

DISCHARGE PLANNING

Key Concepts

Nationally, inadequate discharge planning has been recognized as a major contributing factor to the growing tragedy of homelessness. Various public and private institutions contribute to homelessness by discharging their wards to the streets or shelters. Ending such practices is an important, current tactic in the struggle to end homelessness itself. A growing body of information documents the large number of people who become homeless upon discharge from jails and prisons, hospitals and treatment facilities, and the foster care system. The role of ineffective discharges from institutions in generating homelessness has been widely recognized. Each such case represents a failure of publicly operated or regulated institutions to fulfill their responsibilities to persons in their care. Each case also reveals the paucity of community resources to meet the housing, health care, and other needs of individuals without personal resources, and demonstrates the responsibility of institutions to work to increase community resources.

Relevant Institutions and Systems of Care

Corrections

- The United States has experienced a huge increase in incarceration. As a result, many people are released from jails and prisons into homelessness. These people face significant barriers as they re-enter society, and without supportive services, may cycle between jail or prison and homelessness. This costs criminal justice systems and communities large amounts of money and resources. Communities must find ways to break connections among jails and prisons, homelessness, and recidivism.

Mental Health/Hospitals/Substance Abuse

- Low-income people with untreated mental illness, substance abuse problems, and physical/emotional impairment face increased risk of homelessness. These problems prevent people from carrying out essential aspects of daily life – self-care, household management, and interpersonal relationships – that are necessary for independent living. People with mental illness encounter greater barriers to employment and housing and tend to have complicated health problems, including co-occurring addiction.
- Homelessness itself functions as a barrier to mental health services. People experiencing homelessness are impoverished, uninsured or underinsured, and alone. Without housing stability, they have difficulty keeping appointments and are often unable to adhere to treatment regimens. Additional barriers to care include lack of documentation and lack of transportation. Without housing, those people experiencing homelessness who are managing their mental illnesses must return to the same high-risk environment of the streets that exacerbates their condition. The realities of homelessness present additional challenges to a mental health system that is sorely under-funded and ill equipped to curb the epidemic of mental illness.

Foster Care

- Foster care is the part of the child welfare system that provides full-time residential care to children in state custody due to separation from their parents who are unwilling or unable to care for them. Many children who “age out” of foster care become homeless as result of lack of services or adequate discharge planning. Runaway and homeless youth emergency services have become the default housing providers for emancipated, “aged out” and runaway foster youth.
- This vulnerable segment of the population has special needs that should be taken into consideration when planning their exit from custodial care. A significant portion of youth currently in foster care has an emotional disorder and/or substance abuse problem.
- The federal government has established programs directly targeted towards homelessness prevention among emancipated or “aged out” youth. The Independent Living Program (ILP) provides federal funds to states for life/employment skills training, education, counseling and peer support to youth between 16-21 about to exit foster care. A similar program, the Transitional Living Program (TLP), provides similar training and support, as well as housing assistance for all runaway and homeless youth. Unfortunately, these programs are limited in their scope, and as a result, states and communities are not taking advantage of these programs. Consequently, many youth end up in emergency shelters and ultimately, homeless.

Elements of Effective Discharge Planning –

Start with a **single entity** overseeing a **discharge planning policy** that coordinates activity of all institutional players

- The single entity develops relationships with other agencies and institutions within a community and coordinates planning activities and ensures a fair and effective distribution of funds.
- The policy must mobilize system integration processes among criminal justice, mental health, and substance abuse treatment systems.

Take a **team approach** to coordinate the work of multiple agencies

- Team members will include the client, the institutional representative, Criminal justice system representatives, the case manager, family members, peers, mental health and substance abuse treatment providers, health care providers, housing specialists, policy makers, and advocates.
- The case manager leads the team and works with the client and the rest of the team to stay on track with the plan or revise it as necessary.
- Clear communication regarding each team member’s role and responsibilities will guard against a fragmented service system.
- A team, which oversees the various services, can serve as a point of accountability or clinical home for each individual. This team can also ensure that the services are oriented to the individual’s evolving needs.

Focus on the **individual**

- Plans must take into account the client's needs and preferences, and cultural identity, considering such issues as race, ethnicity, religion, gender, age, primary language, and sexual orientation.
- Assessing the needs of the individual involves¹:
 - Cataloging the individual's psychosocial, medical, and behavioral needs and strengths
 - Gathering information – from law enforcement, court, corrections, correctional health, families and community provider systems – necessary to create a fully informed transition plan
 - Incorporating a cultural formulation in the transition plan to ensure a culturally sensitive response
 - Engaging the individual in assessing his or her own needs
 - Ensuring that the individual has access to and means to pay for treatment and services in the community

Ensure a **seamless transition** to appropriate housing and services

- Integrated service planning can fulfill the needs of the individual after he or she is released from care or incarceration.
- Continuing support after housing placement is particularly important.
- Providing long-term uninterrupted support may involve:
 - Assistance in rebuilding connection to family support system for all individuals during institutionalization.
 - Determination of status of community connections and reestablishment of those connections and reestablishment of those connections whenever possible for all individuals at the time of entry into system.
- Efficient discharge plans must identify and secure a variety of housing options, which are based on an assessment of the community's housing stock and the existing partnerships with housing and service providers.
- Discharge planning may require the following services: health care, mental health and substance abuse treatment, income support, social supports, and a range of other services such as transportation, job training, money management, and help with daily living skills.

Partner and Collaborate with appropriate institutions and agencies

- Partnerships may include:
 - Representatives from institutional corrections, probation/parole, law enforcement, the judiciary
 - Social and human service agencies (e.g., treatment providers, health care agencies, housing, employment, and education service providers, victim advocates)
 - Nongovernmental community support organizations (e.g., faith-based groups, neighborhood advocacy groups and civic associations)

- Any other entity that can facilitate an individual's transition to community providers (e.g., Business Improvement Districts, private foundations, advocates, and the media).
- *Who* is involved is only the first step in effective collaboration and partnerships. Other essential elements of an effective partnership include:
 - How often these partners meet
 - What they discuss,
 - How decisions are made,
 - What operational practices are put in place, and
 - Who is responsible for delivering what part of the process.
- Partnerships must involve their members at three levels: policy development, operational practice, and staff decision-making.
- Achieving collaboration may involve using incentives to persuade the representatives of the essential groups to invest time and energy to address this issue area that they may not have recognized as part of their responsibilities.
- The continuum of collaboration may range from shared information and memoranda of understanding to blended staff and joint financial agreements.
- Representatives from the institutions and community behavioral health providers should meet in ongoing forums to monitor the process, resolve problems, and hold staff and program components to standards or performance measures established by the team members.
- The following are recommendations for developing a mechanism to monitor outcomes of discharge plans and identify opportunities to improve the processⁱⁱ:
 - Establish appropriate quality indicators with realistic benchmarks that can be measured easily.
 - Develop a mechanism to establish corrective action plans for systems unable to meet those expectations.
 - Document that all responsibilities delineated above occur and that they do so within appropriate time frames.
 - Include all stakeholders, including people in recovery, in oversight of the quality management process.
 - Incorporate established standards into contracts with managed care organizations to assure proper incentives in reimbursement.

General recommendations for good discharge planning policies that will help prevent homelessness include:

1. **Prohibit discharges into homelessness** from all publicly funded institutions such as hospitals, treatment facilities, prisons and jails, and the foster care system. Invest in recuperative care facilities for patients without homes who require supervised medical care but are not ill enough to remain hospitalized.
2. **Require all publicly funded institutions providing residential care, treatment or custody** to secure all available entitlements for residents prior to discharge and to provide staff persons trained in housing placement assessment and assistance.
3. **Establish assisted living type recuperative care facilities** for homeless individuals who require medical, mental health and/or addiction services over a period of time in order to sustain their housing stability while they recuperate, recover, and prepare to enter permanent housing.
4. **Support legislation to encourage better planning and services** for individuals being discharge from correctional institutions into the community.
5. **Create sufficient jobs and incomes, affordable permanent housing, universal health insurance, accessible health care, and other community services** to meet the needs of all persons at risk of homelessness.

ⁱ Fred Osher, et al., *A Best Practice Approach to Community re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model* (2002), The National GAINS Center.

ⁱⁱ *AACP Continuity of Care Guidelines* (August 26, 2001), American Association of Community Psychiatrists.

BEST PRACTICES AND COMMON SOLUTIONS

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| Program | Allegheny County State Forensic Program (Allegheny County, PA) |
| Web Information | www.county.allegheny.pa.us/dhs/BH/bh.html ; reentrypolicy.org/documents/PA_000.pdf |
| Practice Used | <ul style="list-style-type: none"> • Works with individuals with serious mental illnesses or substance abuse disorders as they are released from Pennsylvania penitentiaries. • Individuals with behavioral health diagnoses who have ties to Allegheny County may be referred to the Program by a Department of Corrections psychologist. The program is voluntary. • A program staff member conducts a confidential interview with the referred individual to assess his interests and need and to determine whether or not he wants to participate in the program. • Program includes: <ul style="list-style-type: none"> ○ Face-to-face meetings while in prison, ○ Post-incarceration housing, ○ Psychiatric treatment ○ Access to bus passes and new clothes, and ○ Help in applying for eligible benefits and job search assistance. • Participants receive stipends to pay for housing for up to 90 days after their release from a corrections facility, even if they will live with family. • In preparation for release from prison, the program staff member arranges for housing, if necessary, and schedules a psychiatric appointment. • When the individual is released, a worker meets him at the bus terminal, or, if he is released from a nearby institution or is incapable of managing a bus ride, the staff person will pick up the individual from prison. • The recidivism rate for program participants is one-fifth of that for all individuals released from a State penitentiary. |

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| Program | Youth Housing Assistance Program (Illinois) |
| Web Information | www.endhomelessness.org |
| Practice Used | <ul style="list-style-type: none"> • The program provides housing advocacy and cash assistance to youth aging out of foster care. • Target Population - Illinois' Youth Housing Assistance Program targets youth at high risk of becoming homeless who are approaching emancipation or who have already emancipated from the foster care system. Housing advocacy is provided for youth between the ages of 17 1/2 and 21 and cash assistance is provided to youth between the ages of 18 and 21. • Referral Process - Caseworkers refer youth to the Youth Housing Assistance Program six months before emancipation if they are in need of housing services. Youth must submit a request for Housing Advocacy and/or Cash Assistance to the Youth Housing Assistance Coordinator. Youth is assigned to a Housing Advocate located in their region for services. • Services <ul style="list-style-type: none"> ○ Housing Advocacy -- service to help youth locate housing, receive budget counseling, and gain access to community resources and social services. ○ Start-up Grant -- Youth can receive up to \$800 (\$1200 if youth is parenting, pregnant, or disabled) to cover start up costs including deposits, furniture, appliances, etc. The start-up grants assist youth to move in to housing at the time of emancipation. ○ Partial Housing Subsidy -- If youth's housing cost exceeds 30% of their income, their landlord will receive up to \$100 per month for up to 12 months following the youth's emancipation. The monthly subsidy is designed to be large enough to provide a cushion for young people learning to live on their own for the first time, but small enough to discourage youth from becoming dependent on the subsidy. ○ Cash assistance -- Cash assistance may be used for housing security deposits, rent, partial rental subsidies, furniture, appliances, utilities, and other item required for youth to avoid or manage a crisis. Youth are provided up to \$2000 per 12-month period following emancipation to help youth stabilize after a crisis. If any employed youth loses a job and needs to pay rent before another job is secured, youth is eligible for \$600 one-time exception. Lifetime limit for all types of cash assistance is \$4000. ○ Follow-up services for a minimum of three months after the client secures appropriate housing. |

SELECTED RESOURCES

Online Resources

Mental Health Consensus Project,

http://www.soros.org/initiatives/justice/articles_publications/publications/cj_mh_consensus_20020601?skin=printable

National Alliance to End Homelessness

www.endhomelessness.org

HomeBase: the Center for Common Concerns/Legal and Technical Services Supporting Shared Prosperity

www.homebaseccc.org

Contact Laxmi Raman-Rees at laxmi@homebaseccc.org

Publications

AACP Continuity of Care Guidelines (August 26, 2001), American Association of Community Psychiatrists.

After Prison: Roadblocks to Reentry: A Report on State and Legal Barriers Facing People With Criminal Records (2004), Legal Action Center, 2004.

James M. Byrne, et. al., *Emerging Roles and Responsibilities in the Reentry Partnership Initiative: New Ways of Doing Business* (January 8, 2002), National Institute of Justice.

Community Integration: The Role of Individual Assessment (2002), Center for Health Care Strategies.

Essential Resources for Discharge Planning (2002), National Health Care for the Homeless Council.

Fred Osher, et al., *A Best Practice Approach to Community re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model* (2002), The National GAINS Center.

Report Preview: Report of the Re-Entry Policy Council (2004), Re-Entry Policy Council.

Taking Stock: Housing, Homelessness and Prisoner Reentry (March 8, 2004), The Urban Institute.