

## MEMORANDUM

TO: Regional Steering Committee on Homelessness and Housing

FROM: HomeBase

RE: Closing the Gates to Homelessness: Discharge Planning by State Institutions

DATE: April 18, 2008

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### **Background**

Recognizing the relationship between discharges from state institutions and homelessness, the Regional Steering Committee regularly discusses discharge planning as an effective means of preventing homelessness. Since 2004, the RSC has focused on best practices within the corrections, foster care, mental health, and healthcare systems, as well as studying discharges from the military. Increasingly, CoC's are looking towards these systems of care to both appropriately discharge clients and pay for the housing and the services that the clients need to remain stable.

### **Reframing the Issue**

In a recent Dennis Culhane study<sup>1</sup>, the authors suggest that communities need more “residential facilities like halfway houses or supported communities ... [and] independent living programs with mobile, as-needed support services.” Culhane states, “These programs would be preferable to homeless shelters because they could be vertically integrated extensions of the care systems from which people have recently come... The vertical integration of such aftercare services would also create a performance framework for these agencies, enabling them to protect their institutional investment in these clients.” In other words, institutions like jails, prisons, and hospitals have a vested interest in providing after-care for clients to prevent their clients' recidivism. As such, these institutions should not only fund after-care, but they should be responsible for converting and managing the existing shelters into residential facilities that respond to the specific needs of the subpopulation.

Culhane's argument is something for which CoC providers have advocated for years, which is that institutions of care should no longer “dump” their clients into the safety net created for homeless individuals and families. The homeless service safety net is overburdened unto itself. Perhaps, as Culhane posits, the various institutions of care should create their own “silo-ed” support network for clients exiting with nowhere else to go.

If we believe other systems of care must develop their own “vertical integration of services,” then the problem is persuading these institutions that building halfway houses and similar transitional housing is both in their interest and their financial responsibility. How do we build support within other systems of care to create better discharge planning policies and programs?

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<sup>1</sup> Dennis P. Culhane and Stephen Metraux. "Rearranging the Deck Chairs or Reallocating the Lifeboats?: Homelessness Assistance and Its Alternatives" *Journal of the American Planning Association* 74.1 (2008): 111-121. Available at: [http://works.bepress.com/dennis\\_culhane/51](http://works.bepress.com/dennis_culhane/51)

How do we close the gates to homelessness when the gatekeepers are distracted by what is happening inside the walls of their fortress?

### **Correcting the Corrections System?**

On April 8, 2008 President Bush signed into law the Second Chance Act of 2007, a bill that funds community and faith-based organizations to deliver mentoring and transitional services. The bill aims to connect people released from prison and jail to mental health and substance abuse treatment, expand job training and placement services, and facilitate transitional housing and case management services. The act authorizes \$165 million in spending per year, including matching grants to state and local governments and nongovernmental groups to experiment with efforts like more schooling and drug treatment inside prison and aid with housing, employment and the building of family and community ties after release. Additionally, the Second Chance Act directs the Justice Department to pursue research on re-entry issues and establishes a national Reentry Resource Center to promote successful approaches and provide training<sup>2</sup>.

Similarly, in the spring of 2007, Governor Schwarzenegger signed into law AB 900, a measure to reform California's prison system. As part of that reform agenda the Governor then signed into law SB 943, which creates California's first secure community re-entry facility. An estimated 16,000 re-entry beds will be created throughout the state. The facilities will provide programs and services such as: intensive substance abuse treatment; vocational training and job placement; education and GED coursework; anger management classes; family counseling; housing placement; and targeted services to help ease the transition from incarceration to a crime-free life on the outside.

Along with the AB 900 reforms, Governor Schwarzenegger approved \$4 million for the PROMISE Program (Program for Returning Offenders with Mental Illness Safely and Effectively). The PROMISE Program proposal stressed the use of homes with services for mentally ill parolees exiting state prisons. However, the governor vetoed SB 851 -- the bill that included the specific details of the pilot program. This means that there is money for the PROMISE program, but the exact parameters of the program remain undefined. Most recently, advocates and legislative staff met with CDCR staff to stress the importance of using the funds as intended by the legislature (i.e. using a model of flexible and integrated services and housing supports that achieved so much success under the AB 2034 program for homeless mentally ill persons). Advocates reported that the meeting was productive, but much work still needs to be done to ensure this model is used.

Finally, the CDCR recently completed pre-release agreements with the federal Social Security Administration to allow persons eligible for SSI to begin the application process while in prison. This agreement should allow eligible inmates to begin receiving SSI immediately upon parole.

With all the movement at the national and state level that focuses on transitional housing for ex-offenders, a number of advocates point out that re-entry housing is just a new name for halfway houses. Advocates remind us that halfway houses fell out of favor, and subsequently closed-shop due to a lack of funding during the 1980's when political leaders wanted to "get tough on crime."

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<sup>2</sup> Eckholm, Erik. "U.S. Shifting Prison Focus to Re-Entry Into Society," *The New York Times*, April 8, 2008. <http://www.nytimes.com/2008/04/08/washington/08reentry.html?st=cse&sq=second+chance+act&scp=1>

Certainly, a shift back to housing-focused transition planning is a victory for the homeless service community, but we must think strategically about making this shift permanent. How do we inspire the corrections community to assume responsibility of these transitional housing programs so that the next time the political pendulum shifts the corrections leaders are on our side? We want a corrections system that is as culturally competent about homelessness as our service providers. How do we bring all corrections staff to that level? How do we engage them as allies?

### **California's Mental Health System— Experiencing Bipolarism?**

At the same time Governor Schwarzenegger was reforming the corrections system, he cut AB 2034 (Integrated Services for the Homeless Mentally Ill), which had been integral to counties providing housing and services to mentally ill Californians. Nationwide, the legislation had been hailed as the best practice model for discharge planning. To help counties temporarily pay for programs usually funded through AB 2034, the Department of Mental Health made a one-time \$64 million in unspent MHSA administrative funds available to cover the cost of services. Many counties have used that or other money provided through MHSA to cover AB 2034 expenses. In response to the AB 2034 cut, the Mental Health Association of California, the California Network of Mental Health Clients, and the National Alliance on Mental Illness (California branch) filed suit against the Governor. The advocacy groups charge that cutting AB 2034 is a direct violation of the Mental Health Services Act (MHSA), because MHSA expressly prohibits the use of its funds to pay for mental health services already in existence when the measure was passed.

Beyond the cut in AB 2034, some homeless service providers are reporting that MHSA funds are being “misdirected” by county mental health staff that are ill-informed about homelessness. For example, one group of service providers reported that even though their county plan called for a “housing first” approach to serve homeless adults, some clients in shelter were told they were ineligible. At the same time, the county was accepting clients coming from Institutes for Mental Disease and amending the definition of “homeless” to include “at serious risk of homelessness.”

### **A Respite from Dumping or a Real Recovery?**

The Governor signed AB 2745 in September 2006. The law requires hospitals to stop “dumping” patients into homelessness. Additionally, the law explicitly prohibits carrying a patient across county lines for the purpose of accessing social services in the neighboring county, unless the receiving social service agency explicitly consents to such a transfer. Importantly, AB 2745 required hospitals to meet with their local CoC and start discussing more appropriate discharge plans. Though the legislation did not specify what exactly would need to come out of the meetings, the deadline for these meetings was January 2008.

Now that the deadline passed, the hospital associations have published reports on what they accomplished, one for Northern/Central and one for Southern California.

The Northern/Central report emphasizes a desire to collaborate and offers some specific ideas about developing discharge policies. Nothing in the report is “news” for CoC members; however, the “future opportunities” listed are positive and include:

- Medical respite care emerged as both the most significant gap and the most promising opportunity to improve services for people experiencing homelessness. Continued efforts, legislation, funding and technical assistance in creating these centers throughout Northern and Central California would add great value to the healthcare needs of homeless residents.
- In communities with case management services for the homeless, all reported that this ‘individualized’ care plan was highly successful. Efforts to support more case management work within each region will continue.
- Regional and local collaboratives are essential to advancing the larger issue of homeless services in any community. Hospitals will continue to be engaged and active participants in these local efforts to strengthen communication, coordination, referrals, and follow-up. When possible, designation of a centralized community or County staff person/agency to coordinate homeless services would greatly enhance local efforts.
- As one sector involved in the care of the homeless, hospitals will work together to identify, collect and monitor relevant data regarding hospital care of homeless patients (within the constraints of federal legislation); shared and streamlined discharge protocol, policies, and referral processes where applicable; and shared resource lists to better meet the patients needs. Hospitals will also continue with their internal staff training regarding their individual community’s homeless needs and practices in caring for this special patient population.
- A focus on leveraging existing funding sources (e.g. Prop 63) and identifying additional revenue streams will continue. In addition, linkages and alignment with existing community resources will continue to be an essential element of every community plan (e.g. expanding the role of community ombudsmen to include acute care hospitals).

The Southern California report is organized by county rather than as a “regional snapshot.” In general, the Southern California group seems more hostile to the AB 2745 requirements. The Hospital Association of Southern California actively lobbied against the bill and explicitly takes issue with the word “dumping.” Despite these political setbacks, the individual county reports have a few interesting highlights.

- Throughout the region, the Association held “Homeless Discharge Training Sessions.” These trainings were paid for by the Association and organized by a private company.
- The Association developed a “template referral form.”
- A few hospitals adopted an official discharge policy.
- A number of communities teamed-up with Volunteers of America to offer “more appropriate” transportation for homeless clients. Usually, these vans go to the local shelter.
- The LA County Department of Health, private hospitals, and foundations have teamed up to build 45 new recuperative beds. (This is essentially respite care.)
- A number of counties are considering countywide discharge policies and protocols to ensure consistency.

The full reports can be found here:

Northern/Central- <http://www.hospitalcouncil.net/cgi-bin/default.asp?AID=205>

Southern- <http://www.hasc.org/notebook.cfm>

Even before AB 2745, however, a number of communities began thinking of the issue of discharging from hospitals. Some have already created promising models. For example, in San Francisco the Direct Access to Housing (DAH) program connects homeless clients to permanent housing upon discharge from local hospitals. Established in 1998, the San Francisco Department of Public Health's (SFDPH) Direct Access to Housing (DAH) program provides permanent housing with on-site supportive services for approximately 600 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions.

SFDPH operates a large public hospital, a skilled nursing facility, 26 primary care and mental health clinics, and contracts for a broad array of services through community-based providers. The DAH program targets "high-utilizers" of the public health system using a "low threshold" model that accepts single adults into permanent housing directly from acute hospital or long-term care facilities, as well as from the street and from shelters.

Funding for the DAH program comes predominantly from the city general fund. Other revenue sources for the project include state money targeted toward homeless mentally ill persons, Ryan White Care Funds, SAMHSA, and reimbursement through the Federally Qualified Health Center system for a portion of the medical and mental health related expenses. Approximately 80% of DAH residents receive SSI and Medi-Cal (California's Medicaid system) benefits. The buildings also receive revenue from tenant rent. Residents pay fifty percent of their income towards rent. Total cost to provide permanent housing and support services in DAH buildings (excluding one licensed residential care facility) is approximately \$1,200 per month per resident. The average rent received from residents is \$300 per month therefore requiring a \$900 per month subsidy from governmental sources.

On a smaller scale, but still very effective, Sacramento County has established an interim care program that leverages private hospital money against county dollars. The Collaborative includes three local not-for-profit hospitals, the County of Sacramento, the Salvation Army, and MAAP, Inc., a community health center clinic. The Collaborative designed a program to "address the needs of the whole person." The program provides short-term housing for homeless patients, post discharge from the acute care setting. The housing is a stable environment that links medically at-risk adults to community based social services. While in temporary housing, case managers establish eligibility for public assistance and health care coverage and facilitate the transition of homeless at-risk adults to permanent housing and employment.

Though the described programs are promising, they are the exception. After AB 2745 many CoC's reported that hospitals are now inclined to coordinate transportation from the hospital to the local emergency shelter to avoid "dumping;" these hospitals seem less interested in a long-term solution for their patients. Many hospitals are resistant to funding respite care, and even more resistant to funding permanent supportive housing.

### **Engaging the Gatekeepers**

As advocates, we have made strides with our sister systems of care. Nonetheless, the gates to homelessness are still wide open. Using what we have learned, how do we not only engage the other systems in a solution, but more importantly, how do we encourage those systems to create Culhane's "vertically integrated extensions of the care systems?"

Questions for the RSC

1. What innovative discharge planning efforts are happening in your community?
  
2. What barriers are your community facing as you attempt to create discharge planning policies and programs?
  
3. How is your community engaging partners within other systems of care? What concerns do these insiders bring? What strategies have been successful to establishing buy-in?
  
4. Is your community feeling the impact of changes with the criminal justice system? Cuts in AB 2034? MHSA issues?
  
5. Do you have other concerns?

\*\* Naomi Mosser, a HomeBase intern, contributed significantly to the research relied upon in this memorandum.

*For more information, please contact Danielle Crowell, HomeBase Staff Lawyer, via email at [Danielle@homebaseccc.org](mailto:Danielle@homebaseccc.org), or by phone at 415.788.7961 x301.*