

## INTRODUCTION AND OVERVIEW

### PREVENTING HOMELESSNESS:

#### TOOLS AND RESOURCES FOR DISCHARGE PLANNING

##### **Preventing Homelessness**

The mission of the Massachusetts Housing and Shelter Alliance (MHSA) and its 80 member agencies is the abolition of homelessness. For the past five years, MHSA has engaged state agencies, including mental health, public health, corrections, youth services, and social services, as well as county corrections and the state's for-profit managed care vendors, to explore homeless prevention through appropriate discharge planning - *discharge planning that prepares a homeless person in an institution to return to the community and links that individual to essential housing and services, including enhancing and expanding their treatment options and effectiveness.*

##### **Federal Recognition of a Local Issue**

In May 1994 the federal government published *Priority: Home! The Federal Plan to Break the Cycle of Homelessness*. The plan reviewed the causes and characteristics of homelessness, and recommended federal administrative and legislative initiatives to alleviate and end homelessness. *Priority: Home!* recognized that inadequate discharge planning can contribute to homelessness among people with serious mental illnesses and/or substance use disorders and recommended that federal agencies collaborate with states and local communities to "review and strengthen discharge and aftercare planning strategies to ensure appropriate linkages with housing and community-based care in order to ensure that supports necessary to avoid subsequent homelessness are in place."

The Federal Plan also recommended that a discharge planning working group be established "to identify discharge planning strategies for hospitals and community-based treatment facilities as well as ensure continuity of care and explore options for federal, state, and local initiatives ... to develop necessary linkages to avoid discharging people who do not have a place to live."

To implement these recommendations, the Federal Interagency Council on the Homeless (ICH) established the "Interagency Work Group on Improving Discharge Planning." This group convened a Working Conference on Discharge Planning in June 1997 "to identify and build consensus for the key elements of effective discharge planning and to develop recommendations for exemplary discharge planning practice." The two-day conference brought together a group of 18 experts from across the United States - all nominated by federal agency members of the ICH or national organizations. This group included researchers, consumers, program directors, managed care representatives, advocates, substance abuse specialists, and social workers.

The result was *“Exemplary Practices in Discharge Planning: Report and Recommendations of the Working Conference,”* a paper published by SAMHSA in June 1997. MHSA was a participant in the Working Group, which applied the four key areas of focus of the White Paper in doing its work. The four areas are: 1) roles and responsibilities in exemplary discharge planning; 2) elements of the plan; 3) collaboration and partnerships; and 4) funding and cost issues.

The conference also heard a paper presented by Dr. John Belcher of the University of Maryland, and MHSA was so struck by his insights that MHSA brought him to Massachusetts to address our annual advocacy conference on ending homelessness. The SAMHSA conference and MHSA’s conversations with Dr. Belcher provided the springboard to develop an advocacy strategy focused on homelessness prevention.

The federal developments described above came at the same time that MHSA’s own efforts to address growing numbers of inappropriate discharges into homelessness were beginning to provide some detailed insight into the growing homelessness problem in Massachusetts.

### **MHSA’s Work in Ending Homelessness**

For the past five years, MHSA has engaged state agencies, including mental health, public health, corrections, youth services, and social services, as well as county corrections and the state’s for-profit managed care vendors, to explore homeless prevention through appropriate discharge planning.

Over the past decade in Massachusetts, literally thousands of homeless people have moved out of shelters, beyond homelessness to housing, employment, and appropriate supportive services. But, despite these efforts over the past years in moving thousands beyond homelessness, there are more homeless individuals in Massachusetts than ever before. Thousands have moved beyond homelessness. Thousands more have fallen in.

Why have emptied shelter beds refilled overnight? MHSA’s efforts to answer that question became the foundation for its multi-year work on discharge planning as homelessness prevention. To undertake this work, focused as it is on multiple systems of care in the public sector, and community based resources at the back door of those systems, MHSA sought support from both government and the private sector.

### **A Major Demographic Trend Emerges in Massachusetts Shelters**

A startling 10% system-wide increase in the demand for shelter in the winter of 1995-96 created an urgent need to identify the source of this growth in homelessness. This surge taxed the ability of shelter operators to meet new clients’ intensified needs for specialized support, supervision and discipline. The growth in numbers also made it more difficult to serve other clients since the addition of large numbers of new guests added to already volatile emergency shelter settings.

While MHSA had long collected nightly occupancy data on demand at the front door, this startling development, coming as it did in the face of many highly successful next

steps programs being created in the state, required a new strategy. MHSA instituted a monthly census of emerging subpopulations in the shelters across that state. This effort, now 5 years old, documented the emergence of growing numbers of individuals falling into homelessness upon discharge from mental health facilities, substance abuse treatment facilities, state and county corrections, foster care, and managed care.

MHSA's research showed that too often, the people without residential or housing options coming to the front door of shelters have come from the back door of state systems and institutions: young people 18-24 years old who have aged out of state services; ex-offenders released from state or county facilities with no place to go; people from detox at the beginning of their recovery; and people with mental illness released directly from a hospital. Research regarding these homeless sub-populations dispelled the old myth that homeless people are anonymous street people wandering from shelter to shelter. Rather they are known - in fact, quite well known - to state funded residential treatment, corrections, and youth programs.

In the homeless programs providers had been strategically and conscientiously creating a continuum of care that responded to needs extending from the street, through shelter, transitional programs, and permanent housing. While our system was acting strategically, the mainstream system acted dysfunctionally without a continuum, without emphasis on transition, without residential outcomes often.

### **Moving to Advocacy and Education**

Once MHSA had gathered information through research, the findings were converted to advocacy and education. Education of the agency itself, of the state legislature, the administration, and our most interested audience, the media.

So, for example, with the Department of Mental Health, MHSA discovered that the public mental health centers were discharging people to the streets and shelters against their own regulations. The Bureau of Substance Abuse Services was truncating the continuum of recovery by discharging people after detox back to the unsafe and un - sober streets and shelters.

Corrections facilities were discharging people to the streets without concern for a residential setting or reintegration. The foster care system was aging out young people at 18 who then had only at - risk alternatives of dysfunctional and dangerous family situations or unstable alternative living arrangements. The managed care system comprised of network hospitals which did not share the discharge regulations or protocols eventually developed by the DMH were releasing people to the streets.

As MHSA discovered and quantified through research the origins of the people at our front door, we engaged in advocacy to educate. Once that was accomplished the next step was two fold.

## **Discharge Planning Policy Change**

First, what needed to follow research and advocacy was **policy change**. Discharge to homelessness was not only inappropriate and undermining of the taxpayer funded services just received, but even more damning, it was a bad performance outcome. MHSA bumper stickered this concern for inappropriate discharge and bad performance outcome into a specific policy mandate: **Zero tolerance for discharge to homelessness**. State systems and institutions, the so-called mainstream programs needed to be held accountable for what happened at their back doors. And a performance outcome that can't be tolerated is a discharge to homelessness.

## **New Resource Development**

The second direction that the research and advocacy point beyond policy change is **resource development**. MHSA found that most state agencies or vendors or institutions, once the initial dance of denial was over, wanted to respond appropriately. What often hindered them was a **lack of resources**. They just did not have the funds to create the next step residential beds or permanent housing that is so necessary for a successful discharge. When MHSA talked to the new discharge planners that began to populate programs as the advocacy gathered momentum, we learned that they were frustrated by the inability to place people because of a lack of next step residential options.

### *The Criminal Justice Initiative*

The availability of new residential and service resources is a "good news" headline that requires its own communications and monitoring strategy. First, front line workers around the state need to be provided with continuous updates on new resources as well as afforded the opportunity to develop working relationships with their counterparts in both directions on the continuum. The placements from which your clients come and to which they progress can be as faceless as public facilities without the venues for working relationships. MHSA has fostered this process in a number of ways, including the convening of Criminal Justice Initiative meetings, involving the Massachusetts Department of Correction (DOC), the DOC substance abuse vendor, the Department of Public Health (DPH), the Office of Community Corrections (OCC), a component of the Administrative Office of the Trial Court, the Massachusetts Parole Board, the Office of the Commissioner of Probation, the Department of Mental Health (DMH), county corrections facilities, and recovery homes. Through the CJI meetings, all constituent groups are able to participate in monitoring, problem identification and resolution, and expansion of recovery home beds targeted to substance-abusing, homeless ex-offenders.

MHSA has thus created a forum for constructive interaction between service providers, advocates, and state and county corrections facilities. The meetings have been essential to crafting coordinated solutions to problems faced by offenders during the reintegration process. Constituent identification of various barriers to the efficacy of the CJI beds provided the means to expand discussion to include issues of health insurance coverage, mental health services (both inside and outside the walls), transportation, parole, probation, and community corrections.

### **Triple 8: The Road Home**

Front line staff also need one-stop up-to-date information to help identify program vacancies and supportive services. MHSA also developed Triple 8: The Road Home, an interactive multimedia information tool. Triple 8 provides current vacancy information on next step resources and can be by by FAX or email for case managers and discharge planners or by visiting the Triple 8 Web site. A discharge planner can interact with the available data by making selections on what region of the state and what type of service they require to meet the needs of their client. Within a few moments, they will receive a FAX or email report with a description of services, eligibility requirements, and contact information offered for programs that match their query.

### **Resource Expansion and Program Implementation**

As advocates MHSA then joined with the state agencies, vendors, and institutions and worked together to begin to create the needed residential resources in the state budget process, working with the legislature and the administration. State agencies learned that adding homelessness to the concerns of their issues often added funds to their line items, funds that were targeted to creating residential options and permanent housing.

On the mental health front MHSA created the Special Initiative to House the Homeless Mentally Ill, permanent housing that has helped hundreds of people succeed. On the substance abuse front MHSA advocated for and won a variety of next step and so – called step down residential beds for people coming out of the acute treatment system detoxes and waiting to move on to recovery homes. These post detox – pre –recovery home beds and the more treatment rich Transitional Support Services beds were won by direct advocacy to the administration to provide the resources to prevent recidivism.

On the corrections front MHSA won resources to create recovery home beds targeted to the back doors of prisons and jails. Ex - prisoners would now have an opportunity to sustain their recovery in a residential setting. MHSA Is now doing the same on the young adult front with age outs from foster care.

So, in both the mental health and substance abuse systems the evolution from research to advocacy to policy has culminated in policies and resources to impede discharge to homelessness and to offer new residential resources.

### **Institutionalizing Change**

Finally, after the research has been shaped into advocacy to create policy and resources, there is another step. An important step. Maybe the most crucial step. The dispensing of the public resources in the contractual relationship must institutionalize the policy through **purchase of service** regulations. That's the institutionalizing of the results of the research, advocacy, and policy change in the contracting of new and historic public resources.

We have been fortunate in Massachusetts in being able to identify opportunities and make progress in the prevention of homelessness. We had a Governor who caught a

vision of reducing homelessness through a strategy paradigm that we advocated: **production / prevention**. We needed to produce more housing to break the gridlock at the back door of homeless programs. And we needed to focus on discharge planning to close the front door.

We have made strides in bringing people to the table, in undertaking the expansion of discharge resources and residential capacity. We think the materials covered here have potential to help address these issues in other states. We thank the National Health Care for the Homeless Program for supporting and expanding the reach of this material and its focus.

### **MHSA's History and Goals**

The Massachusetts Housing and Shelter Alliance, established by local homeless providers and citizens, seeks to create a coordinated strategy to end homelessness. Incorporated in 1988 as a planning and advocacy coalition, MHSA now represents 80 non-profit agencies operating over 200 programs that serve homeless individuals across the state. Currently, the clients of member agencies comprise over 98% of all homeless single adults in Massachusetts.

MHSA is unique both in its role and in its record among agencies and institutions concerned with homeless people. MHSA has one mission: the abolition of homelessness. In pursuit of this mission, MHSA:

- Initiates solutions to homelessness which facilitate the movement of people out of crisis to permanence;
- Creates the antidotes to homelessness through targeted housing, services, and employment initiatives;
- Decreases the dependence of homeless people on the government by increasing resources and creating options for homeless people to exercise their self-determination;
- Uses research and new technologies to identify subpopulations of consumers and then target resource laden strategies to prevent homelessness and intervene in the lives of those who are homeless;
- Ensures that homeless people are at the table where public policy decisions are made and resources are allocated;
- Encourages a sense of moral indignation that any person is without a decent place to live; and
- Advocates for the prevention of homelessness through the creation of appropriate residential responses for populations at risk of homelessness.

MHSA engages the public and private sectors in the following ways to carry out these objectives:

- Conducts strategic planning and advocacy in partnership with government at all levels, national organizations, private philanthropies, service providers, homeless individuals, and businesses;

- Develops and implements pilot programs, initiating innovative approaches to treatment, housing, and services beyond shelter for replication throughout the Commonwealth;
- Provides technical assistance to emergency service, mental health, substance abuse and housing providers in the development of new services, resources, and revenue;
- Facilitates coordination among service providers, increasing efficiency and promoting a seamless continuum of care; and
- Promotes public policy and resource generation targeted to the identification and interception of at-risk homeless populations.

MHSA has achieved substantial success by remaining close to the daily experience of homeless individuals, by remaining persistent in the conviction that the problem of homelessness is solvable, and by being inclusive in its search for partners in the development of a solution to homelessness.

The materials developed by the Massachusetts Housing and Shelter Alliance (MHSA) and presented here are drawn from a variety of tools, reports, and analyses developed over time. Many are a direct result of MHSA's partnerships with state agencies described herein. Others are the products of MHSA's hardworking and committed staff, who created, developed, refined, and sustained these important efforts over the last five years. We are grateful for their efforts in pursuit of MHSA's mission to abolish homelessness.

We also welcome this opportunity to partner with the National Health Care for the Homeless Council and the U.S. Department of Health and Human Services to broaden the reach of this material and collaborate in supporting health care providers and other advocates in addressing homelessness in their communities.

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*Philip Mangano was Executive Director of MHSA from 1990-2002.*