

---

Vermont Department of Mental Health  
**Homeless Discharge-Planning Policy**

---

***Mission Statement***

The Department of Mental Health (DMH) and Vermont Psychiatric Care Hospital (VPCH) along with all acute care MH bed options, promote inclusionary, person-centered, effective and efficient services to enable individuals with behavioral health needs to live as independently and responsibly as possible in their community in the DMH discharge-planning process.

The Department of Mental Health (DMH) discharge-planning is the process undertaken by the DMH Care Management Team & Housing staff to prepare a housing plan for a homeless person with psychiatric and/or co-occurring substance use disorders to return to the community. Further, it entails the linkage of the individual to essential community services and supports. This linkage is documented and recorded in the Homeless Management Information System (HMIS). Further, each client awarded a DMH Housing Subsidy will have outcomes reported to DMH every 90 days by the local service provider. The goal of the discharge-planning process is to provide individuals the opportunity for full access to available housing, and mainstream resources that will support their continued mental health in their community.

The DMH homeless discharge-planning process is consistent with the state mental health vision statement in that Vermont citizens with behavioral health needs are supported and assisted in reaching their goals and leading responsible, high-quality lives as part of their communities.

**Community Responsibility**

Discharge-planning is a partnership between the local community partner agencies and the Care Management Team. Designated Community Mental Health Agencies, SSA PATHWAYS to Housing, and Designated Hospitals / Acute Care Beds have the primary responsibility for assisting individuals returning to their communities.

Discharge-planning from acute care is a plan of return to community. The hospital social workers have the primary responsibility for connecting clients and their care with and to the local community and its resources. The DMH Care Management team helps to facilitate this process. This is accomplished through DMH's established, active partnerships with the agencies that provide the primary support and services to the consumer in the community.

In instances where the consumer is transient or an out-of-state resident, the Care Management Team will attempt to connect the consumer to the most appropriate and desired community of choice.

Community agencies and institutions have the responsibility of communicating and following through on the plans to ensure that the consumer is offered all the services and supports necessary to live as independently and self-sufficiently as possible in the community.

### **Care Management Team Approach to Discharge-Planning**

The discharge-planning process is a team approach that involves all people with significant discharge and client transition responsibilities. This Care Management Team approach facilitates efficient communication and effective use of resources. When warranted, the discharge-planning process *may* include the development of a new service program for a particular individual with special needs.

The Care Teams have been developed with DMH staff & collaborative partnerships among designated agencies as well as local institutions that are responsible for service, support, housing, and treatment for the client.

The team composition is always flexible and can include any of the following persons:

- Care Management Team leader
- Care Manager staff
- Treating physician\*
- Consumer\*
- Family member(s) or other supporters
- Community case manager\*
- Designated Hospital social worker\*
- Designated Community MH or SSA housing resource specialist\*
- Mental health and substance abuse specialists
- Local Housing Authority HUD (Housing & Urban Development) Section 8 program specialist
- Benefit and entitlement/income specialist
- Criminal justice system representative
- Health care system representative
- Payee representative
- DMH housing policymaker
- Advocate
- Peer supporter

\* The core members of the discharge-planning team. While the team can have additional members depending on the situational needs of the consumer, not every team member is present at every meeting with the consumer.

Team members have the ability to commit the resources of the agency/institution that they represent. In the case of the Community Mental Health Housing Resource Specialist, this resource is for local housing information and access to local housing/treatment support funds. DMH oversees the Housing Subsidy & Care program.

### The Team Leader

While the consumer is in an acute care bed, the care team leader is the person with the primary responsibility for coordinating the return of the consumer into the community.

In most instances, the care management team leader oversees the DMH care monitoring process. The team leader collaborates with the other members of the team to ensure that the client has the necessary resources and support available to assist with an expedited appropriate return to the community.

Once the client has returned to the community and the DMH care team staff has identified the local community case manager, that local staff person is responsible for following up with the client to ensure the implementation of the discharge plan and ongoing support. This includes the need for ongoing assessment, completion of SSOMs and adjustment to the individual support plan as warranted.

The team leader identifies the need for other team members beyond the core noted above. The team leader secures their participation and ensures communication among the team members.

### **DMH Coordinates the Homeless Discharge-Planning System**

DMH is the single agency in Vermont that has the primary responsibility for coordinating the activity of all stakeholders involved in the community re-entry system for homeless mental health consumers who are in treatment in acute care beds.

In Vermont, two entities have fiscal and legal responsibility for developing and implementing discharge plans. The DMH Care Management Team has this responsibility for mental health consumers and those with co-occurring disorders of mental illness and substance abuse whom it serves. Locally, each of the ten designated community mental health agencies statewide, and SSA PATHWAYS in designated jurisdictions, has the responsibility for mental health consumers in their community who have also been served in an acute care setting.

The DMH Care Management Team develops and maintains relationships with other agencies and institutions within each community and coordinates the discharge-planning process.

The local participating stakeholder agencies and team representatives have the responsibility for ensuring the development and implementation of discharge plans and the effective utilization of resources.

### **Vermont State Government Role**

The State Mental Health Authority is responsible for monitoring the implementation of the discharge-planning system. All Vermont state agencies and quasi-governmental agencies with an interest in community returns collaborate within this system. The Department of Mental Health monitors the utilization of the Housing Support Fund (HCF & HRF combined 7/14), The DMH Housing Subsidy & Care Program, and also funds a small homeless housing start-up fund for consumers who are homeless and mentally ill. PATH (Programs that Assist in Transition from Homelessness) providers in seven communities across the state utilize these funds.

The Department of Mental Health has the responsibility for monitoring the implementation of its state discharge policy and planning.

The Vermont state mental health authority has made discharge-planning a priority for all consumers and particularly homeless consumers. It has involved other state agencies, including Vermont State Housing Authority, Vermont Housing and Conservation Board, Vermont Housing Finance Agency, and the Department of Corrections.

### **Vermont Psychiatric Survivors and Vermont Protection & Advocacy**

Both of these advocacy groups have maintained the role and responsibility of monitoring and providing feedback to the State Mental Health Authority and they work to ensure that State Mental Health Facilities and the Designated Community Mental Health Agencies fulfill their responsibilities.

### **Consumer Involvement and Cultural Competence**

Discharge plans are developed with consumers and utilize extensive input from consumers.

Discharge plans are coordinated among the consumer, service providers, institutions, and the designated community mental health housing representative.

Discharge plans are culturally competent and sensitive to the important issues of race, ethnicity, religion, gender, sexual orientation, and US resident status.

## **Housing, Health Care, and Treatment**

For a discharge plan to be successful, it must facilitate the consumer finding and maintaining housing, health care, and treatment.

Each discharge plan identifies and assists the consumer in securing a housing option that suits the individual's needs. It also recognizes that the needs and preferences of the consumer can vary and change over time as conditions and interest(s) change. A discharge plan evolves accordingly. Outcomes are monitored by use of the Self Sufficiency Outcome Measures in HMIS.

The care manager developed discharge plan stems from staff's ongoing assessment of each community's housing stock and from the partnerships between housing and mental health service providers. Under no circumstances is a consumer served by DMH discharged to the streets. These resources are offered to the consumer, who chooses the option most appropriate to the need.

## **Income, Employment, and Entitlements**

The Green Mountain Psychiatric Care Hospital and other acute care bed settings discharge plans encourage consumers to be as independent and self-sufficient as possible.

Consumers are supported in making applications and receiving the entitlement benefits for which they are eligible. Further, they are supported by the Department of Mental Health's Housing Support Fund and Housing Subsidy & Care Program.

Discharge plans review and take into consideration the possibility of employment, education and training. Discharge plans support budgeting and money management as prudent.

## **Personal Support and Life Skills Training**

Consumers have better opportunities for a successful and permanent/long-term return to their community if they can develop adequate support systems. All discharge-planning facilitates the development of this support through designated community mental health providers, SSA PATHWAYS and private practitioners as directed by the consumer.

Discharge plans are coordinated by the four DMH care managers under the direction and support of a Care Management Chief. With small caseloads, the team leaders work with consumers, community agencies and stakeholders to ensure that the discharge plan is followed or revised and improved as necessary.

Each discharge plan can involve family members, friends and other supporters as appropriate or requested.

Vermont Psychiatric Survivors', the Wellness Co-op and the rich array of peer support groups have been helpful to community return. Discharge plans make use of these resources whenever appropriate.

### **Timing of the Plan**

The average length of stay in an acute care bed has declined sharply in the past 20 years. Currently, in the majority of cases, discharge-planning begins immediately upon an admission.

### **Difficult and Challenging Cases**

There are some individuals who may be difficult to engage or maintain a positive working relationship. Not complying with plans -- or relapse -- can be part of their experience of returning to the community. Discharge-planning recognizes and anticipates that these possibilities exist.

Some clients will choose to become disconnected from the system of care that has been established. Therefore, peer and other alternatives have been developed in the Mental Health System of Care. PATH outreach services are offered in seven locations across the state. Vermont has two Safe Havens - in Burlington and Central Vermont. In addition, we have embarked on a jail diversion and alternatives to hospitalization initiative.

### **Community Resources and Systems Integration**

DMH discharge-planning seeks to limit the duplication of services and administrative functions, thereby increasing the amount of resources available to support a client's return to the community. The Vermont Coalition to End Homelessness is seeking to achieve greater systems integration by including the policy in various official policy and strategic-planning documents.

DMH discharge-planning procedures and policies can be supported by all relevant community planning documents, including the Consolidated Plan, Continuum of Care, and mental health and public housing authorities' strategic plans. Vermont Psychiatric Care Hospital discharge-planning systems currently make use of all available resources: Projects in Transition from Homelessness (PATH), Supportive Housing Program (SHP), Shelter Plus Care, CMHC Housing Support Funds, DMH Housing Subsidy & Care, HUD Section 8 funds, and 811 and 202 funding as appropriate.

## **Funding Considerations**

Ensuring that discharge-planning is successful, requires adequate funding for the resources and programs deemed to be the most successful in assisting a clients' return to the community.

The Department of Mental Health currently administers a statewide CMHC-based CRT Housing Support Fund & DMH Housing Subsidy & Care Program (for the homeless) to assist clients who have been served in an acute care bed and who are at risk of re-hospitalization. The CRT Housing Support Fund was established in 1988 (formerly named Housing Contingency Fund) to support individuals with temporary rental assistance as they wait for the HUD Section 8 housing subsidy. The DMH Housing Subsidy and Care Program was initiated in 2011. This DMH state fund pays for security deposits, ongoing rental assistance (while consumers wait for Section 8), and housing start-up with acquisition of furniture, etc. In addition, the fund pays rent if clients need additional treatment and support outside of their home for periods of time (up to 90 days )after they have found housing. Each of the designated community mental health centers has Housing Contingency funds to assist in discharge-planning as warranted.

DMH also provides start-up funds for homeless mentally ill consumers who choose to avoid the traditional mental health system of care. The PATH providers in seven communities across the state utilize these funds for security deposits, start-up costs and temporary rental assistance.

All of these supports are considered in the development of the Discharge-Planning Process