

Policy: To ensure that every person discharged from a mental health facility has safe, decent, affordable housing.

Procedure:

A. The Mental Health Discharge Planning Process includes the following components:

1. All consumers will receive an Individual Needs Assessment at admission to include the person's medical, employment, housing, and family or support network.
2. Clinicians will coordinate Pre-Release Skill Training to overcome needs or problems identified for the individual including topics such as goal setting, control of one's emotions, pre-employment skills, money management, and educational attainment.
3. Clinicians will coordinate Pre-Release Qualification for Benefits possessed at the time of entrance to care or for which the person qualifies, to include restoration of civil rights, identification and supporting documentation, and mainstream human services programs such as food stamps, SSI, Medicaid, and welfare cash assistance.
4. A written Discharge Plan will be developed and reviewed with the individual prior to the scheduled release date.
5. Each plan will iterate appropriate referrals to community based providers for post-release services to assure the individual has appointments or action plan to obtain and continue follow up services, treatment, and care without interruption.
6. At Discharge, provision of essential resources to include such items as medications, medical supplies, clothing, transportation or other basic resources needed and in quantity to enable the individual to transition back to the community are provided.
7. At Discharge, a notice to the planned housing provider will be sent to confirm that the person to be released is expected to arrive and occupy the available housing.

8. The Clinician will provide post-release monitoring and evaluation to track whether the individual was able to transition into the community, remain self-sufficient, and avoid becoming homeless.
  9. Composition of the discharge planning team is flexible and may include: the individual, family members, community case manager, institutional representative, community resource specialist, mental health and substance abuse specialists, housing specialist, entitlement/income specialist, criminal justice system representative, health care system representative, pay-or representative, policy maker, advocate, peer supporter.
  10. The designated team leader (community case manager) is responsible for following up with the individual to ensure the implementation of the discharge plan, including ongoing assessment, identification of team members, and coordination.
  11. Team members will utilize a well-designed information system to link the community and institution that track procedures, feature safeguards and consent agreements.
- B. A discharge plan will be developed for consumers with significant health care, mental health or housing problems that will require complex or coordinated community health care that the patient cannot arrange for themselves and supervision in the community. The Clinician is available as a resource for assistance with discharge planning.

The discharge plan will include as needed:

- Place of residence upon Discharge. Does the individual have access to stable housing options upon release so as to avoid homelessness? Where no stable housing is identified or available other than to emergency shelters, assure referral to the local homeless coalition for assistance in sheltering the person.
- Transportation Need. Does the individual need transportation assistance to their place of residence upon discharge back to the community?
- ◆ Aftercare Referrals. What follow up care or services does the individual need after release, and to what agencies or providers has the individual been referred for services?

- ◆ Resources Provided at Discharge. What medications, medical supplies, clothing, transportation, or other basic resource needs, will the individual be provided at the time of discharge?
- ◆ Eligibility for and enrollment for Benefits upon Discharge. What programs of assistance does the individual need upon release, has the individual's eligibility been determined for services, and has the individual been approved for receipt of the benefits prior to discharge?
- ◆ Employment. Does the individual have a job placement secured upon release, or, if not, what referrals or assistance have been arranged for the individual on discharge?
- ◆ Identification and Documentation. Has the individual been provided with personal identification paperwork, and copies of back-up documentation to support such identification, such as birth records, Social Security Number, and copies of back-up documentation to support such identification, such as birth records, SSN, and resident status?
- ◆ Risk Assessment for Homelessness. Given the availability of stable housing, employment, and the need for after care treatment or services, is the individual at-risk of becoming homeless upon discharge? What efforts should be made to link the individual to the community's homeless services network?
- ◆ Support Network. Does the individual have family, friends or other support entities to assist him/her in transitioning back into the community? Have these support persons or entities been participating in creating the discharge plan?
- ◆ Post Release/Discharge Actions. Will there be follow up contact or services provided to the person after discharge to help adjust their plan as needed? Does the agency evaluate the effectiveness of the discharge plan on the individual's success in transitioning back into the community?

## C. Responsibility

### 1. **AREA RESPONSIBILITY:**

Individuals who are currently receiving in-patient, out-patient, or any type of after-care treatment within the mental health system and those persons who, through screening, have been determined to be in need of mental health services:

- a. In no instance should a person be discharged from an inpatient facility with directions to seek housing or shelter in an emergency shelter. Every effort must be made through careful discharge planning to work with the client and area resources to seek adequate, permanent housing.
- b. If "temporary" shelter placement is unavoidable, the reasons for this should be well-documented. Active case management should focus on locating a suitable housing alternative as well as ensuring that the client continues to receive appropriate mental health services. In all instances, a case manager should be identified.
- c. If a client exercises the right to refuse treatment and/or aid with placement, this should be documented. Documentation should include case management efforts. Whenever possible, outreach efforts should continue.
- d. If a client receiving out-patient services becomes homeless, the clinician/case manager should work actively with the client and community resources to locate suitable housing. Service gaps and resource inadequacies should be identified and documented whenever possible.

**2. AREA RESPONSIBILITY TO EXISTING SHELTERS:**

- a. The Area in which a shelter is located has the responsibility to provide consultation and education to the shelter regarding health issues and services. Under no circumstances should this be construed as the Department's (or a particular Area's) acceptance of responsibility for the individual residents of a shelter, nor for the health, social and financial problems associated with homelessness.
- b. Any shelter resident who requires emergency psychiatric care should be provided that care in the shelter's host Area; however, subsequent to the management of any emergency, an individual in need of mental health services is the responsibility of the Area that provided the last hospitalization (if any) where the client has ties and a confirmed support system (if any). The originating Area also retains responsibility for case management.
- c. Any shelter resident who requires mental health services and who has no Area ties or previous history of hospitalization should receive services provided by the host Area.

**3. GENERAL AGENCY INVOLVEMENT IN HOMELESSNESS:**

- a. In order to respond effectively to the multitude of social and economic problems that contribute to homelessness, it is

recommended that mental health participation include both the public and private sector at the Area/Community level. Area mental health personnel should participate in any community activities and committees that address the general problem of homelessness.

- b. The purpose of this involvement is twofold:
  - 1. To provide assistance to community representatives and planners in dealing with the overall problem.
  - 2. To provide mental health expertise, including accurate clinical and managerial information.
  
- c. In no instance should any one agency take sole responsibility for homelessness, but this agency should clearly demonstrate a willingness to participate with the community and other agencies in responding to the problem. Each Area Director should be knowledgeable as to the extent of homelessness in that catchment Area, especially as it pertains to mental health needs. This information should be reported to the respective District Manager, the Chief Operating Officer, and the Governor, to support agency planning and policy development.