DMH Policy

Homeless Individuals	**Policy #: 83** **Date Issued:** February 22, 1983 **Effective Date:** February 22, 1983
Approval by Commissioner **Signed by: Mark J. Mills**	**Date:** February 22, 1983

OVERVIEW:

Homelessness is defined as the lack, for one or more days and nights, of safe, decent, humane lodging that is affordable and available to individuals or families. Homelessness may be caused by the lack of housing facilities, the lack of funding to pay for housing, the inclusion of certain categories of persons from available housing, or the lack of appropriate referral-coordination services. The problem of homelessness is not a new one; however, the number and needs of those who are homeless have increased in recent years. To date, there has been little documentation of this population's various characteristics.

The Governor's Advisory Committee on homelessness has recently identified seven groups with various characteristics and service needs who comprise the current homeless population:

1. chronically, long-term homeless (including alcoholic)
2. mentally ill
3. recently unemployed
4. battered women/children
5. adolescent runaways
6. elderly
7. families

In some cases, these groups overlap. Estimates of the number of mentally-ill people who are homeless vary, in part due to varying definitions of this group.

AREA RESPONSIBILITY FOR CURRENT DMH CLIENTS:

"DMH clients" refers to those individuals who are now receiving in-patient, out-patient, or any type of after-care treatment within the mental health system and those persons who, through screening, have been determined to be in need of mental health services.

1. In no instance should a person be discharged from an in-patient facility with directions to seek housing or shelter in an emergency shelter. Every effort must be

made through careful discharge planning to work with the client and area resources to seek adequate, permanent housing.

2. If "temporary" shelter placement is unavoidable, the reasons for this should be well documented. Active case management should focus on locating a suitable housing alternative as well as ensuring that the client continues to receive appropriate mental health services. In all instances, a case manager should be identified.

3. If a client exercises the right to refuse treatment and/or aid with placement, this should be documented. Documentation should include case management efforts. Whenever possible, outreach efforts should continue.

4. If a client receiving outpatient services becomes homeless, the clinician/case manager should work actively with the client and community resources to locate suitable housing.

Service gaps and resource inadequacies should be identified and documented whenever possible.

AREA RESPONSIBILITY TO EXISTING SHELTERS:

1. The Area in which a shelter is located has the responsibility to provide consultation and education to the shelter regarding health issues and services. Under no circumstances should this be construed as the Department's (or a particular Area's) acceptance of responsibility for the individual residents of a shelter, nor for the health, social and financial problems associated with homelessness.

2. Any shelter resident who requires emergency psychiatric care should be provided that care in the shelter's host Area*; however, subsequent to the management of any emergency, an individual in need of mental health services is the responsibility of the Area that provided the last hospitalization (if any) where the client has ties and a confirmed support system (if any). (See "Department Policy--Area Responsibility for Previously Hospitalized Clients" - effective January 15, 1983.) The originating Area also retains responsibility for case management.

3. Any shelter resident who requires mental health services and who has no Area ties or previous history of hospitalization should receive services provided by the host Area*.

GENERAL AGENCY INVOLVEMENT IN HOMELESSNESS:

In order to respond effectively to the multitude of social and economic problems that contribute to homelessness, it is recommended that mental health participation include both the public and private sector at the Area/Community level. Area mental health personnel should participate in any community activities and committees that address the general problem of homelessness. The purpose of this involvement is twofold:

1. To provide assistance to community representatives and planners in dealing with the overall problem.

2. To provide mental health expertise, including accurate clinical and managerial information.

In no instance should DMH take sole responsibility for homelessness, but this agency should clearly demonstrate a willingness to participate with the community and other agencies in responding to the problem. Each Area Director should be knowledgeable as to the extent of homelessness in that catchment Area, especially as it pertains to mental health needs. This information should be reported to the respective District Manager, the Chief Operating Officer, and the Commissioner, to support agency planning and policy development.

* In those instances where a large number of shelters are concentrated in one Area, provision of mental health services may be assigned on a District-wide basis.