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Discharges to the Streets: Hospitals and Homelessness

Sidney D. Watson
Mercer University, Walter F. George School of Law

DISCHARGES TO THE STREETS: HOSPITALS AND HOMELESSNESS

SIDNEY D. WATSON*

INTRODUCTION

Imagine the children's game of musical chairs, but played with both an individual aim to keep a chair and a collective goal to keep everyone seated. Imagine, as well, that in this game not only are seats gradually removed, but the number of players is progressively increased.

At the start of the game, adjustments are made easily enough, and for a short time the collective goal is achieved. True, the number of seats decreases and the pool of individuals competing for them gets bigger, but those sitting down accommodate the others by sharing their chairs or allowing them onto their laps. The seats are small, however, and there are limits to how much weight people can bear. Inevitably, some people find themselves standing, their number growing as time passes.

As the game continues, many small dramas unfold. Some of those seated on laps are pushed off, then allowed back again. Seats are periodically relinquished, and the appearance of an empty seat precipitates a scramble among those outside the circle. Indeed, many people move back and forth between standing up and sitting down, but the total number of people standing continues to grow, and the collective goal of the game becomes untenable.

Who gets left standing is not determined merely by chance. Some players are fast and strong; some are impaired. Some are unpleasant and disruptive, and others are very heavy: these players are unlikely to be invited onto an occupied chair. Some are timid and ashamed to enlist help, or perhaps just don't know any of the other players. Still others don't understand the rules of the game and wander through the scene.

* Visiting Professor of Law, St. Louis University (1999-2000); Professor of Law, Mercer University School of Law. This work was supported by a Mercer University School of Law faculty research grant. My thanks to Nateesha Gupte (St. Louis University, Class of 2001) and Laura Bedingfield (Mercer University Class of 2002) for their help with research and ideas. Thanks to Patsy Tye of the Mercer Law Library for help locating source material. I am grateful to Ray Brescia, Mary Eden Hombs, and Sue Jamieson for their advocacy and for the time they spent with me discussing these issues.

> The grossly disadvantaged are the first to lose their seats and the least likely to grab replacements; they are disproportionately present among those on their feet.[1]

Musical chairs paints a graphic picture of homelessness in America. At its root, homelessness is about a lack of affordable housing: too few houses for too many people. Anyone who is poor is at risk of becoming homeless, and many poor people move in and out of homelessness, doubled up housing, and transient shelters. However, the most vulnerable among the poor—those with mental illness and substance abuse, single, minority men with little education and those without family and friends—are at increased risk of losing housing and being unable to ever regain it. Those with multiple vulnerabilities fall out of housing first.[2]

This article is about those most at risk of homelessness because of mental illness and substance abuse. In the game of musical chairs, they tend to fall, or be shoved off the chairs. Often, their chairs are health care institutions—state psychiatric hospitals, acute care hospitals and detoxification programs. Repeatedly, these caring institutions push people into the streets and emergency shelters.

The homeless who are mentally ill are not anonymous street people wandering from doorway to shelter. They are frequent inpatients—at state psychiatric hospitals, short term, acute care hospitals, and detox programs. However, too often, these institutions treat and stabilize mentally ill and substance–using homeless people only to discharge them to streets and shelters where they begin another downward spiral of illness that ultimately ends in another inpatient admission, jailing, or worse.

Part I explains the programs and services that can successfully treat people with severe mental illness and substance abuse. Homelessness is not the necessary byproduct of either condition. Parts II and III describe how and why health care institutions discharge people who are mentally ill and substance abusers to the streets and into homelessness. Part IV outlines how hospitals and detox programs can design discharge planning programs to break the cycling of people from institutions to homelessness and back again. Part V develops the concept of a right to discharge planning—legally enforceable statutes, regulations and managed care contracts—that mandate good discharge planning and prohibit release to the streets and shelters.

1. Paul Koegel et al., *The Causes of Homelessness, in* HOMELESSNESS IN AMERICA 24 (1996).

2. Koegel, *supra* note 1, at 24-25.

I. MENTAL ILLNESS, SUBSTANCE ABUSE, AND HOMELESSNESS: TREATMENT THAT WORKS

Researchers have consistently documented high rates of severe mental illness and substance abuse among the homeless. Two-thirds of homeless persons report current problems with mental illness, alcohol, or substance abuse.[3] Estimates of the prevalence of current, major mental illness among homeless people range from 25 to 50 percent, with the most frequently reported figure being 33 percent.[4] Substance abuse is even higher. Estimates are that 50 percent of homeless people have had a diagnosable substance abuse problem.[5] Moreover, many homeless people have dual diagnoses, suffering from both mental illness and substance abuse. In one study of drug abusers, 40 percent were also diagnosed as having mental illness, and half also had alcohol abuse problems.[6]

The relationship between homelessness and alcohol is variable. For some, drinking is the cause of homelessness.[7] Others use alcohol to self medicate the anxiety and depression that tends to accompany the trauma of becoming homeless.[8] Still others may be "environmental alcohol users" adapting to a culture that encourages drinking.[9]

Similarly, the causal relationship between homelessness and mental illness varies: mental illness can contribute to homelessness, and homelessness can contribute to mental illness. Some illnesses result in people becoming homeless, the most frequent being schizophrenia.[10] Yet, major mental illnesses

3. *See* HOMELESSNESS: PROGRAMS AND THE PEOPLE THAT THEY SERVE 24 (1998). Thirty nine percent of homeless people say they have had indicators of mental illness, 36 percent report alcohol problems, and 26 percent report drug use programs [hereinafter HOMELESSNESS: PROGRAMS AND THE PEOPLE]. *Id*.

4. COMMITTEE ON HEALTH CARE FOR HOMELESS PEOPLE, HEALTH AND HUMAN NEEDS 51-52 (1988) [hereinafter HOMELESSNESS, HEALTH & HUMAN NEEDS].

5. Koegel, *supra* note 1, at 31. Alcohol abuse is more prevalent among the homeless than is drug abuse. One half of homeless people studied abused alcohol, while one third abused other drugs. *See also* HOMELESSNESS: PROGRAMS AND THE PEOPLE, *supra* note 3, at 24. Thirty six percent of homeless people report alcohol abuse within the last month. Less is known about other drug use because most estimates combine alcohol and drug use under the rubric of substance abuse. However, a recent study reports that 26 percent of homeless people report drug use programs during the previous month. *Id.*

6. HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 65. Among drug abusers, 42 percent of the men and 41 percent of the women could also be classified as mentally ill, 59 percent of the male clients and 46 percent of the female clients who abused drugs also evidenced a problem with alcohol.

7. HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 62.

8. *Id*.

9. *Id*.

10. HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 40. Other health problems that tend to lead to homelessness are disabling physical conditions that cause a person to become unemployed, or any major illness that results in massive treatment costs.

like schizophrenia are unlikely to result from the trauma of being homeless. Rather, these conditions cause a level of disability and impaired social functioning that in the absence of treatment and support can lead to homelessness.[11]

On the other hand, homelessness can exacerbate less severe mental and emotional problems like depression. Becoming homeless is a psychologically traumatic event that commonly is accompanied by anxiety and phobic disorders. People with these symptoms—both homeless and housed—sometimes try to "medicate" these feelings away with alcohol and drugs.[12]

Thus mental illness, substance abuse, and homelessness cycle around each other, each exacerbating the other. Ultimately, it does not matter where it begins, the cycle remains. The challenge becomes to break the cycle, and it can be broken.

Although mentally ill and substance abusing people who become homeless present special treatment challenges, they can be successfully treated and housed in the community.[13] New medications for mental illness offer clinicians a wider range of treatment options and help many who did not respond to, or experienced severe side effects from, previous generations of psychotropic drugs. Innovative, integrated mental health and substance abuse services that address both problems simultaneously show real promise in helping those dually diagnosed with mental illness and substance abuse problems.[14] Aggressive outreach combined with treatment and rehabilitation promises to reach those who may otherwise hide from care.[15]

11. *Id.* at 51.

12. *Id.*

13. Homeless people are likely to present special treatment challenges. They have often had negative experiences with the mental health system and are determined not to be involved in further treatment. Some have suffered unpleasant side effects from medications. Some do not believe they need treatment, while others do not trust the system to deliver appropriate and humane care. Homeless people often do not have a support system of family and friends, and are distrustful of authority figures, including those in the health care delivery system. *Id.* at 58.

14. HEATHER BARR, PRISONS AND JAILS: HOSPITALS OF LAST RESORT 7-8 (1999). Traditionally, the mental health and substance abuse fields have been separate and, at times, even antagonistic. The result was often that mentally ill substance users received treatment for only one of their problems, or at best, received mental health and substance use treatment from separate providers who did not work together or even communicate to create a joint treatment plan. Research shows that integrated services are more effective than mental health and substance use treatment offered separately or sequentially, and a number of integrated treatment modalities show real promise treating mentally ill substance abusers. *Id.*

15. HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 59. *See generally* MICHAEL ROWE, CROSSING THE BORDER (1999). The author discusses different experiences while participating in doing outreach to persons who are homeless and mentally ill and substance abusers.

"Client-centered" programs that address both mental illness and substance abuse have succeeded in engaging people resistant to conventional treatment.[16] Psychosocial clubhouses operate on a self help model. They provide day support and socialization activities to help members develop life skills.[17] Assertive Community Treatment (ACT) Teams use a mobile team of paraprofessionals, nurses, and psychiatrists to bring a range of services—medical and psychiatric treatment, case management, drug counseling, transportation and vocational training—to the client in the community.[18] ACT Teams are now recognized as one of the most effective treatment modes for severely mentally ill people at risk of homelessness.[19]

Moreover, an impressive array of models successfully combine housing with treatment for mental illness and substance abuse.[20] Supervision and services range from heavy to the light: group homes with 24 hour supervision, single room occupancy units (S.R.O.'s) with caseworkers and psychiatric support on the premises, and rent subsidized apartments with visits from a case manager or ACT team.[21] Among the least restrictive models are those that provide housing to homeless mentally ill people who have long resisted treatment and who continue to drink, do drugs, and resist medication. Residents are assigned a case manager who sees them regularly and makes

16. BARR, *supra* note 14, at 7, 11.

17. For examples on discussion for the psychosocial rehabilitation services see Cumberland Mountain Community Services Board Website, *at* http://www.cmcsb.com/ mentalhealth.htm.

18. Michael F. Hogan, *Medicaid and Mental Health Care: Can This Relationship Thrive*?, 57 POLICY & PRACTICE OF PUBLIC HUMAN SERVICES, 1999 WL 16094012, at *1520. ACCESS, a five year, federally funded demonstration project showed real success in providing services to those with serious mental illness and substance abuse. All sites provided service integration through assertive community treatment (ACT) teams, outreach, and case management. ACT teams work with clients who are housed but who also have great service needs and are generally unable to access necessary services without assistance. *See also* MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, PREVENTING HOMELESSNESS: POLICY, PROTOCOLS, AND PRACTICES FOR DISCHARGE AND AFTERCARE PLANNING 6-7 (1999) [hereinafter PREVENTING HOMELESSNESS].

19. Hogan, *supra* note 18, at 1520. Not only has the federal government approved Medicaid payment for ACT services, but it is encouraging states to reimburse for ACT under their Medicaid programs. Letter from the Director of the Center for Medicaid and State Operations, Health Care Financing Administration (HCFA) to State Medicaid Directors (June 7, 1999), *at* http://www.hcfa.gov/medicaid/smd60799.htm. These letters notified states that Medicaid will pay for ACT Teams and that given its effectiveness as a treatment approach, states Medicaid programs should cover it. *See also* NATIONAL ALLIANCE FOR THE MENTALLY ILL, *Using Medicaid to Expand Programs of Assertive Community Treatment* (1999), *at* http://www.nami.org/update/unitedpact.html.

20. Deidre Oakley & Deborah Dennis, *Responding to the Needs of Homeless People with Alcohol, Drug and/or Mental Illness*, *in* HOMELESSNESS IN AMERICA 179, 183-184 (Jim Baumohl ed., 1996); Micheal Winerip, *Bedlam on the Streets*, N.Y. TIMES, May 23, 1999, at 42.

21. Winerip, *supra* note 20, at 42.

sure their mental health and substance abuse problems are reasonably under control.[22]

The key to successful treatment is that different approaches work for different people: one size does not fit all. Researchers consistently find that successful programs are ones which match not only the individual's needs, but also his or her treatment preferences.[23] Consumers must be involved in developing their treatment plans and choosing their housing. Options need to be available to appeal to different people.

Homelessness need not be the necessary byproduct of mental illness and substance abuse. Community treatment can succeed. Regrettably, though, hospitals and detox programs discharge homeless mentally ill and substance abusing patients to emergency shelters and streets where, because of their vulnerabilities, they just get worse.

II. DISCHARGING TO THE STREETS

> Julia is 28 years old. Atlanta Regional Hospital, a public, short-term psychiatric facility in Atlanta, Georgia, has admitted and discharged her 92 times. Most recently, the discharges have been to homeless shelters. As Julia explains, "I have a personality disorder, a substance abuse problem and feel very depressed. Tranquilizers and anti-psychotic drugs do not really help any of these things. They give them to me when I am suicidal or lose control but as soon as possible, I am put back into shelter, which is no way to live."[24]

The homeless who are both mentally ill and substance abusers are thought of as anonymous street people wandering from doorway to doorway, shelter to shelter. They are not. Such people are known—generally, well known—to state psychiatric hospitals, short term acute care hospitals and detox programs.[25] About 30 percent of homeless persons are just out of inpatient

22. *Id*. At the Pathways to Housing Program in Harlem and Queens New York, among residents who had been homeless for more than 10 years before entering the program, 88% remained housed at Pathways for five years. *See, e.g*., Virgina Shubert & Mary Ellen Hombs, *Housing Works: Housing Opportunities for Homeless Persons*, 29 CLEARINGHOUSE REV. 741-751 (1995) (discussing housing for formerly homeless HIV positive people who continue to drink).

23. Oakley & Dennis, *supra* note 20, at 183-184.

24. THE ATLANTA LEGAL AID SOCIETY, THE MENTAL HEALTH LAW PROJECT, *available at* http://www.law.emory.edu/PI/ALAS/mental.html [hereinafter THE MENTAL HEALTH PROJECT]. "Julia" is a pseudonym adopted for this article.

25. PREVENTING HOMELESSNESS, *supra* note 18, at 2.

detoxification.[26] Roughly one-quarter have been released from inpatient mental care.[27]

Treatment facilities discharge people into homelessness in two ways. Some hospital and detox discharge sheets literally release mental health and substance abuse treatment patients "to the streets."[28] Others give the about-to-be released patient the name and address of a homeless shelter that may or may not have a bed available. The discharge sheet may include instructions to the patient about on-going medication and follow-up at a community mental health clinic, but few homeless people have the financial and emotional resources to follow through.[29]

Discharge "to the street" is a prescription for relapse, readmission or worse.[30] The streets are dangerous places. Not only is life uncomfortable and unhealthy, but violence—assault and rape—are commonplace.[31] The stress of life on the street invites backsliding. For those trying to continue recovery after detoxification, the streets are an invitation to relapse with their easy access to drugs and liquor and the temptation to use the only easily available "medicine" to blunt the harshness of reality.

Discharge to a shelter can be as bad a prescription as discharge to the streets. Hospital discharge planners may be under the mistaken impression that shelters provide "care" that takes over where inpatient care ends; they do not. Shelters are not funded or staffed to provide ongoing psychiatric and substance abuse treatment. Shelters provide an emergency place to sleep for the night, but daytime means a return to the street. In street parlance, most shelters provide a "cot and a hot": a place to stay for twelve hours and a meal.

26. Eric N. Lindblom, *Preventing Homelessness, in* HOMELESSNESS IN AMERICA 188 (Jim Baumohl ed., 1996). Up to half the poor people in inpatient alcohol or drug treatment are people without homes.

27. *Id*. at 188. Roughly one-quarter of all homeless people were previously in mental institutions.

28. *See* Jolayne Houtz, *Back on the Streets Right After Giving Birth*, THE SEATTLE TIMES, Mar. 11, 1994, at B1.

29. *See* Lynda Richardson, *Helping the Mentally Ill Return to the World*, N.Y. TIMES, Mar. 21, 1993, §1, at 35.

30. *See* Lindblom, *supra* note 26, at 188-9; *see also* MENTAL HEALTH PROJECT URBAN JUSTICE CENTER, THE REVOLVING DOOR: REPEATED PSYCHIATRIC HOSPITALIZATIONS OF THE HOMELESS 2 (1999) [hereinafter THE REVOLVING DOOR]. Dennis Culhane et al., *Impact of Continuity of Care on Recurrence of Homelessness Following an Acute Psychiatric Episode* (1997) (unpublished paper, on file with the University of Pennsylvania).

31. Life on the streets both causes illness and exacerbates poor health. It increases the risk of trauma, especially from rape and assault. *See also* HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 43-44.

When 6 or 7 a.m. rolls around, everyone must leave. Discharge to a shelter means 12 hours a day out on the street.[32]

Moreover, discharge with the name and address of a shelter does not even guarantee a bed for the night. Many shelters take whoever arrives first each day, requiring a daily queuing to get a bed for the night. If the shelter is full, the discharged patient spends the night on the street.

Moreover, shelters can be as frightening and uncomfortable as the street. Many are crowded with ten or more people in a room with no privacy. The crowd, noise, and confusion can be as nightmarish as the street. Thus, some homeless discharged patients bypass them, returning directly to the street, the back alley, or the bridge upon release.

Most mentally ill and substance abusing patients released to shelters and the streets regress.[33] They become unstable, disruptive or endanger themselves until they are either re-hospitalized, jailed or dead. When patients leave inpatient care stable their mental illness is controlled by medication, and alcohol and drugs are purged from the system. They may have a prescription for medication and a referral to a mental health clinic but no insurance or money and no inclination to follow through. Without a continuous supply of medication and regular psychiatric appointments their mental conditions deteriorate. In one study, nearly 40 percent of mental patients discharged from acute care hospitals to homelessness were re-admitted for hospital care within six months.[34] Others end up re-institutionalized in the prison and jail systems instead of the hospital ward after being arrested for sleeping in the park, panhandling, vagrancy, public drunkenness or disorderly conduct.[35]

For some, discharge to the street or shelter is a death sentence. Thirteen homeless people died on Boston streets between late 1998 and early 1999. All

32. Marsha McMurray-Avila, *Medical Respite Services for Homeless People: Practical Models* (March 2000), *at* http://www.nhchc.org/respite.html. There are a number of reasons that shelters do not allow guests to remain during the day. Some expect their clients to be looking for employment. Others do not have the resources to staff their program during the day, or use daytime hours to perform maintenance of the facility. *Id.*

33. PREVENTING HOMELESSNESS, *supra* note 18, at 4-5; REVOLVING DOOR, *supra* note 30, at 2; Culhane, *supra* note 30, at 3-4.

34. *See* THE REVOLVING DOOR, *supra* note 30, at 2, 8, 11 n.3. Thirty-eight percent of discharged patients were re-admitted within six months. Celia Dugger, *Follow-up Care for Mental Patients is Criticized*, N.Y. TIMES, Apr. 29, 1993, at B5 (citing the State Commission on Care for the Mentally Disabled). One in four patients received no outpatient services. On average, patients received only an hour and a half of service per month. One in ten had spells of homelessness. None of the ten patients who abused drugs or alcohol received services designed for those with both mental illness and addiction. All patients had elaborate discharge plans but no follow-up was done. In New York City, eight percent of mental health patients discharged from public hospitals were readmitted to the same hospital within 30 days of discharge. The readmission rate would be higher if admissions to other hospitals were included.

35. BARR, *supra* note 14, at 4.

were discharged by health care institutions to shelters or the streets just weeks before their deaths.[36] All had been in inpatient detox within two weeks of their deaths.[37]

Others become long term shelter users. Homeless people who have severe mental illness and substance abuse problems, particularly those who have been admitted for detox programs and mental health treatment, tend to become chronic shelters users—spending years on the street and in shelters in between hospital admissions.[38] A full 80 percent of all shelters users are "transitional," using shelters for two weeks or less, typically because of some emergency, and then moving on to more permanent housing. Chronic shelters users, although they comprise only 20 percent of those who use shelters, use most of the shelter services. Chronic shelters users, unlike transitional users, find it hard, if not impossible, to move from shelters into permanent housing. Thus, the point of institutional discharge offers a unique opportunity to help people who are especially vulnerable to long term, intractable homelessness to make the transition into permanent housing and stabilized lives.

In many areas of the country, the extent to which hospitals discharge to homelessness is unknown because states and localities do not have good data about who is using emergency shelters. Shelter providers are reluctant to ask their guests too many questions for fear they will discourage them. Hospitals do not compile and report data about mental health and substance abuse discharges. Stories of people like Julia, the woman in Atlanta who appears at the beginning of this section, are compelling. However, better data is needed to determine whether, in a particular community, discharge into homelessness is a sporadic problem or a systemic issue. Massachusetts offers a model for developing such information.

In Massachusetts, the Massachusetts Housing and Shelter Alliance, a state-wide advocacy group,[39] worked with shelter providers to develop an accurate picture of who was using emergency shelters. Shelters throughout the state began asking each guest where he or she had just come from. Running tallies were compiled for the year, and a state shelter census was developed. For the first time, figures were available describing who was using Massachusetts

36. PREVENTING HOMELESSNESS, *supra* note 18, at 3-4.

37. *Id.*

38. Culhane, *supra* note 30. *See also* Randall Kuhn, Center for Mental Health Policy and Services Research: *Applying Cluster Analysis to Test Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data* (Univ. Of Pennsylvania) (Feb. 19, 1996).

39. The Massachusetts Housing and Shelter Alliance (MHSA) is a stateside coalition of seventy groups and agencies committed to reducing and ending homelessness. Its members include providers of permanent housing, transitional programs, emergency shelters, health care, employment and day drop-in resources for homeless people.

shelters.[40] The figures confirmed what the anecdotes suggested: in 1998, Massachusetts detox programs discharged 1,557 people into homelessness, while public and private hospitals in Massachusetts discharged 806 mental health patients into homelessness.[41] As a result of these statistics, advocates, state policy makers, and health care providers have focused renewed attention on discharge planning.[42] Convinced of the need for better information about discharges from inpatient care, Massachusetts is implementing a computer database, the Automated National Client-Specific Homeless-Services Recording System (ANCHoR) developed by the University of Pennsylvania. ANCHoR collects three sets of data from shelters and other service providers: (1) an unduplicated count of shelter use; (2) a breakdown of shelter users by demographic characteristics and by services used; and (3) information on people who use multiple services, including people who move between other programs and institutions, and the emergency shelter system.[43] The ANCHoR system can produce accurate, quantitative data to help target discharge planning efforts more effectively.

Similarly, in New York City, concern about hospitals discharging people to the street has prompted a number of empirical studies and reports. New York City's Urban Justice Center, an advocacy group, has released two reports. One, *The Revolving Door: Repeated Psychiatric Hospitalizations of the Homeless*, substantiates the connection between poor hospital discharge planning and homelessness and recommends policies and practices to reduce the problem.[44] The second, *Prisons and Jails: Hospitals of Last Resort*, focuses on the effects of the lack of discharge planning for the mentally ill incarcerated in New York's jails and prisons.[45] The City of New York Health

40. MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, COMPARISON OF EMERGING SUBPOPULATIONS IN MASSACHUSETTS' EMERGENCY SHELTERS (1997, 1998, and 1999).

41. Philip Mangano, *Prevention: Populations at The Front Door*, *in* PREVENTING HOMELESSNESS 4-5 (1999).

42. *See, e.g.*, HOMELESSNESS IN MASSACHUSETTS: ARE STATE-FUNDED RESOURCES AND SERVICES ALLOCATED AND COORDINATED EFFECTIVELY? HOMELESSNESS POLICY RESEARCH TEAM, MASSACHUSETTS EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE 25 (Dec. 20, 1999) [hereinafter HOMELESSNESS IN MASSACHUSETTS]. *See also* Mangano, *supra* note 41, at 5.

43. HOMELESSNESS IN MASSACHUSETTS, *supra* note 42. In the ANCHoR system, shelter operators and other providers transmit uniform data reports to a central server which produces aggregate data reports.

44. THE REVOLVING DOOR, *supra* note 30.

45. BARR, *supra* note 14. The report explains how prisons and jails are replacing hospitals for the mentally ill. It documents how thousands of people with mental illness are incarcerated for petty crimes, revolving between the jail and prison systems and life on the streets because of inadequate or non-existent diversion programs and discharge planning. While incarcerated, mentally ill people receive basic mental health services, including medication. Upon discharge, they are driven to Queens Plaza and released between 2 and 4 a.m. with three subway tokens. Generally, discharged inmates get no referral to community treatment and have no income, insurance or housing. The report recommends mechanisms to divert criminal defendants with

and Hospitals Corporation, the agency that operates the city's public hospitals, released a report examining hospital discharge and admission records that confirms that people are bouncing back and forth between hospital inpatient care and the streets.[46] Finally, the state of New York compiled a comprehensive study of the state's mental health services, including statistics on the lack of discharge planning and its consequences.[47] All four reports serve as blueprints for state policy and budget discussions.

Discharge from inpatient care does not have to signal the end of treatment and the beginning of a downward spiral into relapse. Community based models exist for helping people successfully transition from inpatient care into the community. Nevertheless, available data suggests that hospitals and detox centers persist in discharging mentally ill and substance abusing patients to shelters and the streets.

III. THE PRESSURES TO DISCHARGE TO THE STREET

Hospitals and detox programs discharge patients to streets and shelters because this country has no health care system. Hospitals, detox centers, outpatient clinics and home health services all provide care, but it tends to be medicalized and disjointed: no overarching system of care exists. Moreover, care providers must operate under increasing cost pressures without the community treatment resources and step-down services needed for recovery and escape from the street.

American medicine is based on a medical and scientific model characterized by a narrow focus on individualistic, procedure-oriented care to "fix" illness rather than a public health approach that seeks to prevent disease.[48] We spend immense amounts of money on sophisticated diagnostic tests, drugs and inpatient treatment but tend to ignore the political, social and behavioral context of illness and injury.[49] Charles Rosenberg's description of

mental illness into mental health services, strategies to create a continuum of care for people with mental illness as they move between the criminal justice system and the community, and the components necessary to provide comprehensive discharge planning to help ex-offenders with mental illness integrate into the community.

46. THE REVOLVING DOOR, *supra* note 30, at 2, 11 n.3. This study found that 8 percent, 1,099 of 13,666 patients discharged from public hospitals, were readmitted to the same hospital within 30 days of discharge, and that the readmission figure would be even higher if the agency were able to track re-admissions to different hospitals.

47. NEW YORK STATE OFFICE OF MENTAL HEALTH, STATEWIDE COMPREHENSIVE PLAN FOR MENTAL HEALTH SERVICES 1997-2001 (1997).

48. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 180-97 (1982).

49. RAND ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 7-8 (1997).

the transformation of New York's Hospital for the Ruptured and the Crippled captures the contrast between medicalized care and public health care.

> James Knight, the leading spirit in [the hospital's] founding and its surgeon-in-chief from 1863 to 1887, was a physician who assumed a holistic—and paternalistic—attitude toward his patients and the hospital's work generally. He placed little emphasis on operative procedures and a great deal on diet, exercise, fresh air, bandages, and appliances. Knight saw local lesions [dysfunctions, deformities] as aspects of more general conditions, just as he saw the child as potential citizen of a larger society and concerned himself with his little patients' moral education and future job prospects. Knight lived in the hospital and served as father of an extended family. By 1898, Knight had become an anachronism. He was succeeded by Virgil Gibney, a youthful and energetic orthopedist. Numbers of operations increased rapidly and lengths of stay decreased. Gibney himself lived outside the hospital. The surgeon was no longer content to guide and monitor, to negotiate a multi-dimensional path to physical and social health. Aseptic surgery had far more to offer many patients than the bandages, regimen, and braces of mid-century, but the new-model surgery construed its responsibilities in increasingly narrow and procedure-oriented terms.[50]

Good patient care is not an either-or phenomenon: it requires attention to both scientific medicine and public health. Dr. Gibney was right; many illnesses can be corrected and improved by surgery and other specific medical interventions. Schizophrenia, manic depression, and other major psychiatric illnesses can be alleviated—although not cured—by medication. Dr. Knight, however, was also correct. Good health outcomes do not depend exclusively on a medical "fix." The patient's life and situation after hospitalization is also important.

Sadly, American medicine tends to embrace Gibney's technical world view, while ignoring Knight's concern about the patient's social context.[51] American hospitals treat the patient's medical illness or disease; they are not staffed or funded to deal with the patient's social problems like homelessness. Medical residents are routinely taught that their role is to fix the homeless person's trauma, varicose veins, mental illness, or substance abuse, and then discharge the patient to a shelter or, if none is available, "to the streets." As the residents learn, the "medical system" cannot fix all of society's ills. Rather, medical professionals help within their training, by diagnosing the medical program and fixing it as best they can, leaving the social work to others.[52]

50. CHARLES E. ROSENBERG, THE CARE OF STRANGERS 149-50 (1987).

51. ROSENBLATT, *supra* note 49, at 8.

52. *See generally* PEDRO JOSE GREER, JR., WAKING UP IN AMERICA (1999) (for the moving story of a physician trying to change medical education's view of the world and its place in it).

Regrettably, "medicalized" inpatient medical care is an inadequate bandage for what ails the homeless who are mentally ill and substance users. Lisbeth Schorr tells of a severely ill, homeless man who was admitted to the intensive care unit. Near death, he was given state of the art care, and his life was saved. A few days and $35,000 worth of treatment later, the man was discharged to the street without even a blanket to keep him warm.[53] Medical care saved the man's life but then sent him back to life on the streets and circumstances that were likely to expose him to another bout of life-threatening illness. As this story illustrates, care is not only medicalized, it is also fragmented.

Our fee-for-service medical reimbursement system has encouraged a hodge-podge of separate, distinct health care institutions. Acute care hospitals, mental hospitals, nursing homes, and detox programs provide different types of inpatient care. Medical clinics and mental health clinics provide outpatient care in office settings, while home health agencies do home-based care. While specialized care can contribute to better outcomes, no system exists to coordinate the many pieces of the complicated health care puzzle.

Moreover, since medical care focuses on fixing illness, medical reimbursement does not pay for non-medical services like shelter, food, and blankets. The Access to Community Care and Effective Services and Supports (ACCESS) demonstration project, funded by HHS and HUD, seeks to integrate fragmented public mental health services to end homelessness by integrating services and fostering partnerships among medical and social service agencies. ACCESS projects have lowered the number of days of homelessness for seriously at risk individuals by as much as 75 percent over a 12 month period proving the need and worth of creating systems of care.[54]

While many hoped that the move to managed care and capitated medical reimbursement would result in a more integrated health care delivery system that would provide a broad array of medical and social services, few communities have a real system of care that coordinates inpatient, outpatient and recuperative medical care with social services. The result is that many, including homeless, mentally ill persons, flounder, lost in the complexities of a non-system with no one to guide them through the maze.

Regrettably, the advent of managed care has intensified pressures on inpatient facilities to shorten inpatient admissions and discharge patients who a few years ago would have stayed in the hospital to recuperate.[55] Ten years

53. LISBETH B. SCHORR, WITHIN OUR REACH: BREAKING THE CYCLE OF DISADVANTAGE 137 (1988).

54. *See* Dep't of Health and Human Services on Mental Health Issues: Division of Aging (June 10, 1999), *at* 1999 WL 19097181 [hereinafter Dep't of Health and Human Services].

55. The force driving this reduction in inpatient stays is the reduction in inpatient reimbursement. In New York, for example, Medicaid pays up to $700 per day for the first few weeks of treatment. However, as soon as the managed care utilization reviewer deems the patient

ago, detox programs lasted 30 days; the average stay is now less than a week.[56] Inpatient mental health treatment has gone from a norm of 30 days to less than 21 days.[57] Managed care views hospitals and other inpatient care facilities as unnecessarily expensive places to provide recuperative and follow-up care. However, in our fragmented health care system, homeless people often have nowhere to go to recuperate or continue treatment.

Convalescent services are limited.[58] Upon discharge from inpatient care many people need what is referred to as a respite or step down bed—a place to rest, recuperate and gain physical and emotional strength following discharge. Respite facilities, unlike shelters, provide a quiet place for bed rest, 24 hour nursing care, and adequate nutrition.[59]

Community mental health clinics and outpatient substance abuse programs are in short supply.[60] Even where they exist, they often do not offer a broad enough range of treatment programs to meet consumers' different needs and

"stable," a determination that usually occurs around day 21, all reimbursement either ceases, or, at best, drops to $175 per day, too little to cover the cost of care—even for a stable patient. Winerip, *supra* note 20. The hospital is thus pressured to discharge the patient—even if there is no appropriate place to which the discharged patient can go.

As part of this financial crunch, hospitals are downsizing inpatient units and attempting to provide more services on an outpatient basis. From 1995 to 1999, New York City cut its public hospital inpatient psychiatric beds from 9,902 to 8,029—a 19% decrease. BARR, *supra* note 14, at 34. Demand has not gone down, but beds have. The result is inevitable: a "people pile up" in emergency rooms. With fewer beds and resources, the pressure is to discharge—and quickly.

56. HOMELESS POLICY RESEARCH TEAM OF THE MASSACHUSETTS EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE, HOMELESSNESS IN MASSACHUSETTS: ARE STATED FUNDED RESOURCES AND SERVICES ALLOCATED AND COORDINATED EFFECTIVELY? 17 (1999).

57. *See* THE REVOLVING DOOR, *supra* note 30, at 7. In New York, the average length of stay in public hospitals was 29.2 days in 1994, but only 23.1 days in 1996. *Id.*

58. *See* HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 63. *See also* McMurray-Avila, *supr*a note 32. Health Care Clinicians for the Homeless are also likely to have something at their website.

59. Convalescence requires a safe setting with adequate nutrition, rest and health care professionals to do extended medical and psychiatric evaluations, which are problematic in detox settings. *See also* HOMELESSNESS, HEALTH, & HUMAN NEEDS, *supra* note 4, at 62-63.

60. When the de-institutionalization movement began, proponents anticipated that 2,500 mental health centers would be constructed throughout the country to provide treatment to discharged mental health patients. To date, a mere 700 have opened. *See* HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 97. One reason that the full range of outpatient substance abuse programs is not available is that not all forms of treatment are covered by Medicaid. Medicaid covers only those treatments that are determined to be "medical care" such as medical detoxification and inpatient hospitalization. It does not cover social detoxification programs, residential treatment acupuncture or recovery housing programs. *See* NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL MEDICAID AND HOMELESSNESS, POLICY PAPERS (2000), *at* http://www.nhchc.org/99papersMcd&hn.html.

preferences.[61] Most communities have a shortage of both transitional and long term supportive housing. Recovery housing for those trying to quit drugs and alcohol is limited.[62]

Some model programs exist, offering respite care and other services to patients discharged from psychiatric and detox facilities—and funding is available for others.[63] Christ House in Washington, D.C. offers medical respite care for the mentally ill, those recovering from substance abuse, and those with a dual diagnosis, offering patients a bed, 24-hour medical care, case management, housing placement and other supportive services. The program also has permanent housing for men who need continued support for their recovery from drugs or alcohol but who cannot work full-time because of chronic medical problems.[64] In Denver, Samaritan House offers respite care for people suffering from mental illness.[65] The Veterans Administration (VA) provides patients who are most at risk of becoming homeless the option to stay until adequate housing is found, and some VA medical centers have facilities on hospital grounds that provide residential treatment for veterans leaving inpatient programs but still looking for more permanent housing.[66]

While programs like these are exemplars, they reach only a tiny percentage of those who are homeless.[67] Most homeless people get their services from

61. The Access to Community Care and Effective Services and Supports (ACCESS) project is producing new knowledge about how homeless people with severe mental illness can be engaged and helped. Funded by HHS and HUD, ACCESS demonstration projects, seek to integrate fragmented public mental health services to end homelessness by using proven integration strategies and fostering partnerships among service agencies. When the right connections are made and maintained, ACCESS-evaluated interventions can lower the number of days of homelessness for seriously at risk individuals by as much as 75% over a 12 month period. *See also* Dep't of Health and Human Services, *supra* note 54.

62. One reason there is a shortage of these services is that they are not covered by Medicaid. Medicaid covers only those treatments that are determined to be "medical care" such as medical detoxification and inpatient hospitalization.

63. The U.S. Dep't of Health and Human Services, Substance Abuse and Mental Health Services Administrations Funds Projects for Assistance in Transition from Homelessness (PATH). The PATH grant program provides states and territories with money specifically to create programs that serve individuals with severe mental illness who are homeless or at risk of becoming homeless. PATH provides links to community based health, education, employment and housing services. PATH also provides Supported Housing and Homeless Prevention grant programs. *See* Dep't of Health & Human Services, *supra* note 54.

64. McMurray-Avila, *supra* note 32. For a first hand account of the work of Christ House, *see generally* DAVID HILFIKER, NOT ALL OF US ARE SAINTS (1994).

65. McMurray-Avila, *supra* note 32, at 33.

66. Lindblom, *supra* note 26, at 196.

67. HOMELESSNESS: PROGRAMS AND THE PEOPLE, *supra* note 3. Across the country, 128 locally run Health Care for the Homeless (HCH) projects operate with funding from the Stewart B. McKinney Homeless Assistance Act. These projects provide interdisciplinary, community based care that includes primary care, emergency services, addiction treatment, mental health care and prescription drugs. They use case managers to link homeless people to housing, income and

mainstream safety net providers which remain medicalized, fragmented, and accosted by cost cutting measures. The pressure, and the temptation, is to discharge patients from inpatient psychiatric care and detox to streets and shelters in hopes that someone else can take care of the outpatient medical, social services and housing needs. Yet, all the studies, statistics and anecdotal evidence confirm that discharge to streets and shelters is a prescription for relapse, readmission or worse. Something ought to be done, and the reality is that the point of discharge offers a unique opportunity to help people who are especially vulnerable to long term, intractable homelessness to make the transition into permanent housing and stabilized lives.

IV. DISCHARGE PLANNING AS HOMELESSNESS PREVENTION

> After 92 admissions to Atlanta Regional Hospital and numerous discharges to homeless shelters, Julia is now living in a supervised group home where a special "personality disorder" consultant leads daily group sessions. A case manager helps assure that she gets the medical, financial and social services she needs to avoid slipping into homelessness again. This time, instead of sending Julia to a shelter, Atlanta Regional Hospital developed a comprehensive, on-going plan for community care and housing before discharging her.[68]

All hospitals and detox centers do discharge planning; it is standard operating procedure. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards specify not only that institutions provide discharge planning for those patients who need it, but that they identify patients, like those who are homeless, for whom planning is critical.[69] Hospital discharge planners routinely arrange transportation, home health and rehabilitation services. A problem arises, though, because hospital discharge planners are less likely to be familiar with the community housing and long term support programs that severely mentally ill and substance abusing people need to stay housed.

Cognizant of the role that inadequate discharge planning plays in exacerbating homelessness for those suffering from serious mental illness and substance abuse, the Substance Abuse and Mental Health Services

transportation. The programs deliver care where homeless people congregate, including shelters, soup kitchens, clinics, drop in centers and on the street. Some, like Christ House and Samaritan House also offer respite care. These programs can play a pivotal role in helping a person transition from inpatient psychiatric and substance abuse treatment to life in the community. However, they reach only a small percentage of those who are homeless. *See id*.

68. THE MENTAL HEALTH PROJECT, *supra* note 24.

69. 1999 HOSPITAL ACCREDITATION STANDARDS, PE 1.5, Intent of PE 1.5 (1999). According to JCAHO, discharge planning should not focus merely on the patient's medical needs, but "identifies patients' continuing physical, emotional, housekeeping, transportation, social, and other needs, and arranges for services to meet them." *Id*. at CC.6.1, Intent of CC 6.1.

Administration (SAMHSA) of the U.S. Department of Health and Human Services has provided research, education and funding to improve discharge planning, including convening a working conference and issuing a report on Exemplary Practices in Discharge Planning.[70] The recommendations stress that discharge planning for homeless people is about "community re-entry," connecting the about-to-be discharged patient with community resources,[71] and that making these linkages requires institutions to enter into active collaborations with community providers.[72] Discharge planning needs to be conceived as a team effort that includes the patient, the institution, someone knowledgeable about community resources and a community case manager or other person responsible for following up with the consumer to ensure the implementation of the discharge plan.[73]

The most important element of good discharge planning is consumer participation.[74] Long term plans for treatment and housing are much more

70. 1997 U.S.D.H.H.S., REPORT ON EXEMPLARY PRACTICES IN DISCHARGE PLANNING 2. *See also* INTERAGENCY COUNCIL ON THE HOMELESS, PUB, PRIORITY: HOME! THE FEDERAL PLAN TO BREAK THE CYCLE OF HOMLESSNESS (1994) [hereinafter U.S.D.H.H.S]

71. U.S.D.H.H.S, *supra* note 70, at 2.

72. *Id*. at 3. "The Working Conference considers discharge planning to be a partnership between local communities and institutions with designated community agencies having the primary responsibility for re-entry." *Id.*

73. *Id*. at 3-4. ("In exemplary discharge planning, a team approach, involving all people with significant discharge and transition responsibilities, is essential. A team approach can facilitate efficient communication and effective use of resources. 1. Teams emerge from partnerships among agencies and institutions which are responsible for the care, support, housing, and treatment of the consumer. 2. Team composition is flexible and can include persons serving in the following capacities: 1. Consumer 2. Family member(s) of other supporters 3. Community case manager* 4. Institutional representative* 5. Community resource specialist (information broker)* 6. Mental health and substance abuse specialists 7. Housing specialist 8. Entitlement/income specialist 9. Criminal justice system representative 10. Health care system representative 11. Pay-or representative 12. Policy maker 13. Advocate 14. Peer supporter (* = Core members of a discharge planning team.). Members of the Working Conference noted that while a team might have many members, not every team member needs to be present at meetings with the consumer.) 3. Team members must have the ability to commit the resources of the institution which they represent. In the case of the Community Resource Specialist, this resource is information." (emphasis deleted)).

74. *Id*. at 6. ("The most important element of the re-entry plan is consumer involvement and buy-in. When the consumer feels a sense of ownership of the plan, the consumer is more likely to follow it. 1. Exemplary discharge plans are developed with consumers and feature the most extensive input possible from consumers. 2. Exemplary discharge plans are written in the form of a contract between the consumer, service providers, institutions, and the community representative. 3. Exemplary discharge plans are culturally competent and consider the important issues in race, ethnicity, religion, gender and sexual orientation. 4. Exemplary discharge plans are conscious of factors such as the relationship between genetics and medication; the role of eye contact, language, social space, and body language in a culture and the relationship of these elements to diagnosis; and the culture's view of mental illness and stigma. 5. Professionals who

likely to succeed when the consumer is involved in the planning process so it meets his or her treatment and living preferences. Consumer buy-in and participation are crucial.

The discharge planning process also needs to include input from those knowledgeable about community resources.[75] Some discharge planning teams include a community-based housing specialist. In New York City, the Urban Justice Center, an advocacy group with an encyclopedic knowledge of community housing and social services programs for the homeless, provides training, a community directory and technical assistance to hospital discharge planners.[76] In Massachusetts, hospital discharge planners will soon have access to a web site which includes information about community programs.[77]

The crux of good discharge planning, though, is that one person—often a community-based case manager—needs to be responsible for following up with the consumer after discharge.[78] Someone needs to assure that the discharged patient is getting the services prescribed in the plan, and that the services are meeting the patient's needs. It is too easy for vulnerable people to get lost in the maze of government agencies and health care bureaucracies. Discharged patients may be unable to navigate public transportation, medication may get lost or stolen and outpatient appointments may be missed. Follow-up alerts the support staff if a Medicaid application is denied or if a patient living alone begins to deteriorate. In short, discharged patients need genuine follow-up to ensure that the linkages with housing, public benefits and aftercare services hold.

The person responsible for follow-up can be a community-based case manager, Assertive Community Treatment (ACT) team, social worker or supportive housing personnel. Funding is always an issue, but a variety of programs will pay for case management for patients discharged from mental health and substance abuse treatment. States have the option of offering Medicaid reimbursement for case management services either as a separate

assist in the development of exemplary discharge plans are culturally competent and achieve a "good fit" between the consumer and the clinician." (emphasis deleted)).

75. *Id*. at 4. The discharge planning team should include someone familiar with community resources. *Id.*

76. Interview with Ray Brescia, Director, Mental Health Project, Urban Justice Center (Mar. 7, 2000).

77. MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP, FISCAL YEAR 2000 PERFORMANCE STANDARDS 3 (1999) [hereafter MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP].

78. U.S.D.H.H.S, *supra* note 70, at 4. ("The team leader is the person with the primary responsibility for the re-entry of the consumer into the community. In most instances, the team leader will be the community case manager. The team leader collaborates with the other members of the team to ensure that the consumer has the necessary resources and support available to assist with the re-entry.").

service[79] or as part of an ACT Team.[80] Federal McKinney Act funds for Continuum of Care services are available to fund community case managers. In New York City, the Urban Justice Center, an advocacy group, receives funding from HUD's Supportive Housing Program for an interdisciplinary legal and social work team to follow-up with discharged mentally ill patients.[81] For a discharge plan to succeed, though, it must not only link the patient with housing, health care and other treatment, it must also assure that the patient has a source of income and health insurance.[82] Supportive housing and group homes are more likely to accept residents with an income. While some free clinics exist, most medical providers require payment, either private insurance, Medicaid or Medicare.[83]

79. Medicaid covers case management as a clinic service. *See* 42 C.F.R. §440.90 (1999). Medicaid also covers targeted case management. *See* 42 U.S.C. § 1396n(g). *See also* Hogan, *supra* note 18 (Optional case management and rehabilitation benefits are reimbursable under a clinic option.).

80. Letter from the Director of the Center for Medicaid and State Operations, Health Care Financing Administration (HCFA) to State Medicaid Directors (June 7, 1999), *available at* http://www.hcfa.gov/medicaid/smd 60799.htm. The letter was to notify states that Medicaid will pay for ACT Teams and that given its effectiveness as a treatment approach, states Medicaid programs should cover it. *See also* NATIONAL ALLIANCE FOR THE MENTALLY, USING MEDICAID TO EXPAND PROGRAMS OF ASSERTIVE COMMUNITY TREATMENt (2000), *available at* http://www.nami.org/update/unitedpact.html.

81. Interveiw with Ray Brescia, *supra* note 76. The UJC represents homeless, mentally ill individuals on the verge of discharge from state and city hospitals. The UJC's interdisciplinary staff of lawyers and social workers, acting at the behest of the patient, his family or a hospital discharge worker, goes into the hospital and represents inpatients. The team works with individual clients to help them articulate their wishes and to make informed choices. They also link clients with housing and services and continue to represent clients for six months after discharge to make sure the discharge plan is implemented, that their care is continuing and that the client's ongoing concerns are addressed. In other words, they assume the responsibility for doing discharge follow-up.

The UJC's individual representation works, in part, because one of its great strengths is its interdisciplinary nature. Lawyers are trained to listen to clients and assert their wishes—not those of the hospitals or the social services system. The lawyer can make sure the client's legal rights are asserted and disentangle the law that so enmeshes itself in poor people's day to day existence by helping with lease provisions, welfare to work contracts, criminal misdemeanors and consumer issues. At the same time, social workers understand and help clients navigate the complex systems for housing, social services and government benefits. Their presence also reminds attorneys that creative problem solving is often the best legal representation and that having a place to live can be more important than winning a point of law.

82. U.S.D.H.H.S, *supra* note 70, at 7-8. ("Exemplary discharge plans encourage consumers to be as independent and self-sufficient as possible. 1. Exemplary discharge plans ensure that consumers receive all the entitlements for which they are eligible. 2. Exemplary discharge plans examine the possibility of employment, education and training. 3. Exemplary discharge plans ensure appropriate management of money and other resources.").

83. Over 70 percent of people who are homeless have no health insurance. NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, HCH CLINICIANS' NETWORK, HEALTH CARE FOR

Before the patient leaves the institution, an application for Medicaid and other benefits should be on file and pending, if not already in place. In theory, people with serious, chronic mental illnesses are eligible for Supplement Security Income (SSI) or, if they have a work history, Social Security Disability benefits.[84] Unfortunately, proof of eligibility based upon a mental illness, particularly for those who also suffer from alcoholism and substance abuse, is often difficult to prove.[85] Starting the process before the person leaves the institution shortens the waiting period and eases the ability to gather and submit hospital medical records supporting the claim.[86]

Finally, the discharge plan must do more than simply prescribe appropriate services: it needs to make sure that services are in place before the patient leaves the hospital. Each patient should have safe and appropriate housing already arranged, be it a respite bed, small group home, supportive housing, or apartment. Ongoing medical care should include a clear plan for how and where to get on-going psychiatric and substance abuse treatment, a scheduled outpatient appointment and sufficient medication to last until that appointment. Patients who are particularly vulnerable to relapse should be introduced to their aftercare providers before discharge.[87]

Hospitals and detox centers can break the crash and burn cycle of mental illness and substance abuse by replacing discharges to streets and shelters with discharge planning to link the about-to-be discharged patient to medical, social and housing resources. As part of this discharge planning process, hospitals and detox centers need to begin working with outpatient mental health providers, housing programs and social services agencies to create a network of care that helps the patient move from inpatient treatment to community living—in a home, rather than in an emergency shelter or on the street.

THE HOMELESS APPROPRIATIONS (2000), *at* http://www.nhchc.org/99ppapersapps.html. Most, though, get their care from mainstream health care providers. HOMELESSNESS: PROGRAMS AND THE PEOPLE, *supra* note 3.

84. The disability standard requires that a person be "permanently and totally disabled" and unable to engage in "substantial, gainful activity by reason of any medically determinable impairment [which] can be expected to last for a continuous period of not less than 12 months" or result in death. 20 C.F.R. §404.1505 (1999).

85. Substance abuse no longer qualifies as a disabling condition for purposes of Medicaid, SSI and SSA disability. Those for whom "drug addiction or alcoholism is a contributing factor material to their disability" are disqualified. However a person with a dual diagnosis of mental illness and substance abuse still qualifies as long as mental illness is the contributing factor to disability. Making sure that the medical records explain the significance of each diagnosis is critical.

86. HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4. Even if a person qualifies for Medicaid as a result of SSI, if the person lives in a hospital, detox or public shelter for more than 3 months in one year he or she loses SSI and thus Medicaid eligibility. *Id.*

87. THE REVOLVING DOOR, *supra* note 30, at 9.

V. A RIGHT TO DISCHARGE PLANNING

> Atlanta Regional Hospital discharged Julia to a group home rather than a homeless shelter because she called a legal services lawyer who filed a complaint in Probate Court challenging Julia's treatment and discharge plan as inadequate. The hospital settled the case, developing a comprehensive discharge plan for Julia that, for the first time, connected her with a community-based, supportive housing program designed to address her particular medical and psychological needs.[88]

It is bad medicine—and probably malpractice—to discharge mental health and detox patients to the street.[89] The standard of care is spelled out in the JCAHO accreditation standards, the federal government's report on Exemplary Discharge Planning Practices and other statements of good discharge planning: patients treated for mental illness and substance abuse should be released to appropriate housing and services, not sent to emergency shelters and the street.[90] Poor discharge planning also fails to comply with federal Medicaid and Medicare requirements for discharge planning services.[91] Repeated hospitalizations because of poor discharge planning may also violate the Americans with Disabilities Act because it unnecessarily institutionalizes and segregates people who can be housed and treated in the community.[92]

Moreover, many patients treated for mental illness and substance abuse have a legally enforceable state law right to discharge planning and aftercare.[93]

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88. THE MENTAL HEALTH LAW PROJECT, *supra* note 24.

89. *See, e.g.*, Jonathon P. Bach, Note, *Requiring Care in the Process of Patient Deinstitutionalization Toward a Common Law Approach to Mental Health Reform*, 98 YALE L.J. 1153 (1989).

90. *See* 1999 HOSPITAL ACCREDITATION STANDARDS, *supra* note 69, at CC.6.1; HOMELESSNESS, HEALTH & HUMAN NEEDS, *supra* note 4, at 147. *See also* AMERICAN HOSPITAL ASSOCIATION, COMPLEX DISCHARGE PLANNING: STRATEGIES FOR HOSPITAL, CONSUMER, AND COMMUNITY PARTNERSHIPS (1991).

91. 42 U.S.C. 1395x (ee); *see also* 42 C.F.R. §482.43. Not only must the hospital prepare a discharge plan for those needing post-hospital services, but it must also arrange for "the initial implementation of the patient's discharge plan" and "must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care." *Id.* at (b)(3), (d).

92. *See* Olmstead v. L. C., 119 S. Ct. 2176 (1999). *See also* Ira Burnim & Jennifer Mathis, *After* Olmstead v. L.C.: *Enforcing the Integration Mandate of the Americans with Disabilities Act*, CLEARINGHOUSE REV. 633 (2000).

93. *See, e.g.*, ALASKA STAT. §47.30.825(i) (Michie 1999); ARIZ. REV. STAT. §36-511(c) (1999); CAL. HEALTH & SAFETY CODE § 1262 (West 2000); COLO. REV. STAT. §27-1-103 (2000); CONN. GEN. STAT. ANN. §17a-542 (West 1999); D.C. MUN. REGS. tit. 47, § 4221 (1999) (substance abuse); DEL. CODE ANN. tit. 16, §5161 (1999); IDAHO CODE § 66-413 (1999); FLA. ADMIN. CODE 59A-3.2055(1)(e)(2); GA. COMP. R. & REGS. 290-4-2-.17; MASS. REGS. CODE tit. 104, §27.09 (1999); 405 ILL. COMP. STAT. ANN. 5/4-703 (West 1999); IND. CODE ANN. §12-24-12-3 (1999); KAN. STAT. ANN. §39-1610(d) (1999); ME. REV. STAT. ANN., health-general §10-809 (1999); MICH. COMP. LAWS ANN. §330.1209a (West 1999); MINN. R. 9520.0640 (1999);

Some states have literally outlawed hospital discharges to streets and shelters.[94] Others are using managed care performance standards to create financial incentives to reduce and eliminate discharges to streets and shelters.[95]

State mandates vary considerably, but they tend to require "discharge planning" or a "plan for aftercare services."[96] Many are similar to Massachusetts' which requires that:

> "[p]rior to a patient's discharge from the facility, the treatment team and other appropriate facility personnel shall take such steps as necessary to assist the patient in his or her return to the community, including but not limited to employment counseling, communication with the patient's legally authorized representative, communication with family, if appropriate, assistance in finding housing, and assessment of and communication with available community and/or educational resources."[97]

These provisions not only require discharge planning, but also list the types of care the plan should address, including the patient's housing, case management and financial needs.[98] Other states' laws simply require discharge or aftercare

MINN. STAT. 253B.20(4) (1999); MONT. CODE ANN. §53-21-180 (1999); N.J. STAT. ANN. § 30:4-27.18 (West 1999); N.Y. MENTAL HYG. LAW §29.15(f)-(i) (Consol. 2000); N.D. CENT. CODE §25-03.1-30(5) (1999); OHIO ADMIN. CODE §5122-14-11(g) and (H) (1999); OKLA. STAT. ANN. tit. 43A, §7-102(2000); OR. ADMIN. R. 309-031-0215 (2000); 50 PA. CONS. STAT. §4102(2-3) (1999); 50 PA. CONS. STAT. §4301 (1999); R.I. CODE R. 21-28.2-17 (2000). S.C. CODE ANN. REGS. 1976 §44-22-70(c) (1999); S.D. Cod. Laws §27A-12-3.7 (2000); See, Tenn. Code Ann. §33-2-601 (1999); Tex. Health Code Ann. §574.081 (West 1999); *see*, UTAH CODE ANN. §62A-12-229(2) (2000); UTAH CODE ANN. §62A-12-241 (2000); VA. CODE ANN. §37.1-197.1(A)(3) (Michie 1999); V.I. CODE ANN. tit. 19, §723a (1999); W.VA. CODE §27-2A-1(b)(1) (1999); WIS. STAT. §51.35(4m) & (5) (1999); WYO. STAT. ANN. §25-10-108(b) (Michie 1999). *See also*, N.M. STAT. ANN. §43-1-9 (2000).

94. *See* MASS. REGS. CODE tit. 104 § 27.09 (1999).

95. *See* MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP, *supra* note 77.

96. While some state discharge planning mandates date from the early 1970's, when the mental health de-institutionalization movement began, others are of more recent vintage and appear to be a response to concerns about homelessness among mentally ill and substance abusing people. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. I §10-809(b)(ii) (1999). "Aftercare services' means services. . .[t]hat enhance the opportunity to maintain a mentally ill individual in the community and to assist in the prevention of homelessness." *Id.* Some mandates are statutory, while others appear in regulatory codes. Some standards apply to all licensed treatment facilities; others apply only to state run institutions. Some provisions apply to all inpatients, while others are limited to patients who are involuntarily committed for treatment. Some apply to patients admitted for either psychiatric treatment and substance abuse; others apply to only one or the other.

97. MASS. REGS. CODE, *supra* note 94, at 104 § 27.09 (1999).

98. S.C. CODE ANN. §44-22-70(c) (Law.Co-Op. 1999) provides:

> For patients committed after a hearing by the probate court for the involuntary inpatient treatment for mental illness or chemical dependency, an appropriate and comprehensive discharge plan must be developed. Planning for a patient's discharge must begin within seventy-two hours of admission, must include input from the patient and must address

planning without detailing specifics.[99] Certainly, adequate discharge planning for mentally ill and substance abusing people does not include discharge to shelters and street. Few discharge planning statutes, though, specifically prohibit such discharges.

Nevertheless, courts seem willing to hold that discharge planning statutes create an enforceable right to adequate discharge planning which forbids discharges to shelters.[100] For example, in *Heard v. Cuomo*[101] and its companion case *Koskinas v. Buford*,[102] the New York courts held that New York's discharge planning statute prohibits New York City public hospitals from discharging mental health patients to the streets or shelters. New York's discharge planning statute dates from 1975, yet for over twenty years, New York City's public hospitals routinely discharged mental health patients to shelters and streets.[103] Now, a court order requires that the hospitals: (1) prepare a discharge plan which includes prescribing adequate and appropriate

community treatment, financial resources and housing. The facility and community treatment staff must be involved in developing the discharge plan. Representatives of all entities which provide services pursuant to the plan must be consulted and informed about the plan. Based on available resources, the department shall make every effort to implement the discharge plan when the patient, in the opinion of the multi-disciplinary team, is ready for discharge.

99. N.J. STAT. ANN. §30:4-27.18 (West 1999) provides:

A person discharged either by the court or administratively from a short-term care or psychiatric facility or special psychiatric hospital shall have a discharge plan prepared by the treatment team at the facility pursuant to this section. The treatment team shall give the patient an opportunity to participate in the formulation of the discharge plan. In the case of patients committed to short-term care or psychiatric facilities, a community agency designated by the commissioner shall participate in the formulation of the plan. The facility shall advise the mental health agency of the date of the patient's discharge. The mental health agency shall provide follow-up care to the patient pursuant to regulations adopted by the commission. This section does not preclude discharging a patient to an appropriate professional. Psychiatric facilities shall give notice of the discharge to the county adjuster of the county in which the patient has legal settlement.

100. *See, e.g.*, Heard v. Cuomo, 610 N.E. 2d 348 (1993) (New York's mental health discharge planning statute requires public hospitals to prepare an individualized, written discharge plan that includes housing and coordinating aftercare efforts). Koskinas v. Carrilo, 625 N.Y.S.2d 546 (1 Dept. 1995) (New York's discharge planning statute requires that hospitals insure that homeless, mentally ill patients reach the residences to which they are discharged); E.H. v. Matin, 284 S.E.2d 232 (W.Va. 1981) (Right to adequate treatment under state law is violated when, inter alia, staff members do not follow-up to assure compliance with treatment plans); Arnold v. Arizona Dept. of Health Servs, 775 P.2d 521 (Az. 1989) (Both county and state have mandatory, non-discretionary duty to provide a full continuum of community mental health care to chronically mentally ill individuals which is breached when the state hospital fails to provide discharge plans to patients or their guardians).

101. *Heard*, 610 N.E.2d at 348.

102. *Koskinas*, 625 N.Y.S.2d at 546.

103. *See Heard*, 610 N.E.2d at 348.

housing and necessary support services; (2) locate the housing and support services described in the discharge plan prior to discharge; and (3) provide follow up services to assure that the discharge patient reaches the housing and is, in fact, receiving the social and medical services prescribed in the discharge plan.[104] Public hospitals may not simply refer a discharged patient to a detox program or group home. Rather, public hospitals are legally obligated to work with community agencies to make sure the released patient gets to the services he or she needs.[105]

The New York litigation has had a rippling effect. Every New York public hospital now has discharge workers, dubbed "Koskinos workers" after the class action litigation.[106] The litigation has sparked ongoing data and research about the role of hospital discharges in creating homelessness and increased awareness of the need for discharge planning as a homeless prevention technique.[107] Finally, in a city which suffers from a severe shortage of housing options for the mentally ill, the litigation has helped build public support for a joint city-state project to build 5,225 units of housing for the homeless mentally ill.[108]

In at least one other state, the regulatory agency responsible for mental health care is strengthening its discharge planning mandate to codify what the New York courts were willing to order—explicit bans on discharges to

104. *Heard*, 610 N.E.2d at 349.

105. With the legal obligation comes the threat of tort damages for failure to comply. *See* Jonathon P. Bach, Note, *Requiring One Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153 (1989) (NY tort article). To quell the City's concerns about the limits of its duty to assist discharged mentally ill patients in finding housing, the court specifically found that neither the statute nor the judgment imposes on the City an explicit duty to build, create, supply or fund housing for the mentally ill homeless. *Heard*, 610 N.E.2d at 350. The court also refused to order a specific time period for follow up activities. Rather, it directed the city to develop a follow up program. *Koskinas*, 625 N.Y.S.2d at 547. The plan implemented by the hospitals provides that hospitals will make phone calls over a three-day period to check on patients. The plan includes no contingency plans for situations in which the patient is not receiving services in the community. Lisa W. Foderaro, *Mental Health Care for Outpatients is Often Lax*, N.Y. TIMES, Feb. 21, 1996, at B3.

106. While funding problems plague New York City's hospitals, the Koskinos litigation has highlighted the need for good discharge planning. While Koskinas workers, like other parts of the city's public hospitals system, remain underfunded and undertrained, they are at least in place and have not been cut in the periodic budget crises that sweep the city and state of New York. Interview with Ray Brescia, *supra* note 76.

107. *See* THE REVOLVING DOOR, *supra* note 30; BARR, *supra* note 14; NEW YORK STATE OFFICE OF MENTAL HEALTH, STATEWIDE COMPREHENSIVE PLAN FOR MENTAL HEALTH SERVICES 1997-2001 (1997); *New York City Hospital Discharge Study*, *in* MENTAL HEALTH PROJECT OF THE URBAN JUSTICE CENTER 2, 11 n.3 (1996).

108. *To Stop Mental Health's Revolving Door*, N.Y. TIMES, Mar. 21, 1991, at A22 (unsigned editorial).

shelters. The impetus is a recognition that legal mandates focusing on the discharge planning process may not send a clear enough message that discharges into homelessness are prohibited.

In Massachusetts, the Department of Mental Health recently adopted a "zero tolerance" policy prohibiting state-run mental institutions from discharging patients to emergency shelters and the street.[109] Massachusetts' discharge planning provision, quoted earlier, is a regulatory provision which applies to all facilities licensed to provide in-patient psychiatric care. However, a 1998 census of the state's emergency homeless shelters reported over 800 illegal discharges from hospital psychiatric care to shelters.[110] In response to these numbers, the department adopted a new, explicit policy prohibiting state run hospitals from discharging patients to streets and shelters.[111] The result was an immediate reduction to almost zero in the number of people entering emergency shelters directly upon discharge from state psychiatric care.[112] However, the state's private hospitals continued to discharge mentally ill patients to shelters and streets, accounting for over 650 discharges to shelters in 1999.[113] In light of its experience with a zero tolerance policy for state hospitals, the department has proposed extending it to all licensed psychiatric facilities.[114]

109. PREVENTING HOMELESSNESS, *supra* note 18, at 4-5. Massachusetts has long had a departmental policy explicitly prohibiting discharges to streets and shelters which was apparently ignored. *See also* MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH, DEPARTMENT POLICY - HOMELESS INDIVIDUALS (Feb. 22, 1983) ("In no instance should a person be discharged from an in-patient facility with directions to seek housing or shelter in an emergency shelter.").

110. MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, INITIATING SOLUTIONS TO END HOMELESSNESS 10 (1999). The 1997 census reported 761 discharges from hospital psychiatric care to shelters. *Id.*

111. Interview with Mary Ellen Hombs, Director of Special Projects, Massachusetts Housing and Shelter Alliance (Mar. 8, 2000) [hereinafter Interview with Mary Ellen Hombs].

112. *See* MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, COMPARISON OF EMERGING SUBPOPULATIONS, *supra* note 40.

113. *Id*. at 9. Six hundred and fifty six individuals were discharged to shelters. *Id.*

114. MASSACHUSETTS DEP'T OF MENTAL HEALTH, TASK FORCE ON HOMELESSNESS 8 (2000). The proposed rule, MASS. REGS. CODE tit. 104, §27.09(1) reads:

> (a) Steps shall be taken to arrange for necessary follow-up clinical services following discharge. Such measures shall be documented in the medical record. (b) Except in the case of competent refusal of alternative options by a patient, discharge to a homeless shelter or the street is inappropriate. The facility shall document in the medical record all efforts made to offer alternative options and shall keep a record of all such discharges and submit it to the Department upon request. Section (c) provides: "When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to MASS. REGS. CODE tit. 104, §27.09, the service planning process outlined in MASS. REGS. CODE tit. 104, §27.09 shall be initiated prior to discharge."

See also MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH, PUBLIC HEARING REGARDING PROPOSED REGULATIONS (2000).

Massachusetts is also experimenting with using managed care contracts to reduce discharges to shelters.[115] In Massachusetts, as elsewhere, managed care cost pressures are pushing patients out of the hospital and into the street. In 1998, Massachusetts' shelter census showed that half the patients discharged to streets and shelters were Medicaid enrollees receiving mental health care from the Massachusetts Behavioral Health Partnership (MBHP), a for-profit managed care entity, that receives a capitated payment rate, to provide mental health and substance abuse treatment services to Medicaid enrollees.[116] In response to these numbers, the Massachusetts Medicaid agency included a number of performance standards relating to homeless prevention and discharge planning in its 1999 contract with MBHP.[117]

Massachusetts has been a leader in using managed care performance standards in its Medicaid contracting. Performance standards are tied to financial bonuses and penalties: if the contractor meets or exceeds a performance standard, it is rewarded financially. These standards are particularly appropriate in the managed care setting which relies on financial incentives to encourage and change old, ingrained patterns of behavior.

The 1999 performance standards, which were intended to reduce inappropriate discharges to shelters and streets, require MBHP to work with the Massachusetts Housing and Shelter Alliance and other advocates to develop and present a half-day training to MBHP discharge planners and to track discharges into homelessness, including attempts at more appropriate community placements.[118] MBHP satisfied the performance standard—it worked with advocates, developed and presented a training session, and instituted a record keeping form, Attempt to Divert from Discharge to Shelter.[119] However, discharges to shelters continued at a substantial rate. In 1999, MBHP providers discharged 1656 people into homelessness.[120]

115. *See* MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP PERFORMANCE STANDARDS, *supra* note 77.

116. MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, COMPARISON OF EMERGING SUBPOPULATIONS, *supra* note 40, at 10.

117. Interview with Mary Ellen Hombs, *supra* note 111.

118. MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP PERFORMANCE STANDARDS, *supra* note 77, at 3. ("The Contractor shall continue to collaborate with the homeless advocacy community to identify strategies and resources to facilitate appropriate psychiatric discharge dispositions for homeless adults. . .[and] will also educate certain inpatient mental health providers. . .and develop a mechanism to monitor their performance relative to the identified strategies. The compliance target for this standard shall be the submission of a final compliance report evidencing that by June 30, 1999 strategies and resources were identified, providers were educated and the developed performance tracking mechanisms were implemented.").

119. Interview with Mary Ellen Hombs, *supra* note 111.

120. MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, COMPARISON OF EMERGING SUBPOPULATIONS, *supra* note 40, at 10. Seventy-three percent of a representative sampling of 2,269 of 4,185 shelter beds across Massachusetts. *Id.*

Massachusetts's experience confirms what others are learning about managed care performance standards: changing the process by which care is provided does not necessarily change the outcome. As a result of the managed care performance standard, MBHP is learning how to do better discharge planning for mentally ill homeless people. However, that learning has not yet translated into better discharges for patients. As states (and employers) become more sophisticated in their managed care contracting, many are moving to performance standards based on outcomes rather than inputs and process. In the discharge planning context, an outcome-based performance standard provides a financial incentive for the managed care entity to reduce the number or percentage of patients discharged to streets and shelters. Like zero tolerance policies, outcome-based performance standards send a clear and unequivocal message about the goal, leaving the details to those who run the institution. Many, in Massachusetts and elsewhere, are advocating for just such outcome-based performance standards for discharge planning.[121]

In the meantime, with each round of managed care contracting, Massachusetts is working with MBHP to improve its discharge planning through outcome measures and process standards. The year 2000 MBHP performance standards continue to provide financial incentives to encourage the managed care plan to work with advocates and conduct more discharge planning training sessions.[122] It rewards MBHP if it develops a web site with information on discharge planning and community services and pays MBHP if it works with shelters and detox centers to enroll homeless people in Medicaid.[123]

The year 2000 performance standards also include two outcome standards, that while not directly addressing discharges to shelters, are likely to reduce such discharges. One outcome standard rewards MBHP if more than 80 percent of discharged patients receive community services within seven days of their release.[124] Since research shows that it is unrealistic to expect patients discharged to shelters to keep their follow-up appointments, this standard is

121. *See, e.g.*, Sidney D. Watson, *The Commercialization of Welfare Medicine*, 45 ST. LOUIS U. L.J. 53 (2001).

122. MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP, *supra* note 77, at 3.

123. *Id*. The Division of Medical Assistance instituted two discharge planning initiatives aimed at making it easier for people leaving institutions to enroll in Medicaid. First, the agency adopted a shortened, easy to follow Medicaid enrollment form for homeless people. Second, it offers an enrollment incentive to shelters and detox centers to compensate them for efforts to enroll homeless people. The program receives a $30 fee for each person enrolled in Medicaid. *See also* Interview with Mary Ellen Hombs, *supra* note 111.

124. MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP, *supra* note 77, at 2.

likely to discourage discharges to shelters.[125] The second rewards MBHP for creating and using an ACT team to deliver community based services.[126]

While managed care carries with it a plethora of potential problems, possibilities abound in the contracting process. States can identify the services and outcomes they want and use financial incentives—rather than law suits or protracted administrative wrangling—to get them.

Thus, law can play a significant role in reducing discharges to streets. A substantial body of law already exists outlawing such discharges. Innovative new approaches—including zero tolerance policies and managed care contracts—are on the horizon. In some states, statutes need to be enforced. In others, regulatory and statutory provisions need to be strengthened to make their messages ring out more clearly.

CONCLUSION

> The last time Julia was in Atlanta Regional Hospital she thought she would never get out or get out only to be sent once again to a homeless shelter. Terrified, Julia suffered a "conversion paralysis," an acute physical reaction to her emotional trauma, that left her entire body paralyzed. Once Julia learned she would soon be discharged to a residential group home, her body gradually began to lose its paralysis. On the day she left the hospital for her new home, she was dancing.[127]

It is bad medicine to discharge mentally ill and substance abusing patients to the street. A stay in a psychiatric hospital or detox center gives the patient a chance to become stabilized, a necessary foundation for successful treatment. Long term stability can be maintained if a continuum of care begins as the person leaves the hospital or detox to reenter the community.

A legal mandate to do adequate discharge planning and to prohibit discharges to streets and shelters is not an onerous obligation. Standards and recommendations abound that explain how to provide discharge planning for patients who are mentally ill and have substance abuse problems. Funding is available for community case managers and to build the community resources that discharged patients need.

The biggest challenge may be that good discharge planning requires that hospitals and detox centers become part of a larger network of community care givers and patients. They must break out of the fragmented work of medicine and join in a community effort. The role of advocates is to help show institutions how to become part of this larger community.

125. *See* John R. Belcher, *Moving Into Homelessness After Psychiatric Hospitalization*, 14 J. SOC. SERV. RES. 63, 75 (1991).

126. MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP, *supra* note 77, at 17.

127. THE MENTAL HEALTH LAW PROJECT, *supra* note 24.