDS

Development and implementation of a pre-release plan will begin when the patient subject to the probate order is admitted to a hospital, including CMH staff responsible for providing community-based care upon discharge. The pre-release plan will utilize EBP and PCP processes to assure that services are provided based upon the patient's behavioral health treatment needs to mitigate risk of harm and rehospitalization.

The hospital must assist and participate with the responsible CMH, in the development of an individualized pre-release plan for appropriate community placement and aftercare services for the patient. The pre-release planning meeting must include:

- The patient.
- The patient's legal representative.
- Any individual the patient chooses.
- The plan coordinator.
- A representative of the responsible CMH.
- If selected, the residential care provider.

An approved, evidence-based assessment tool must be utilized to inform the level of services an individual will need to be supported in the community.

The hospital must not file a petition for a second, or continuing, order of involuntary hospitalization if a patient is determined to no longer require treatment pursuant to the MMHC. If the hospital director, the responsible CMH, or another individual believes the patient continues to require treatment they may file a petition under Section 434 of the MMHC for initial order of involuntary mental health treatment.

PROCEDURE

- Assessment of goals for patient discharge will be established within three days of hospital admission. Reassessment of discharge goals must occur not less than 90 days. A level of care assessment tool must be completed within 30-days of the patient's anticipated discharge.
- Plan coordinator will add the pre-release plan to the PCP IPOS.
- The plan coordinator will provide the responsible CMH an update whenever a reassessment is completed. The responsible CMH will update the pre-release plan as needed.
- When the goals of the pre-release plan are met and the patient is determined to be ready for a lesser restrictive setting the treatment team, in conjunction with the CMH, must update the pre-release plan utilizing a PCP process, supported by evidence-based evaluation, practical clinical assessments, available community resources, and the patient’s (or their guardian or patient advocate, if applicable) wishes. The plan coordinator must request an update from the CMH every 30 days on barriers that may delay integration into the community in accordance with the patient's pre-release plan.

Discharge without AOT

- A hospital director may discharge a voluntarily hospitalized patient when the patient is determined to be clinically suitable for discharge.
- A hospital director must discharge a patient who has been hospitalized by court order when the patient's mental condition is such that they no longer meet the criteria of requiring treatment.
- If a patient has been hospitalized by court order, or if court proceedings are pending, the hospital must notify the court of the patient's discharge.
- If the patient is discharged before the pre-release plan can be completed, the CMH must offer a post release plan within 10 days after discharge per Sec. 209a of the MMHC.
- A patient, legal representative, or guardian with the patient's assent, may sign a formal voluntary form to remain in the

hospital to ensure a safe transition to a less restrictive setting if risk mitigation strategies or an appropriate placement is not available. Any delay of discharge past 14 days must be reviewed by the Senior Deputy Director of the State Hospital Administration or their designee.

- A patient will be discharged with appropriate treatment recommendations if the patient, legal representative, or guardian will not sign a formal voluntary form and the patient does not require hospitalization or an AOT. The plan coordinator will assist the patient with referral to the CMH for aftercare services.

Discharge with AOT

- A petition for an AOT must be filed by the hospital if it is determined patient continues to meet criteria requiring treatment and is ready for a lesser restrictive setting but would benefit from an AOT to adhere to outpatient treatment.

- The recommendation for AOT must be made when it has been determined the patient is ready for a lesser restrictive setting but would benefit from an AOT to ensure appropriate level of care and risk mitigation strategies are in place before discharge.

- If a person is currently on a combined order for hospitalization and AOT the decision to discharge the patient from the hospital to the AOT program must be a clinical decision made by a psychiatrist designated by the hospital director in consultation with the director of the AOT program.

- Notice of discharge of the patient to the AOT program must be provided to the court by the hospital with a statement from the designated psychiatrist explaining the belief that the person is clinically appropriate for AOT.

- Not less than five days before discharging a patient from the hospital to the AOT program, the hospital director, or their designee, must notify the supervising CMH that the patient will be discharged. The hospital must share relevant information about the patient for the purpose of providing continuity of treatment.

- If there is a disagreement between the hospital and the CMH regarding the decision to discharge a patient to the AOT

program, either party may appeal the decision of the department to the court in writing within 24 hours after the department's decision.

REFERENCE

Michigan Mental Health Code, MCL 330.1209a, 330.1209b, 330.1401,330.1468, 330.1469a, 330.1474, 330.1482,330.1472a, 330.1483, 330.1484. 330.1708.

CONTACT

For additional information concerning this policy, contact the State Hospital Administration.