

Countywide Forum on Discharge Planning and Homelessness

July 14th, 2008

Next Steps

Veterans

- 1) Provide training to providers on VA services & funding
- 2) Better tracking systems within VA

Health Care

- 1) More respite services (shelter-based respite)
- 2) Advocate for more PSH
- 3) Revisions to discharge planning standards (hospital accreditation)

Cook County Jail

- 1) Benefits – suspend, not terminate
- 2) Lessen restrictions on providers visiting the jail

Youth

- 1) Compile data to determine populations most in need of better discharge planning
- 2) Resource guide for providers – Government programs available

IDOC

- 1) Medicaid reinstatement upon release
- 2) IDs upon release

Mental Health

- 1) More communication re: discharge (esp. with other systems. i.e. jails, training for providers)
- 2) More permanent supportive housing (fewer barriers, evictions. More MH tx w/in housing)
- 3) IDs

Substance Abuse

- 1) Resource database of available services
- 2) Uniform discharge planning for substance abuse system

Notes From the Seven Breakout Groups

IDOC

Issues/Challenges

- Funding cuts
- Suspension of benefits, etc
- Reducing recidivism
- Documenting homelessness (prison time)
- CHA:extensive background checks
- Moving clients into PH/finding decent housing
- Identification
- Sex offender restrictions
- Community education
- Unstable housing situations
- Housing AND employment
- Collaboration between agencies and prisons
- Beginning services on the inside
- Pre-release agreements (SSA)
- Sharing info/not duplicating efforts
- Bringing DOC to “table” sooner
- Unknown/uncertain timelines for release
- How do we build bridges w/ family?

Solutions/Action Plans

- **Medicaid upon release – law exists**
- **Real ID (Indiana doing it!)**
- Video-conferencing (w/ families)
- TRAC
- Outcome data that is MEASURABLE
- Reporting unjust things/ethical outcomes
- Do your time and you’re hired; advocacy
- Advocacy around background checks
- Education about individual rights to individuals and the community
- Continuity of medical information/records
- Education for those incarcerated
- **Access to benefits**
- **Communication**

words = starred on original document

Health Care

Challenges

- Medication and med. Management (literacy)
- Lack of placements (eg. Interfaith House) for discharge – turn away 3 for every 1; Interfaith also does not discharge to street
- Documentation/health history not available
- Suburban Cook: no 24-hr/daytime shelter options
- Shelters not equipped for medical needs
- Lack of respite care
- Income requirements for nursing homes AND homeless housing programs
- Undocumented
- Nursing home: getting out/so won't take homeless w/ only short-term med. Needs
- Employability because of disability/illness
- Lack of health insurance leading to homelessness
- SSI determination VERY slow (Stroger program: 3-4 weeks)
- DP and social work programs in private hospitals closed or limited staff capacity there/turnover
- Criminal background/sex offender as a related challenge
- Inconsistency across the system, that one good social worker and if he/she leaves...
- West Sub. PADS sending referral letters
- lack of affordable housing
- Documentation of disability for PSH and unresponsive doctors to document
- Level of services necessary is less than nursing home level – no money for that

Opportunities

(B) Cost effectiveness, communicating about social determinants of health (and negative press around “dumping”) ...CHHP Study

- Continuum of services, visiting nurses, assisted living, impact on nursing home utilization (\$\$)
 - Medicaid (or other) eligibility adjustments – torture victim example (pays for nursing homes but not so much the community housing options)
 - Plan: Put #s together for specialized interim housing need (like Interfaith)
 - Hospitals' community benefits funds, hospitals fund the housing - PSH & respite
 - In Chicago: prioritize PSH admissions for Interfaith/interim housing guests
 - Educate hospital social workers about the housing options and resources that ARE available
- (A)** Incorporate a few respite beds into existing shelters and suburban TH (REST, CCIL) eg, 30-60 days (maybe by partnering w/ I.H.); more PSH

- Continue the CHHP model
 - Suburban: needs PSH for health ppl.
 - Use HCH to provide services (TB example: pair services w/ housing)
- (B)** Incorporate housing/discharge planning – part of JCAHO accreditation – at least require them to staff the effort; State law re: DP (ind. Housing) required of all hospitals; Metro. Chicago Healthcare Council.

No. IL Public Health Consortium. HMPRG – Health and Medicine Policy and Research Group. CMAP go to 2040 – add health; communicate appropriate standards and data/advocacy around that.

- Prioritize the ill for homeless resources.
- Stroger H. now contracting w/ nursing homes for 6 weeks of care
- Model DP standards for all hospitals (ind. Housing)

Jail

Challenges

- Family reunification difficult for families in PH (CHA)
- Misdemeanor – waiting period
- Private landlords aren't obligated to rent to those w/ backgrounds
- Released w/ no ID, no meds
- Jail restrictions create barriers for providers
- Public benefits terminate after 30 days – Medicaid, SS
- Lack of info – lack of contact w/ inmates, jail workers
- Employment barriers
- Late night release – no resources given
- Jail's jurisdiction – charges dropped vs. probation

- subpopulations
- women better organized, substance abuse
- mental illness, jail sentences – 300-500 ind

Actions

- Expungement – less red tape – automatic? Resources, waiting area
- More expedient discharge? (long wait to process out, get personal effects, etc)
- More perm. Supp. Housing
- **Fewer barriers for those w/ convictions...harm red., MISA, safehaven, employment **
- Change “no bond” status
- Inmate education/advocacy
- **Reinstate benefits upon release**
- Probation: better coordination/trust between jail and court system;
- more alternative sentencing options
- **Education w/ CPD – divert arrests**

Subpopulations

2000 are over 40, aging population

Interaction between CCDOC and IDOC

Those homeless before arrest vs. those homeless as a result of detention

Actions

****Ease restrictions on providers in entering facility****

****No release past 9pm****

Transition Center

****Suspend Medicaid, don't terminate****

****words**** = starred on original document

Substance Abuse

Challenges

- 1) Anxiety
- 2) Relapse
- 3) MH issues
- 4) Clean time (6 months) – relapse
- 5) IDs (birth cert, picture IDs)
- 6) Documentation
- 7) Undocumented Immigrants
- 8) Diversity – cultural
- 9) Criminal background
- 10) HIV
- 11) Stigma

Brainstorming

- Linkage w/ other agencies
- Ability to house children
- Family support
- Waiting list
- Lack of overall resources
- Funding
- Collaboration amongst programs
- Lack of education to access funding streams
- Training – staff
- Resources (service delivery)
- Education for field
- Identify Resource data base
- Timeline for plan development
- Enhancement of relationships
- Identify a uniform discharge planning process

Strategies

- 1) Identify a resource data base
- 2) Identify a uniform discharge planning process

Mental Health

Challenges

Jail population
HUD 30 day Rule
Access to treatment and medication
ex. Leave with 3 days of medication but have to wait 4-6 week for an appointment
No/poor discharge planning
Gaps in insurance
Lack of communication between Social Security, Birth Certificates and State ID's
No ID's are barriers to finding housing
When discharged from jail, form of ID is returned
Funding used to pay for ID's
Tenant readiness and supportive services
Expectation of sobriety
Eligibility of entitlements SS and Medicaid can take up to 1 yr
Reapplication after incarceration even person had benefits previously
Undocumented or ineligible due to citizenship
Medication assessments not getting at Mental Health Issues

Next steps

Expand on Housing First-meet people where they are at
More expansive Mental Health information for Medicaid application
those with SSI/SSDI
More communication about people who are being discharged
Availability of housing
Health care providers and hospitals working together
No Vacancies in Housing
Understand who are we keeping out and why

Two next steps/who should be involved

ID's

Service Providers providing as much services as possible to make sure they are under the best care.
Access to entitlements and supportive services

Note card Questions

1. Outreach and engagement allows more than one person to go out on outreach. It can be used to reach into other institutions. 7% of people who are in jail are homeless.
2. What is done for supportive housing?
 - There is a written policy of supportive housing to promote a development of more housing. There is about \$7 million in funding which will be used towards Permanent Supportive Housing not residential.
 - DHS Permanent Supportive Housing Page: www.dhs.state.il.us/page.aspx?item=38631

Next Meeting Date: Wednesday August 13th, 2008, 9:00AM at United Way (Lake/Clinton)

Veteran's

Challenges

Skills of veterans frequently do not translate into those needed in civilian life

VA is only allowed to help vets to move to transitional housing.

Other institutions discharge individuals to the VA. (VA does do outreach with other institutions to see whether vets can be served by the VA.)

VA is a behemoth.

People don't understand the VA, and the VA doesn't understand the community services

Benefits and health services are not always connected within the VA system

*Process for securing services from VA is tedious; too much paper work

Vets who are dishonorable discharged can not access vet services

Opportunities

Need reentry job training for vets; should be geared to help with either totally new skills or with translating military skills to civilian living.

Everyone who enters a (homeless) program should be asked whether he/she is a vet.

*Organizations need to be educated about the VA system and its services.

*Hold more dialogues, like this and others, to continue to develop strategies to work with the VA system

*Secure money for training on VA systems and how to access them

Have a VA speakers bureau.

Follow-up care should be face-to-face not limited to phone contacts.

Need real tracking systems.

*Need list of advocates (with contact info) for accessing VA benefits

Discharge planning for service personnel should start at enlistment

Homelessness does not happen immediately from discharge from active duty

*How can the VA and the general community develop an effective network?

Youth

Challenges

- 1) Disrupted adoptions/subsidized guardianships
- 2) Leaving juvenile detention
- 3) Getting re-enrolled in school
- 4) Sexual identity issues
- 5) Pregnant and parenting status
- 6) Mental illness – not enough resources for older adolescents
- 7) Grandparents moving into senior care
- 8) Finding good, affordable housing – willingness of landlords to rent to youth
- 9) Minors have legal obstacles b/c they can't sign for themselves
- 10) Runaways (from DCFS, etc)
- 11) Resources for adoptive parents re: the transition to adolescence
- 12) Resources for biological parents – family reunification (CCBYS?)
- 13) Employment – not prepared for living wage jobs
- 14) Not adequately prepared for discharge into adult systems
- 15) Need better coordination between public systems
- 16) Encouraging youth to take responsibility
- 17) Developmental challenges
- 18) Prevention
- 19) Life skills education
- 20) CCBYS – not an effective system

Next Steps

- 1) Research – what % of homeless youth come from various systems? Ask youth what barriers they face and what they want
- 2) Involve youth in the research process
- 3) Encourage housing solutions to be part of all systems
- 4) Look at outcomes of pilot programs – Thresholds/surge (?) – ID what works and what doesn't
- 5) Policies to promote alternative education and transitional jobs
- 6) Reform CCBYS system
- 7) Better educating DCFS and social service providers/case workers on public benefits/public systems

Action Steps

- 1) Compile and analyze available data to identify sub-populations most in need of effective discharge planning and successful program models and collaborations to do so
- 2) Create a resource guide and professional developmental manual for (HY) soc. Service providers re: discharge planning including multiple statewide systems (DCFS, IDHS, DMH, etc)