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Vermont Psychiatric Care Hospital Policy and Procedure		
Discharge Planning		
Effective: April 2014	Revised: June 2024	Due to Review: June 2026

POLICY

Every person admitted to the Vermont Psychiatric Care Hospital (VPCH) shall have an individualized aftercare plan specifying the providers and services they will receive upon discharge. VPCH staff will work closely with the hospitalized individual, guardian, appropriate community agencies, and, with the individual's permission, their family and/or significant others, to ensure continuity of care. Aftercare planning is an inherent and important part of the overall treatment planning process.

PROCEDURE

In general, aftercare plans shall be created at the time of admission and updated periodically, provide specific interventions and supports designed to promote recovery in the least restrictive manner possible, and provide placements which are likely to maintain or improve the hospitalized individual's level of psychosocial functioning.

Social workers will have the primary responsibility for coordinating aftercare planning for hospitalized individuals at VPCH. The Vermont Department of Corrections retains responsibility for ensuring appropriate aftercare planning for individuals returning to their custody once discharged from VPCH.

The discharge planning process is as follows:

1. The hospitalized individual's assigned social worker will complete a Comprehensive Social Assessment within 7 business days after admission. This assessment shall include a preliminary discharge plan focusing on the individual's strengths and needs and setting forth recommendations for aftercare. The preliminary discharge plan shall address, among other things, the individual's medical and psychiatric needs, financial resources, housing, employment, educational and vocational opportunities, family and social relationships, community supports, legal issues, and transportation needs.
2. Within seven (7) business days of an individual's admission to VPCH, the assigned treatment team shall prepare, in collaboration with the hospitalized individual, a Comprehensive Treatment Plan (CTP) setting forth specific assessments and interventions for that individual. Each CTP shall contain a Social Service Intervention which addresses goals related to discharge planning. The treatment team shall prepare the CTP in collaboration with appropriate community agencies. With the hospitalized individual's approval, the treatment team shall also encourage family members, significant others, and/or external supports to assist in formulating the CTP.
3. Discharge planning is a process that continues throughout a person's hospitalization. Changes in condition and/or circumstances may require changes to the discharge plan. The discharge plan shall be regularly and systematically

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reviewed by the social worker, the treatment team, outpatient providers, and with the hospitalized individual. The discharge plan shall be periodically updated to reflect the evolving needs and desires and the availability of resources in the community. Clinical progress and any changes in the aftercare plan will be noted in the weekly Social Services Aftercare & Discharge Planning Progress Note.

4. At the time of discharge, the Social Worker must complete an Aftercare Referral Form. This form provides specific information regarding the individual's living situation, source of income, medications, medical needs, appointments, and contact information. Upon discharge, the hospitalized individual will be given a copy of this form and a copy will be sent to the Designated Agency or outpatient provider in order to ensure continuity of care, and a copy may be provided to a person designated by the individual.

Approved by	**Signature**	**Date**
Emily Hawes, Commissioner, Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	6/3/2024