
For the Law & Justice Interim Committee

A Policy Brief outlining
discharge planning to reduce
homelessness

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House Bill 395, legislates discharge planning for Montana's State Hospital under the direction of Department of Public Health Human Services. Research and recommendations found in this brief support Warm Spring's current practice of patient-centered discharge planning. HB 395 also addresses the pressing need to adequately assist patients adapt to community life after they are discharged from care. Our research indicates that attention to housing in discharge planning will reduce re-hospitalization and reduce the sequela of crisis-stabilization costs emanating from housing instability.

What is discharge planning?

Discharge planning is a structured process that plans for the safe and successful transitioning of individuals with mental illness from the time of their admission to a state hospital through re-entry into the community. As defined by the Montana State Hospital, discharge is the termination of an admission/commitment to Montana State Hospital that ends the provision of treatment and other legal obligation of the Hospital toward the patient.¹ Best-practice, patient-centered discharge plan as outlined by HB 395 begins when a patient enters a mental health facility.² Discharge teams include a patient, family members, doctors, and mental health practitioners. These teams decide, on the first day of a patient stay, how the patient will re-enter the community. House Bill 395 provides housing upon discharge. It opens up opportunities for individuals to reintegrate in society, increase their mental and physical wellness, and maintain their stability in order to become self-sufficient.

How are mental illness and homelessness interrelated?

The Interagency Council on Homelessness identified inadequate discharge planning for individuals exiting mental health facilities as a significant factor contributing to homelessness among persons with mental illness.³ A surprising number of people in our state are currently experiencing homelessness. Many of these individuals struggle with mental illnesses that impacts their ability to find or retain adequate housing for themselves or their families. According to the Montana Homelessness Coalition, of the 2,311 citizens identified as homeless throughout Montana⁴, 408

¹ Montana Department of Health and Human Services, *Montana State Hospital Policy and Procedure: Discharge from Hospital*, <http://msh.mt.gov/volumei/admissiondischarge/dischargefromhospital.pdf> December 12, 2011.

² Baron, Erlenbusch, Moran, O'Conner, Rice & Rodriguez. *Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails*. (Los Angeles Coalition to End Hunger and Homeless, 2008), 29.

³ T. E. Backer, E.A. Howard & G.E. Moran. "The role of effective discharge planning in preventing homelessness." *Journal of Primary Prevention* (Special Issue on Prevention of Homelessness) 28 (2007): 230.

⁴ Montana Coalition on Homelessness. "No longer Homeless in Montana: a Report on the State of Homelessness and a Ten Year Plan to End It." (2008): 6.

have been diagnosed with a mental illness⁵. Sixty-six percent of all people with serious mental illness have experienced or been at risk of experiencing homelessness⁶. Unmanaged mental illness symptoms can greatly reduce an individual's ability to maintain a stable income, which may put them at risk for eviction. According to a study conducted by the Oregon state hospital, the "lack of available housing causes a domino effect for persons living with mental illness, limiting their ability to work, afford treatment for their mental illness, and resulting in a more frequent need for hospitalization."⁷

Without a stable and consistent place to live, symptoms and crises related to mental illness are more easily triggered. Former patients may relapse requiring their re-admission to the state mental health system, necessitating their reliance on expensive systems of care for their basic needs. Emergency-care facilities are inadequately positioned to provide the preventative care that may reduce costs and save lives. Chronically mentally ill patients may also divert emergency care resources away from acute populations.

What is the cost?

Housing instability and homelessness pose a significant cost to individuals and communities. It is a preventable cost to tax-payers. In the absence of sufficient, preventative discharge planning those with mental illness who end up on the street may cost Montana taxpayers an average of \$15,500 per year per homeless individual with visits to crisis centers, emergency care, jail and shelter care⁸. This cost decreases by 86% when that same individual lives in permanent, supported housing. Montana's ten largest hospitals spent 136 million dollars on charity services in 2006.⁹ Common Ground, a New York state service provider, found that homeless individuals use hospital emergency services for their primary medical care, and that there is a "subset of who are *frequent* users of

⁵ Montana Coalition on Homelessness, 17.

⁶ Montana Coalition on Homelessness, 20.

⁷ Oregon State Hospital. *Frameworks Master Plan: Phase II Report*, (KMP Architects with New Heights Group, 2006), 29.

⁸ Montana Coalition on Homelessness, 25.

⁹ Montana Coalition on Homelessness,

these services.”¹⁰ In Montana, this subset would include those suffering from severe mental illnesses. The average stay at Montana State Hospital is \$544 per day. Housing and preventative homecare cost much less than hospitalization; studies in California and Connecticut showed a 50% reduction in Medicaid costs when these services were implemented.¹¹

Currently, our State Hospitals are permitted to discharge individuals into homelessness. While best practices indicate that patient-centered discharge planning should allow clients freedom of choice to transition into an unstable housing placement, the practice of discharging individuals into homelessness simply because there are no other options is an oversight in our communities extremely costly to our state. This cost could be reduced through minimal effective preventive measures. House Bill 395 encourages Department of Public Health and Human Services, Warm Springs and local leadership committees to work together with local agencies and patients to reduce homelessness, recidivism rates regarding use of State services, improve wellness, assist individuals in the reintegration process, and provides an opportunity for them to become productive working members for our community.

What are other states doing about this issue?

Many states have adopted aggressive discharge planning from state hospitals. Vermont also has a hospital staff liaison who works to coordinate care with police departments and community mental health centers. States like Oregon and Vermont begin discharge upon admission and address housing in their discharge plan lessening the reliance on taxpayers’ dollars and creating sustainable ways for people to transition from hospitals. These states have a far lower patient return rates than states who do not employ comprehensive discharge planning. Maine and North Dakota specifically detail the description of needed services and providers’ expectations. Massachusetts now uses a state-wide electronic discharge planning process with quick service descriptions, eligibility

¹⁰ Baron, Erlenbusch, Moran, O’Conner, Rice & Rodriguez, 34.

¹¹ Baron, Erlenbusch, Moran, O’Conner, Rice & Rodriguez, 34.

requirements, and updated contact information. By adopting similar practices Montana has the opportunity to become a regional leader in innovative patient-centered discharge planning and save tax payer revenue while enhancing citizen safety and well-being

Recommendations: The Discharge Planning Process

Discharge planning should begin as soon as a patient is admitted to a mental health facility and should include the following:

- 1.) inclusion of a housing plan;
- 2.) identification of team members responsible to assist a patient with the plan (e.g. social worker, psychiatrist, intake coordinator, mental health staff, family members, the patient, and any other pertinent members involved in the patient's treatment);
- 3.) Referrals to community-based agencies or individuals who will serve as contacts to assist the patient with post-discharge needs.

Further Reading

The Role of Effective Discharge Planning in Preventing Homelessness.

Journal of Primary Prevention

Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails.

Los Angeles Coalition to End Hunger and Homeless.

Building Bridges: Consumers and Representatives of the Mental Health and Criminal Justice Systems in Dialogue.

Rockville, MD: Center for Mental Health

Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness.

Community Mental Health Journal.

Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of Consumer Driven and Operative Service.

Journal of Mental Health

Preventing Homelessness Among People with Serious Mental Illness: A Guide for States

U.S. Department of Health and Human Services, Rockville, MD

Evaluability Assessment of Discharge Planning and the Prevention of Homelessness: Final Report
<http://aspe.hhs.gov>

Frameworks Master Plan: Phase II Report
Oregon State Hospital

Government of Maine: Rights of Recipients of Mental Health Services; Part B - III. Individualized Treatment and Discharge Plan
<http://www.maine.gov/dhhs/mh/rights-legal/recipients/RightsRecipients/PartB/individualized-treatment.html>

No Longer Homeless in Montana: a Report on the State of Homelessness and a Ten Year Plan to End It
Montana Coalition on Homelessness

Sources

Backer, T. E., Howard, E. A., & Moran, G. E. (2007). *The role of effective discharge planning in preventing homelessness. Journal of Primary Prevention* (Special Issue on Prevention of Homelessness), 28: 229-243.

Baron, Erlenbusch, Moran, O'Connor, Rice & Rodriguez (2008). Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails. Los Angeles Coalition to End Hunger and Homeless

Center for Mental Health Services. Building Bridges: Consumers and Representatives of the Mental Health and Criminal Justice Systems in Dialogue. DHHS Pub. No. (SMA) 05-4067. Rockville, MD: Center for Mental Health.

Gulcur L., Tsemberis S., Stefancic A., & Greenwood R. M. (2007). Community integration of adults with psychiatric disabilities and histories of homelessness. *Community Mental Health Journal*, 43(3): 211-228.

Lawn, Smith & Hunter. Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service. *Journal of Mental Health*, October 2008 pp. 498-508.

Lezak, A.D., Edgar, E. (1998). Preventing Homelessness Among People with Serious Mental Illness: A Guide for States" Center for Mental Health Services Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services Rockville, MD

Moran, G., Semansky, R., Quinn, E., Noftsinger, R., & Koenig, T. (2005). *Evaluability assessment of discharge planning and the prevention of homelessness: Final report*. Retrieved from <http://aspe.hhs.gov>

Oregon State Hospital (2006). "Frameworks Master Plan: Phase II Report". KMP Architects with New Heights Group

Maine Government Website

<http://www.maine.gov/dhhs/mh/rightslegal/recipients/RightsRecipients/PartB/individualized-treatment.html>

Mtcoh.org (ten year plan)

www.nd.gov

Appendix A

Discharge Planning: Detailed Recommendations

Assessment

A thorough needs assessment upon admission should include the following analysis of the individual's life outside of the institutional setting, all of which would assist with proper discharge planning: 1.) housing, food, and clothing assessment; 2.) medication management; 3.) transportation; 4.) income sources; 5.) health care; 5.) mental health and/or substance abuse services; 6.) access to social or recreational supports; 7.) employment history; 8.) spirituality; 9.) the need for education and skills development.

A Collaborative Discharge Team

In research, exemplary discharge planning includes a continuum of collaboration centered on the patient as director, featuring partnerships amongst all entities that help facilitate an individual's community re-entry and stability. "A single entity often oversees the discharge planning policy, and develops relationships with other organizations, coordinates planning activities, and ensures fair distribution of available funds."¹² This collaboration encourages agencies or institutions that have historically been competitive or adversarial to work together for the health and well-being of the

¹² T. E. Backer, E.A. Howard & G.E. Moran, 233.

individuals being served. As encouraged through Montana's existing regional Leadership Committees, "discharge planners should already have in place partnerships with local community providers, as well as agreements with housing providers."¹³

The Housing First Model

According to both national and international best practices, successful, cost-reducing community re-entry and stabilization is based upon securing a safe and permanent place to live¹⁴. The best discharge plan cannot overcome a lack of community housing and services. Given the discretion of some property management companies in refusing renters with certain histories, it is advised to set up agreements with rental agencies to address eviction concerns and poor rental history in order to mitigate this issue for those who are newly discharged into the community.

Support Networks and Peer Mentoring

Assisting Montana's citizens to strengthen their support network (friends, family, community providers, and former patients) is an effective way to reduce the isolation that often leads to expensive re-hospitalization. "The phenomenon of cyclic hospital re-admission of people with mental health conditions is well identified internationally in the literature. International research identifies lack of community support, rather than a person's illness symptoms, as a main factor in re-admission."¹⁵ Integrating a volunteer peer-mentoring program as part of a discharge plan can connect consumers with a healthy support network. Such a network is currently available through the Montana chapter of the National Alliance for Mental Illness, and should be made available and known to those exiting state institutions as a viable option for support.

The isolated location of the Montana State Mental Hospital naturally creates problems with consumer reintegration and community collaboration. It would be advantageous to allocate

¹³ T. E. Backer, E.A. Howard & G.E. Moran, 233.

¹⁴ T. E. Backer, E.A. Howard & G.E. Moran, 230.

¹⁵ S. J. Lawn, A. Smith, & K. Hunter, 499.

funding to enhance the capacities of smaller mental health hospitals within the larger communities of Montana, which would also have the benefit of reducing over-crowding at the state hospital.

Community support of local hospitals reduces stigma, increases job and volunteer opportunities, and enhances a connected mental health system in Montana in keeping with best practices for both patients and communities.