Evaluability Assessment of Discharge Planning and the Prevention of Homelessness

Final Report

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September 22, 2005

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Acknowledgments

The authors of this report wish to acknowledge the assistance of many individuals who contributed to this study. Peggy Halpern from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services, the project officer for the study, provided invaluable guidance throughout the course of the study and contributed helpful comments on both the form and substance of this report. Dr. Halpern and her ASPE colleague Walter Leginski provided the project vision and research questions that served as the basis of the study and contributed to an ongoing dialogue as our work progressed. Canta Pian of ASPE provided essential direction throughout the project.

We are also grateful to members of the Technical Expert Panel (TEP), who brought their broad range of knowledge and experience to this project at both its early and late stages. TEP members were Amy Baker, Robert Battjes, Denise Juliano-Bult, Ronna Cook, Dennis Culhane, Peter Delaney, Deborah Dennis, Wayne Fenton, James Herrell, Mary Ellen Hombs, Robert Keane, Debra Rog, Marian Schwager, Mary Bruce Webb, Michael Wiseman, and Marty Zanghi. Howard Goldman served as cofacilitator for the TEP.

We are grateful to several Westat colleagues who contributed to this effort. Janet Ciarico and Jane Mettenburg assisted with foster care site visits. John Rogers assisted with statistical issues, and Robert Orwin provided research methodology consultation. Susan Azrin provided editorial assistance, and Jeanie Kemp provided word processing and other administrative support throughout the project. Martha Franklin and Jenny Crabb provided assistance with style review and production of this final product.

We are particularly grateful to the primary contacts and other staff members who represented the sites participating in the documentary analysis and site visit aspects of this study. While study protocol prohibits naming institutions or individuals, their contribution to this process was quite significant. Nineteen sites participating in the documentary analysis phase provided documents related to their discharge planning process. In addition, they provided information and clarification through telephone discussions, and access to other staff members when appropriate. Eight sites selected for site visits provided additional information; access to clinical, administrative, and IT staff for onsite interviews; introductions to community programs with which they work; and scheduling and logistics support for our visits. Their gifts of time,

knowledge, experience, and hospitality are much appreciated, as is their dedication to the populations they serve. Staff members of collaborating agencies in the communities we visited also contributed a great deal to our knowledge and understanding of the challenges of discharge planning for those persons experiencing homelessness or who are at risk of homelessness.

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Executive Summary

Introduction

The purpose of this study was to determine the evaluability of discharge planning as a strategy to prevent homelessness. In 1994 the Federal Interagency Council on Homelessness identified inadequate discharge planning as a significant factor contributing to homelessness among persons with mental illnesses and/or substance use disorders. The prevention of homelessness is a key goal in the U.S. Department of Health and Human Services (DHHS) action plan to end chronic homelessness.[1] This study is related to a strategy in the plan that recommends identifying and promoting the use of effective, evidence-based homelessness prevention interventions.

Past research has indicated that many people with severe mental illnesses and substance abuse problems who experience homelessness travel in "institutional circuits," or move repeatedly through systems and institutions such as state psychiatric hospitals, jails and prisons, homeless shelters, and drug treatment programs. However, although discharge planning is often recommended as a strategy to prevent homelessness among people released from institutions or youth aging out of foster care, very few studies have examined this strategy. The Assistant Secretary for Planning and Evaluation of DHHS sponsored this study in order to build knowledge for researchers and policy makers in the field of homelessness regarding the evaluability of discharge planning in institutional and custodial settings. The four institutional and custodial settings listed below were included in this study because previous research has indicated that many of those entering shelters have recently come from one of these settings.

- Adult inpatient psychiatric treatment units in state psychiatric, private psychiatric, or general hospitals;
- Residential treatment centers serving children and youth with serious emotional disturbances and/or substance use disorders;
- Residential treatment programs for adults with substance use disorders; and
- Foster care independent living programs.

[1] U.S. Department of Health and Human Services (DHHS). (2003). *Ending chronic homelessness—Strategies for action: A report from the Secretary's Workgroup on Ending Chronic Homelessness.* Washington, DC: Author.

Key Research Questions

Some of the key research questions of this study are listed below; a more exhaustive list can be found in this report's Methods section.

- Is a meaningful evaluation of discharge planning in relation to the goal of preventing homelessness feasible within and across settings?
- Can discharge planning be disentangled from other program activities in the various settings?
- What target population(s) in relation to homelessness could be evaluated, and how do these vary within and across settings?
- How available are the key community resources within and across settings, and what are the implications for evaluability?
- What are the relevant independent, dependent, and mediating variables that should be studied in each of these settings and how will these be defined and operationalized?
- What is the appropriate followup period after discharge to determine clients' housing status and other outcomes by setting, and what are the implications for evaluability?
- What alternative research designs could be considered for evaluating or studying discharge planning in relation to preventing homelessness in each of these settings, and what would their costs be?

Methods

The study involved the following components:

1. A review of the literature and key analytic issues pertaining to discharge planning;
2. An Expert Panel process where members discussed key analytic issues and nominated "exemplary" discharge planning programs for use in a documentary analysis and site visits;
3. An analysis of discharge-planning-related documents (e.g., discharge planning policies, procedure manuals, job descriptions, forms, and screening instruments) from 19 programs;

4. Site visits to 8 of the 19 programs;
5. An Analytic Findings Report that synthesized findings from the documentary analysis and site visits in order to address key research questions and determine whether discharge planning is evaluable;
6. Development of evaluation design options outlining possible research studies on discharge planning and related homeless prevention issues; and
7. This Final Report, which summarizes the key findings from the study.

The primary data sources for this study included the documentary analysis materials; staff discussions at the primary and affiliate agencies of the site visit programs; and a review of procedures, forms, and a limited number of medical records (with client consent). The study has a number of methodological limitations. Most important, findings are based on qualitative examination of a modestly sized convenience sample of program sites selected because experts thought that their discharge planning processes were superior to other programs. The sites studied are examples from four extremely different and diverse settings. We did not interview clients, nor did we systematically examine quantitative data to confirm staff reports.

Key Findings

In this Executive Summary we present only the key findings that hold across all four settings. Please refer to the Analytic Findings section of the report for key findings specific to each setting.

- **A Summative Evaluation of Discharge Planning Is Not Justified at This Time**

The study team concluded that a rigorous summative evaluation (i.e., an outcome or impact evaluation) of discharge planning as a strategy to prevent homelessness in institutional and/or custodial settings is not justified at this time. The recommendation against conducting a summative evaluation of discharge planning as a strategy to prevent subsequent homelessness is based on the findings that discharge planning is not readily separable from the broader program, that it is not well defined or consistently implemented, and that a summative study would be costly and is premature given the state of knowledge in this area. However, we found that alternative study designs to evaluate specific issues or activities related to discharge planning and

homelessness prevention are feasible and justifiable, and these designs are described in this report.

- **Discharge Planning Is Not Readily Separable From the Broader Program**

A key evaluability question for each of the four settings is whether the discharge planning process is separable from the broader program in which it operates. Many discharge planning activities, such as client assessment, are also critical to treatment planning and are often performed by the same staff. While there are distinct, identifiable activities associated with discharge planning, they take place within the context of the broader treatment or service delivery process and cannot be clearly separated from that context. For example, the primary goal of a residential substance abuse treatment program is to reduce or eliminate a client's dependence on alcohol or other drugs.[2] However, the intervention of interest for the evaluability assessment is not the entire treatment (which includes discharge planning) provided in the residential substance abuse treatment program. Rather, the evaluability assessment focuses on the discharge planning process alone; other activities that occur in the residential substance abuse treatment program would be mediating variables in an evaluation of the discharge planning process.

- **The Discharge Planning Process Is Not Well Defined or Consistently Implemented**

Few programs appear to have a well-designed and integrated model of the discharge planning process, nor have they implemented the process in a systematic manner likely to produce consistent results over time or across clients. Although most programs do have at least rudimentary discharge planning procedures and forms, few of the programs examined have a written protocol to ensure that staff members apply the interventions uniformly or document discharge planning processes well. None of the 19 programs studied used screening instruments to identify clients at risk of homelessness and in need of intensive discharge planning efforts.

In addition, most programs examined lack rigorous staff training and quality assurance activities in support of discharge planning. As a result, the discharge planning process is inconsistently applied within each program. Likewise, programs collect very little systematic

[2] Center for Substance Abuse Treatment (CSAT). (1995). *Detoxification from alcohol and other drugs, Treatment Improvement Protocol (TIP) #19*. Department of Health and Human Services (DHHS Pub. No. BKD172). Substance Abuse and Mental Health Services Administration (SAMHSA).

postdischarge data that could create a feedback loop to improve the discharge planning process over time.

The discharge planning process consists of an imprecisely defined set of activities. While some governmental and professional organizations have developed consensus standards on what constitutes a model discharge planning process,[3] we found little evidence that these models have been effectively disseminated or widely implemented. No studies have yet tested the effectiveness of these models in actual practice. Critics have suggested the models were not attuned to "real world" scarcity of housing and other resources, or to the tendency of organizations to pursue self-interest rather than collaborate effectively.

- **Housing and Community Services Are Also Essential for Preventing Homelessness**

The study team found that avoiding homelessness, the outcome of interest, is determined as much or more by the availability of suitable housing and support services in the community as by the discharge planning process. An example of this was found in the most well-structured and best implemented discharge planning process observed in this study. This model discharge planning process was implemented in a rural community so lacking in housing options that many clients were placed in large congregate semi-institutional conditions upon discharge. The best discharge planning process cannot overcome a lack of community housing and services.

- **Practical Research Design Considerations Would Make a Summative Evaluation Challenging and Costly**

The tremendous variability in the discharge planning process across clients, programs, settings, and communities dictates that a summative evaluation enroll thousands of clients across many programs. The discharge planning process is highly complex and tightly bound to programmatic, client, interorganizational, and community resource factors. Numerous mediating variables affect the discharge planning process and its outcomes; some of these variables lack well-formulated measures. A summative evaluation of the discharge planning process as a

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[3] Substance Abuse and Mental Health Services Administration (SAMHSA, 1997). *Exemplary practices in discharge planning*. Rockville, MD: Author.; American Association of Community Psychiatrists (AACP, 2001a). *Continuity of care guidelines: Best practices for managing transitions between levels of care.* Dallas: Author.; American Association of Community Psychiatrists (2001b). *Continuity of care guidelines for addictions and co-occurring disorders.* Dallas: Author.; Osher, F., Steadman, H. J., & Barr, H. (2002). *A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model.* Delmar, NY: The National GAINS Center.

strategy to prevent homelessness would be complex, lengthy, costly, and could not be assured of producing clear and definitive findings. Further preliminary and exploratory research is called for before undertaking a study of such complexity and resource requirements.

- **Eligibility and Funding Sources Dictate Intervention and Discharge Planning Tracks**

Within a single residential or custodial program, there are several intervention and discharge planning "tracks" depending on who pays for or oversees a client's care and the community programs for which they are eligible. These tracks often result in differences in clinical interventions, lengths of stay, agencies involved in the discharge planning process, community housing alternatives, and available community services. For example, the treatment and discharge planning process a patient receives in a psychiatric hospital will be determined in part by whether the person meets eligibility criteria for Supplemental Security Income (SSI), Medicaid, a private insurer, the state mental health department, or is self-pay and of limited means. For youth in residential treatment centers, the discharge process is partially determined by who has custody of the youth—the family, child welfare, or juvenile justice. The availability of services in the patient's community of residence is another important determinant. Each funding source or community program may have its own complex eligibility standards and application process that is time-consuming to negotiate. An evaluator of the discharge planning process must address the complexity of multiple discharge planning tracks that results from the involvement of these diverse payers and community contexts.

- **No Separate Payment Exists for Discharge Planning Activities**

In most cases the discharge planning process is funded as incidental to the treatment and custodial care, often as part of a bundled per diem rate. Any study will face challenges in determining financial expenditures for discharge planning activities since they are not billed separately and are usually carried out by the same program staff who provide clinical care.

Key Study Design and Measurement Issues

If a study of discharge planning is conducted, a number of key study design and measurement issues will need to be considered. The initial bullet points below address factors critical to designing a study, while later bullets discuss mediating variables that would need to be

controlled for in a summative evaluation and other design considerations. In most cases, there are existing measures that could be used, although they will require some adaptation depending on the study context and setting. There are some key concepts, such as the availability of appropriate community housing, that will have to be carefully negotiated and for which no definitive measures are readily available. This section outlines some of these measurement, data collection, and other design issues.

- **Sample Size Depends on Purpose of the Study**

The sample size needed will depend on the purpose of the study. A sample of several thousand will likely be necessary to achieve sufficient statistical power if a summative evaluation is the goal. A more modest sample size of 100 or fewer might suffice if the purpose of the evaluation is formative or exploratory. Although obvious, it is important to state that precise calculations of sample size and statistical power will require a clear articulation of study goals and design.

- **Recruit Clients Who Are at Risk of Homelessness**

The study should recruit clients who are at significant risk of homelessness. Some programs serve only those who are homeless or at high risk of homelessness; however, most of the programs examined serve a significant proportion of clients who typically return to stable housing after the conclusion of their residential stays. Clients should be screened and included in an evaluation study only if they meet some risk threshold for homelessness.

- **Develop Strategies To Track Early Terminators**

Early terminators—those who leave programs after a brief stay, sometimes against professional advice—present particular challenges to any evaluation study of discharge planning. Some programs have high early termination rates (50 percent or higher) and followup data on these clients are often limited. These clients may be at the greatest risk of homelessness, yet are least likely to receive adequate treatment or discharge planning because of their early termination. They may also be more difficult to enroll and follow in a tracking study, but are critically important to include if the goal is to prevent homelessness.

- **Use Followup Period of 1 Year or More for a Summative Evaluation**

If a summative evaluation study of discharge planning in any of the four settings is undertaken, the study team recommends a followup period of 1 year or longer. The rationale for this position is based on two observations. First, the short-term base rate of homelessness following discharge is relatively modest in many settings, even given flawed, "non-exemplary" discharge planning processes. This rate can be highly variable across programs depending on the characteristics of the program and the population it serves, the availability of housing and services in the community, and other factors. Unless the followup period is extended to a year or more to allow a longer period for measuring homelessness (since the risk of homelessness often increases with time), it may not be possible to distinguish the impact of "exemplary" discharge planning in further lowering that already modest rate of homelessness. The second rationale relates to the ability of a study design to differentiate the effects of the discharge planning process from the progression of a disorder or the course of maturation. In the case of an individual in acute care treatment for mental illness and/or substance abuse, a short-term followup study of discharge planning runs the risk of confounding "natural relapses" with the outcomes of an inadequate discharge planning process. In parallel fashion, for studies of youth "aging out" of care, a longer followup period is necessary because of the possible confounding of developmental changes with factors attributable to discharge planning. A longitudinal design of a year or more allows for examining multiple transitions across settings and levels of care and better distinguishes between factors associated with the natural course of the individual's disorder or maturation and those factors attributable to the discharge planning and transition process.

- **Meaningful Formative Evaluation Is Possible Without a Followup**

Conversely, if the evaluation is formative or exploratory in nature an argument can be made for conducting a study that examines only what happens at the immediate point of discharge. In that case, the housing measure is not residential stability, but only what setting the client is placed in on the day of discharge. The measure of service linkage is not attendance at scheduled appointments, but only that appointments are made and the client informed. These types of measures are clearly insufficient to assure residential stability in the community but could, in conjunction with a variety of other measures, provide rough indicators of the quality of a program's discharge planning process.

- **A Study Will Require Infrastructure for Data Collection and Followup**

Any evaluation study examining homelessness outcomes will require a resource commitment to develop the infrastructure for data collection and client followup. Existing program data (hardcopy and electronic medical records) contain some but not all the information needed to conduct a discharge planning evaluation, and these data are of varying quality. Furthermore, most programs do not have the resources to follow up with clients after discharge or collect data on followup outcomes. The response rates for programs that do collect data on followup outcomes are inadequate for a rigorous evaluation. If a study is conducted it will be critical to tighten procedures and provide additional resources for program data collection and followup up; alternatively, the data collection activities could be contracted to external organizations with expertise in this area.

- **Use Separate Studies for Different Program Settings**

The four broad program settings addressed in this study actually represent many discrete types of programs. This observation suggests that care must be taken in determining which programs to compare in a discharge planning evaluation, and in generalizing evaluation findings from one program setting (or subtype within a setting) to another. For example, the psychiatric inpatient treatment settings category includes state psychiatric hospitals, psychiatric units of general hospitals, and free-standing private psychiatric hospitals. Yet these three types of psychiatric inpatient units differ in many important respects, including characteristics of clients served, length of stay, staffing patterns, risk of subsequent homelessness, and form and extent of linkage to community agencies, all of which bear upon the discharge planning process. Similar distinctions are apparent between subsets of programs within the other three settings.

Unlike the other three settings in the evaluability assessment, foster care independent living programs are not primarily "treatment" programs, but are fundamentally about assisting youth to make a transition to living independently in the community. Although these programs have processes that correspond to each element of exemplary discharge planning, they are unique in many respects and are subject to a range of particular influences and constraints. It would be particularly questionable to generalize findings from foster care independent living programs to other settings, or from the other settings to foster care.

- **Identify Client Demographic and Clinical Characteristics To Be Measured**

Differences in client characteristics affect the discharge planning process, options available to discharge planners, and postdischarge outcomes. Key client characteristics that should be measured in a discharge planning evaluation include presence of mental illnesses, substance use disorders, physical disabilities, developmental disabilities, co-occurring disorders, current and historical involvement with criminal or juvenile justice, and past success in mental health or substance abuse treatment. Critical factors for youth in foster care include the age of emancipation and educational attainment, as well as the presence of serious emotional disturbances, substance use disorders, and developmental disabilities. These individual history, demographic, and clinical characteristics also affect a client's eligibility for entitlements and services upon discharge, and influence discharge planning outcomes.

- **Measure the Availability of Housing and Other Supports**

Another critical variable is the availability of appropriate housing and supports in the communities the programs serve. The arrangement of stable housing and other needed services depends not only on the quality of the discharge planning, but also on the availability of appropriate resources in the community. Even in exemplary discharge planning programs, the outcomes achieved can be disappointing if the housing resources and services are not available.

- **Measure the Policy Context**

Each program is defined in part by the larger policy context in which the program operates (e.g., contractual obligations; accreditation standards and requirements; and state laws, rules, and regulations). The regulatory and accrediting bodies, like the payers, influence the conditions in the program and the discharge planning process. Their policies help determine which services are provided, how discharge planning activities are implemented, and who provides oversight.

- **Measure the Program's Relationship to Other Organizations**

The program's relationship to other organizations is also an important factor. If the treatment or custodial program is part of an umbrella agency that also provides outpatient care or housing, it may be easier to link clients to those intramural services. Similarly, if the program has

invested in strong and trustful working relationships with community partner agencies, the housing and services provided by those agencies may be more easily accessible.

Alternative Research Designs

We have identified at least four possible study designs, detailed in the full report, that would advance the field's understanding of discharge planning as an intervention to prevent subsequent homelessness. These studies are:

- **Client Screening Protocols To Predict Risk of Homelessness.** This study would examine the role of screening protocols in identifying people at risk of homelessness at discharge so that special efforts could be directed to securing appropriate placement. Such screening protocols have been developed, but their use does not appear to be common practice.
- **Early Terminators/Foster Care Runaways and Methods To Engage Them.** Foster care runaways and those who terminate prematurely from treatment programs are at high risk of homelessness. This study would aim to increase our knowledge of effective ways to engage this at-risk population and provide more effective discharge planning services.
- **State Policies To Improve Discharge Planning and Prevent Homelessness.** States have developed a range of policies intended to improve the discharge planning process in order to prevent homelessness. This study would catalogue those policies and their features for settings similar to those included in the evaluability assessment. It would also examine promising policies in greater detail, and identify common elements and themes associated with effectiveness; for example, use of performance measures, incentive provisions, penalties, and changes in the rates of homelessness over time.
- **Discharge Planning Process and Outcomes.** A quasi-experimental study targeting one of the four institutional or custodial settings in this evaluability assessment is the most rigorous alternative design proposed. It would examine the relationship between discharge planning practices and client outcomes over the 2-year period following discharge This research would be structured somewhat like the National Outcome Performance Assessment for the Collaborative Initiative to End Chronic Homelessness, but with comparison sites included in the original design, and could

use some of the same instrumentation. The study could identify discharge planning practices that are effective in preventing homelessness.

I. Introduction and Background

The purpose of this study was to determine the evaluability of discharge planning as a strategy to prevent homelessness. In 1994 the Federal Interagency Council on Homelessness identified inadequate discharge planning as a significant factor contributing to homelessness among persons with mental illnesses and/or substance use disorders. Currently, the prevention of homelessness is a key goal in the U.S. Department of Health and Human Services (DHHS) action plan to end chronic homelessness.[4] This study is related to a strategy in the plan that recommends identifying and promoting the use of effective, evidence-based homelessness prevention interventions.

Past research has indicated that many people with severe mental illnesses and substance abuse problems who experience homelessness travel in "institutional circuits," or move repeatedly through systems and institutions such as state psychiatric hospitals, jails and prisons, homeless shelters, and drug treatment programs. However, while discharge planning is often recommended as a strategy to prevent homelessness among people released from institutions or youth aging out of foster care, very few studies have examined this strategy. The Assistant Secretary for Planning and Evaluation of DHHS sponsored this study in order to build knowledge for researchers and policy makers in the field of homelessness pertaining to the evaluability of discharge planning in institutional and custodial settings. The four institutional and custodial settings listed below were included in this study because previous research has indicated that many of those entering shelters have recently come from one of these settings.

- Adult inpatient psychiatric treatment units in state psychiatric, private psychiatric, or general hospitals;
- Residential treatment centers serving children and youth with serious emotional disturbances and/or substance use disorders;
- Residential treatment programs for adults with substance use disorders; and
- Foster care independent living programs.

[4] U.S. Department of Health and Human Services (DHHS). (2003). *Ending chronic homelessness—Strategies for action: A report from the Secretary's Workgroup on Ending Chronic Homelessness.* Washington, DC: Author.

Because discharge planning processes vary by setting, community context, and program model, an evaluation of discharge planning to prevent subsequent homelessness presents many challenges. The primary goals for this evaluability assessment were to (a) determine whether it was possible to rigorously evaluate discharge planning in the selected settings, (b) identify the key evaluation questions for each setting, and (c) develop possible evaluation designs.

The study involved the following components:

1. A review of the literature and key analytic issues pertaining to discharge planning;
2. An Expert Panel process where members discussed key analytic issues and nominated "exemplary" discharge planning programs for use in a documentary analysis and site visits;
3. A documentary analysis of discharge-planning-related written materials (e.g., discharge planning policies, procedure manuals, job descriptions, forms, and screening instruments) from 19 programs;
4. Site visits to 8 of the 19 programs;
5. An Analytic Findings Report that synthesized findings from the documentary analysis and site visits in order to address key research questions and determine whether discharge planning is evaluable;
6. Development of evaluation design options outlining possible research studies on discharge planning and related homeless prevention issues; and
7. This Final Report, which summarizes the key findings from the study.

Institutional Circuits

There is an interest in discharge planning as an intervention to prevent homelessness because many studies of individuals experiencing homelessness have found that persons frequenting homeless shelters are often individuals who have just been released from a social services system or a state, local, or Federal institutional setting and have no other housing options.[5] The particular path to homelessness also depends in part on the age of the individual. For example, youth under the age of 18 are less likely to be discharged into homelessness or a shelter and are more likely to become homeless at some time after the discharge.

[5] Burt, M. R., Aron, L. Y., Lee, E., & Valente, J. (2001). *Helping America's homeless: Emergency shelter or affordable housing?* Washington, DC: The Urban Institute Press. Burns, P., Flaming, D., & Haydamick, B. (2003). *Homeless in LA: A working paper for the 10-year plan to end homelessness in Los Angeles County.* Los Angeles: Economic Roundtable.

People with substance use disorders exiting institutional facilities such as detoxification and/or treatment programs, youth and adults with mental illnesses and/or substance use disorders released from inpatient treatment or residential settings, and young people aging out of foster care and state social services are all at risk of becoming homeless and may or may not have received treatment while participating in a program. The 1996 National Survey of Homeless Assistance Providers and Clients asked persons who were clients of homeless assistance programs whether they had ever received inpatient treatment for alcohol, substance use, or mental health problems in their lifetime.[6] Seven percent of the respondents reported having received inpatient treatment for alcohol abuse, 7 percent for drug abuse, and 8 percent for mental health problems.[7] A study of homeless shelters in Los Angeles found that 31 percent of single adults had been released from some type of institutional setting (e.g., jail, general hospital, or psychiatric hospital unit) prior to arriving at the shelter.[8]

Many of these individuals have been said to travel in *institutional circuits*, moving back and forth between the streets or shelter and some kind of institutional setting.[9] This observation suggests that effective discharge planning might be a means to break the cycle and help people move toward permanent housing with supports as needed.

Several Federal organizations have identified and are promoting discharge planning as an intervention for preventing homelessness. In its 1994 review of the causes of homelessness, the Interagency Council on Homelessness identified inadequate discharge planning as a significant factor contributing to homelessness among persons with mental illnesses and/or substance use disorders.[10] The council recommended that Federal agencies work with states and communities to review and strengthen their discharge planning strategies to ensure appropriate service and

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[6] Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). Homelessness: Programs and the people they serve. Highlight report. Findings of the National Survey of Homeless Assistance Providers and Clients U.S.; Washington, DC: The Urban Institute Press.

[7] Burt, M. R., Aron, L. Y., Lee, E., & Valente, J. (2001). *Helping America's homeless: Emergency shelter or affordable housing?* Washington, DC: The Urban Institute Press.

[8] Burns, P., Flaming, D., & Haydamick, B. (2003). *Homeless in LA: A working paper for the 10-year plan to end homelessness in Los Angeles County.* Los Angeles: Economic Roundtable.

[9] Hopper, K., Jost, J., Hay, T., Welber, S. & Haugland, G. (1997). Homelessness, severe mental illness, and the institutional circuit. *Psychiatric Services, 48,* 659–665. Milofsky, C., Butto, A., Gross, M., & Baumohl, J. (1993). Small town in mass society: Substance abuse treatment and urban-rural migration. *Contemporary Drug Problems, 2,* 433–471. Shinn, M., & Baumohl, J. (1999). Rethinking the prevention of homelessness. In L. B. Fosburg, & D. L. Dennis (Eds.), *Practical lessons: The 1998 National Symposium on Homelessness Research.* Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development. Snow, D. A., & Anderson, L. (1993). *Down on their luck: A study of homeless people on the street.* Berkeley & Los Angeles, CA: University of California Press.

[10] Interagency Council on the Homeless (ICH). (1994). *Priority home! The Federal plan to break the cycle of homelessness* (HUD-1454-CPD). Washington, DC: Author.

support linkages and to avoid subsequent homelessness. DHHS, an active participant in the Interagency Council, has also identified effective discharge planning as an important strategy in preventing subsequent homelessness. However, there have been no studies that examine whether discharge planning can prevent homelessness.

What Is Discharge Planning?

Discharge planning procedures were first developed at general hospitals with a focus on determining the medically appropriate time for leaving the hospital and arranging for the patient's next appropriate level of care.[11] Some state laws or regulations prohibit the discharge of patients from hospitals unless an appropriate plan has been developed and approved by the patient or the patient's legal representative. However, institutions may become financially responsible for patients who are not discharged at the time determined by utilization guidelines, which creates strong incentives for the institution to discharge a patient before his or her insurance coverage runs out. The emergence of managed care plans, with their typically strong emphasis on shorter lengths of stay, has also created additional pressure to discharge patients quickly.

A Structurally Based Intervention

Discharge planning has been categorized as a structurally based intervention to prevent homelessness. For individuals with a mental health or substance use disorder, it has been defined as "the process to prepare a person for return or reentry to the community, and the linkage of the individual to essential community treatment, housing, and human services".[12] By necessity, discharge planning is a collaborative process among the individual who is being discharged, family (as appropriate), and a case manager or team of service providers. Successful discharge planning also requires coordination and cooperation between institutional settings and the local community service providers that offer the services necessary to meet the client's needs after discharge.

Comprehensive discharge planning will ensure that all clients who leave institutional and custodial settings have links to necessary postdischarge services such as adequate housing arrangements, as well as access to health, mental health, and substance abuse treatment,

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[11] Kadushin, G., & Kulys, R. (1993). Discharge planning revisited: What do social workers actually do in discharge planning? *Social Work, 38,* 713–726.

[12] Substance Abuse and Mental Health Services Administration (SAMHSA). (1997). *Exemplary practices in discharge planning*. Rockville, MD: Author.

entitlements and income support, and vocational training or employment support. Because it requires such extensive collaboration of service providers between fields and across agencies and settings, discharge planning can be particularly difficult to implement.

Transition Planning

Some mental health organizations have proposed reframing discharge planning as "transition planning." In 2001, the American Association of Community Psychiatrists (AACP) released its *Continuity of Care Guidelines - Best Practices for Managing Transitions between Levels of Care.*[13] The guidelines list 13 principles and outcome indicators for managing care transition regardless of population or setting. The AACP gives special attention to persons with substance abuse disorders, in geriatric care, forensic (criminal justice system) situations, and children and adolescents. Subsequently, the AACP has addressed these issues in *Continuity of Care Guidelines for Addictions and Co-occurring Disorders*[14] and AACP Guidelines for Recovery Oriented Services.[15]

In the introduction to the initial Guidelines document, AACP cites interruption of care as one of the most significant obstacles to stable recovery. It also critiques traditional terminology such as *discharge planning.* According to AACP, the traditional discharge planning terminology has negative connotations and is counterproductive. It goes on to say that *discharge* implies:

- "Termination rather than transformation of service variables and continuation of care in another setting,"
- There is sufficient recovery and stability so that services are no longer needed, and
- One provider's responsibility is ending completely and another provider is completely assuming responsibility.

The AACP suggests that *transition planning* better captures the concept of *continuing care* (versus *aftercare*). *Transition* is preferred because it implies collaboration of providers, which AACP believes necessary for "successful progression through the continuum." The AACP describes transition planning as a priority that should begin upon admission and remain part of

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[13] American Association of Community Psychiatrists (AACP). (2001a). *Continuity of care guidelines: Best practices for managing transitions between levels of care.* Dallas: Author.

[14] American Association of Community Psychiatrists. (2001b). *Continuity of care guidelines for addictions and co-occurring disorders.* Dallas: Author.

[15] American Association of Community Psychiatrists. (2003). *Continuity of care guidelines for recovery oriented services.* Dallas: Author.

the treatment plan. As discussed by AACP, essential features of transition planning include the following elements.

- **Comprehensiveness.** A transition plan includes all aspects of the consumers' service needs across systems. Coordination of and collaboration among various elements of the service delivery system involved with the client on either side of the transition should be part of the treatment plan. All transitions should consider elements of pre-existing treatment and transition plans.
- **Individual Engagement.** People with serious mental illnesses should be engaged and every effort should be made to elicit information on difficulties they anticipate in the transition process and their preferences. Likewise, family members and other persons who provide support to the individual should be involved (provided the individual wishes their involvement).
- **Responsiveness to Special Populations.** The needs of special populations (e.g., co-occurring disorders, geriatrics, jail populations, youth) must be recognized, and transition plans for individual consumers must reflect those special needs. The plan must also be culturally sensitive.
- **Maximizing Resources.** To be effective, transition plans must be practical and realistic and maximize the resources available to the people with serious mental illnesses for continuing care and fostering self-reliance.
- **Relapse Prevention.** Plans should also include a comprehensive relapse prevention component.
- **Clear Responsibilities.** Protocols must clearly delineate responsibility for consumer care during transition and should encourage overlapping responsibilities between referring and receiving entities. Reimbursement should provide incentives for concurrent responsibilities where appropriate.
- **Contingency Plans and Tracking.** People with serious mental illnesses must be well informed, and backup plans should be in place at any and all transitions between levels of care. They should be carefully tracked and should know the tracking plan. A process of re-engagement should be initiated whenever an unplanned alteration occurs in the plan.
- **Monitoring Outcomes.** Quality indicators with measurable outcomes must be in place and outcomes must be monitored.

Some critics have suggested that the American Association of Community Psychiatrists (AACP) model with its emphasis on transition planning does not reflect the "real world" scarcity of housing and other resources or the tendency of organizations to pursue self-interest rather than collaborate effectively.[16] However, some treatment models and suggested best practices for discharge planning at jails and prisons developed since the AACP Guidelines were issued have adopted this transition planning and continuing care terminology.[17] Use of such terminology acknowledges that many people move through a continuum of care, and that various care providers and institutions may see this person cyclically. Further, it reinforces the critical elements of care coordination and shared responsibility among providers and institutions. A discharge planning bibliography issued by the U.S. Department of Housing and Urban Development indicates there are a large number of initiatives to improve discharge planning from individuals released from jails and prisons.[18]

Exemplary Discharge Planning

The Working Conference on Discharge Planning issued detailed recommendations on how to conduct exemplary discharge planning in hospitals, other institutions, and systems of care administered by the Department of Veterans Affairs.[19] The recommendations address relevant roles and responsibilities of the involved parties and outline the action elements of a comprehensive plan. Under its discussion of roles and responsibilities, the working conference recommends the adoption of a team approach to facilitate communication and the effective use of resources. The conference's other recommendations include:

- Core members of a discharge planning team should include people with serious mental illnesses, a community case manager, an institutional representative, and a community resource specialist.

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[16] Segal S. P. (2004). Managing transitions and ensuring good care. *Psychiatric Services, 55*(11), 1205. Sowers, W. E., & Rohland, B. (2005). Managing transitions to the community. *Psychiatric Services, 56*(1), 107–108.

[17] Osher, F., Steadman, H. J., & Barr, H. (2002). A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model. Delmar, NY: The National GAINS Center. Community Shelter Board (CSB). (2002). *What's new? Preventing homelessness: Discharge planning from corrections facilities*. Columbus, OH. Retrieved December 4, 2003, from http://www.csb.org

[18] U.S. Department of Housing and Urban Development (U.S. HUD). (2005). Customized bibliography: Discharge planning from publicly funded institutions. Washingotn, DC: Author.

[19] Working Conference on Discharge Planning (1997). *Exemplary practices in discharge planning: Report and recommendations of the working conference June 1997.* Rockville, MD: Substance Abuse and Mental Health Services Administration Center for Mental Health Services.

- Team members must be able to commit resources (e.g., information, staff time, and services) to the discharge plan.
- The team leader, usually the community case manager, will be responsible for a person's re-entry into the community.

Other recommendations call for the designation of a single organization to be fiscally and legally responsible for coordinating the activities of all entities involved in the discharge planning. The Department of Veterans Affairs was identified as the most appropriate agency to hold this responsibility for veterans. A community agency would be designated for all other individuals.

Information systems that link institutional and community settings were singled out as essential for improving communication, facilitating access to resources, and tracking completion of the discharge plan. Privacy concerns must be fully addressed when implementing such information systems.

The conference also identified additional characteristics of an exemplary discharge plan as including the following features:

- **Individual Involvement.** Individual involvement and buy-in of the discharge plan by the client is the most important element.
- **Contract.** The discharge plan should be written in the form of a contract between a person with serious mental illnesses and other involved organizations, with each party having defined responsibilities.
- **Addressing Basic Needs.** The discharge plan must address two basic areas of need—housing and health care treatment.
- **Multiple Housing Options.** When considering housing, an exemplary discharge plan identifies multiple housing options that could meet changing consumer housing requirements and preferences.

Generic Logic Models

For this project, we used the development of logic models in the documentary analysis to assist in answering the question of whether discharge planning programs are evaluable. Logic modeling is a graphic technique for displaying the causal relationships or logical connections between the context and resources devoted to a programmatic effort, the activities supported by

the effort, and the outcomes intended as consequences of those activities. They are constructed as a logical series of "if-then" statements.

During preparation of materials for the first technical expert panel meeting in the first stage of this study, we developed a logic model of exemplary discharge planning to avoid homelessness for inpatient psychiatric units, residential treatment centers, and residential substance abuse programs (see Exhibit 1). The model displays the relationships and linkages between the at-risk populations, the discharge planning activities, and outcomes and also includes program characteristics and external or mediating influences. Due to the basic differences between foster care and these settings (described below and in the Foster Care section of this report), we developed a separate logic model for exemplary discharge planning for youth in foster care using a similar framework (see Exhibit 2).

Exhibit 1: Preliminary Logic Model of Exemplary Discharge Planning (DCP) To Avoid Homelessness at Inpatient Psychiatric Units, Residential Treatment Centers, and Residential Programs

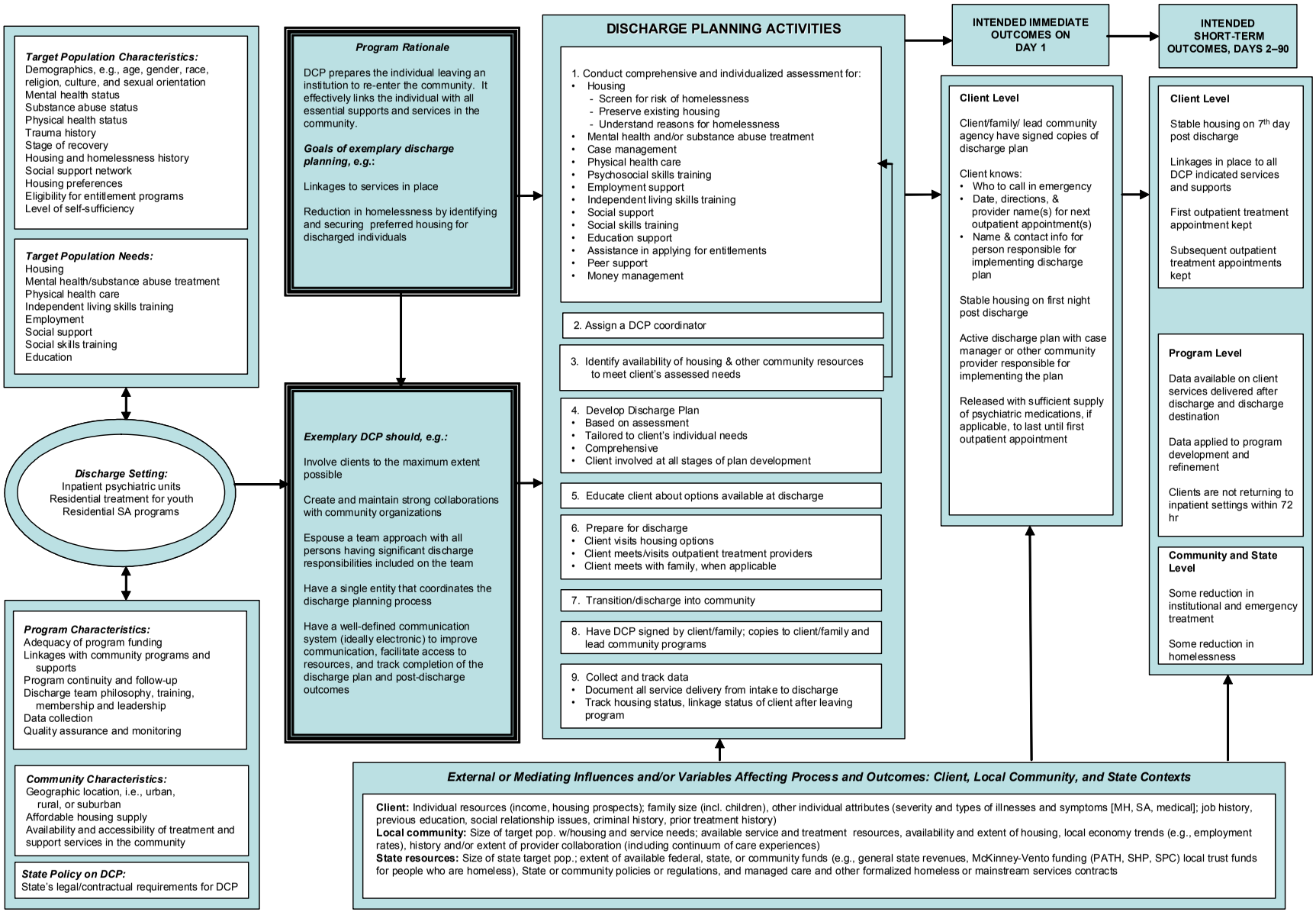
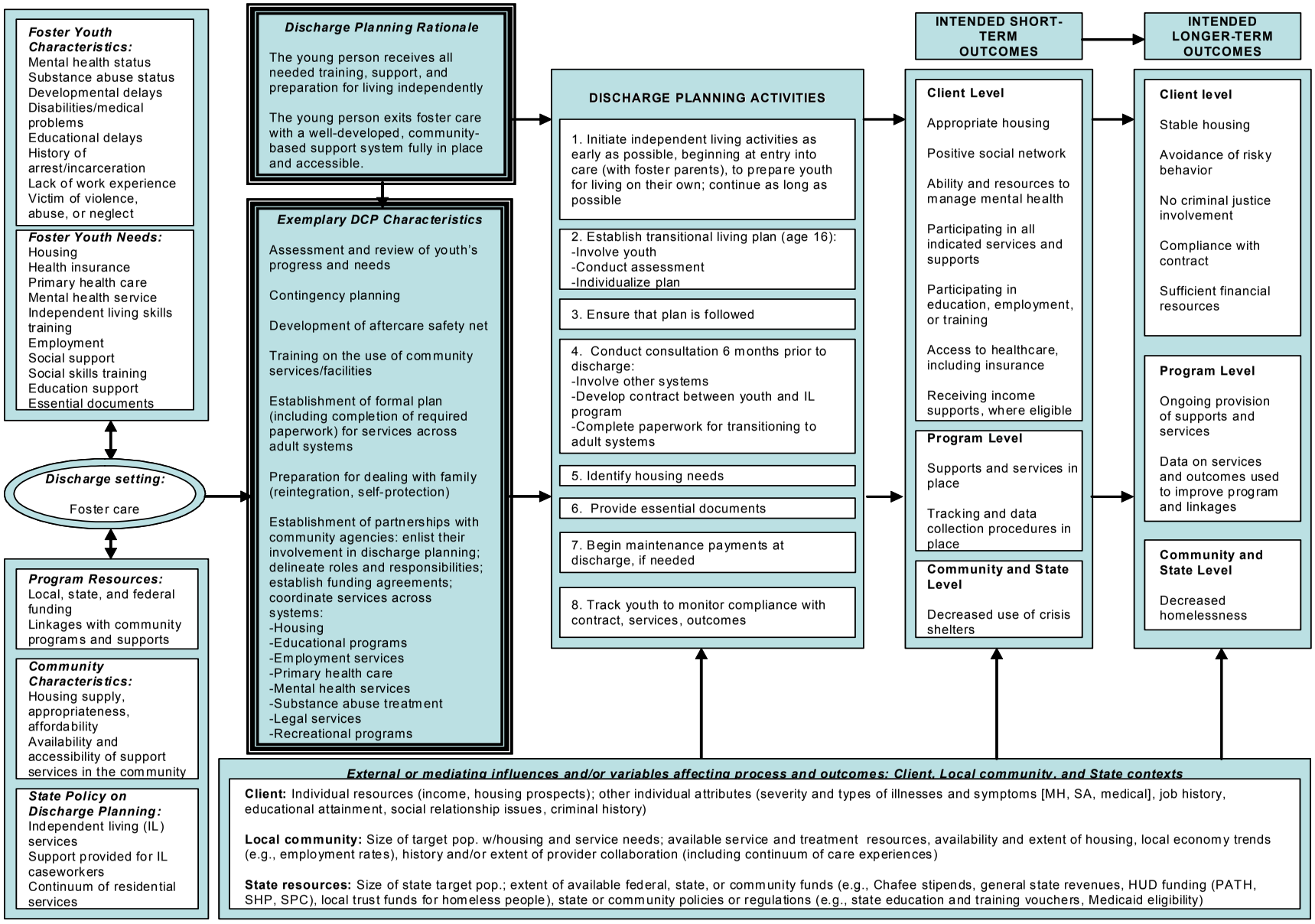


Exhibit 2: Preliminary Logic Model of Exemplary Foster Care Discharge Planning (DCP) to Avoid Homelessness



A major programmatic difference between foster care and the other settings is the funding stream and set of services provided through the Federal Chafee Foster Care Independence Program (CFCIP) that was created in 1999 and involved a vast expansion of services. Through the CFCIP, states receive flexible Federal grants to provide independent living services to youth in foster care. These services include education, training, employment, counseling, housing, and financial supports for young people leaving foster care, and are supposed to begin several years before high school graduation and continue, as needed, until youth emancipate from foster care, establish independence, or reach 21 years of age. States can use up to 30 percent of their grants to pay for room and board for young people who age out of foster care, up to age 21. In addition, the CFCIP provides education and training vouchers (up to $5,000 per year) for youth to use for attending college or other postsecondary programs. Although state implementation of the CFCIP has been uneven and some states had difficulty expanding their services to utilize the increased funding during the first few years, the amount of funds returned to the Federal Government has declined and states now are making fuller use of the program.[20]

Thus, the CFCIP offers advantages that are not generally available in the other settings, including:

- States have flexibility in the services that can be provided while youth are in foster care. Thus caseworkers can target services to youth's specific needs, and the services can cover a wide range of life skills training, employability and job search support, education support, and housing support. This extensive and flexible list of allowable services provides the opportunity for more extensive discharge planning than in the other settings.
- States can use a portion of their Chafee grants to pay for room and board after youth age out of foster care, up to age 21. Some states use their room-and-board budgets to give youth a monthly stipend; others directly pay for apartments for the youth to live in. (A few states have not opted to use this Chafee benefit.) Clearly homelessness could be prevented within states that use this benefit for youth who age out of foster care but need financial support for a limited period while they complete their education or find a job.

[20] U.S. GAO, November 2004, *Foster Youth: HHS Actions Could Improve Coordination of Services and Monitoring of States' Independent Living Programs*, GAO-05-25.

- The Chafee Foster Care Independence Act of 1999, which established the CFCIP, also required that states coordinate their CFCIP services with other Federal and state programs for youth (as well as Indian tribes). Although there have been barriers that have prevented linkages and full coordination, states have made efforts to comply.[21] Currently, for example, all states have established linkages with local high school completion services and assistance to prepare for, locate, or maintain employment for youth in or emancipated from foster care.

Discharge Planning Characteristics

Discharge Planning as a Process Within a Program

Although seemingly a minor word-choice issue, the distinction between the discharge planning process and the larger program in which the discharge planning occurs is critically important to the question of evaluability. Discharge planning is a set of activities that takes place within the context of a treatment (or custodial) program that is intended to enable a smooth transition from the treatment setting to a lower level of care or independent living.[22]

Thus, one of the questions we ask for each of the four settings is whether the discharge planning process is separable from the broader program in which it operates. For example, the primary goal of a residential substance abuse treatment (RSAT) program is to reduce or eliminate a client's dependence on alcohol or other drugs.[23] However, the model of interest for the evaluability assessment is not the model of the (considerably) broader RSAT program. Rather, the evaluability assessment focuses on the discharge planning process alone; other activities that take place in the RSAT program would be mediating variables in an evaluation of the discharge planning process.

The discharge planning process in any of the four indicated settings can be expected to differ on a great many characteristics, including the following:

- Time available for discharge planning;

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[21] U.S. GAO, November 2004, *Foster Youth: HHS Actions Could Improve Coordination of Services and Monitoring of States' Independent Living Programs*, GAO-05-25.

[22] Julian, D. (1997). The utilization of the logic model as a system level planning and evaluation device. *Evaluation and Program Planning, 20* (3), 251–257.

[23] Substance Abuse and Mental Health Services Administration (SAMHSA). (1995). Detoxification from alcohol and other drugs Treatment Improvement Protocol (TIP), Series 19. Retrieved November 19, 2003, from http://www.health.org/govpubs/bkd172/default.aspx.

- Qualifications and experience of staff responsible for discharge planning;
- Level of resources dedicated to discharge planning;
- Characteristics of the target population, such as history of homelessness or presence of behavioral health problems;
- Need for and availability of community treatment services and supports;
- Coordination between institution/state system and community;
- Availability of affordable housing; and
- Followup period after discharge.

Below we discuss some of these characteristics of the discharge planning process and how they might affect the quality and outcomes of the planning.

Time Available for Discharge Planning

Adequate time is important for discharge planning since it provides an opportunity for assessment of the client and the development and implementation of the discharge plan. The length of time available for discharge planning varies among the different institutional settings. Interviews with various institutional programs indicate that the time available for discharge planning affects the adequacy of discharge planning efforts. Length of stays at state psychiatric hospitals can range from a week or less to more than 6 months.

Compared with state psychiatric hospitals, the lengths of stay at psychiatric units at general hospitals tend to be shorter, from several days to 1–2 weeks. These institutions are seen as having less adequate discharge planning efforts. Stays at residential treatment centers for children and youth with mental and emotional disorders are much longer, about a year on average in Maryland and Oregon (R. Lieberman, personal communication, December 4, 2003; P. Petralia, personal communication, December 4, 2003).

Length of stay in foster care varies the most, but is longer than in the other settings—children who come in as babies may spend 18 years in the custody of the state. Ideally, planning for discharge starts at an early age and continues through the teens, when a youth in foster care participates in independent living services and activities. Thus, there usually is more time available to plan a youth's discharge from foster care; however, states do not always make use of it.

Early discharge is another factor that affects the time available for discharge planning. It can also be an indication that an individual is unlikely to cooperate with discharge planning staff. Studies have found that discharges against medical advice (AMA) are common among individuals in inpatient psychiatric units, and it is estimated that between 6 percent and 35 percent of individuals under inpatient psychiatric treatment fall into this category.[24] A lower level of discharge planning is more likely for this subpopulation because of limited time, the individual's willingness to cooperate on the plan, and other factors related to the AMA discharge.

Pages and colleagues found that patients with AMA discharges were more likely to have a substance abuse disorder.[25] A model to predict AMA discharge identified six significant predictors of early discharge from psychiatric units:

- Multiple inpatient hospitalizations,
- Ethnicity other than Caucasian,
- Absence of functional impairment because of physical illness,
- Male gender, and
- Mild to no suicidality at admission.

Individuals who were homeless were found to be more likely to terminate psychiatric hospitalization.[26] Caton found that 11 percent of homeless people had terminated their most recent psychiatric hospitalization against medical advice, compared with 1 percent of individuals who were never homeless.[27] Adult residential substance abuse treatment settings also have relatively high dropout rates with mean lengths of stay far shorter than planned.[28]

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[24] Pages, K. P., Russo, J. E., Wingerson, D. K., Ries, R. K., Roy-Byrne, P. P., Cowley, D. S. (1998). Predictors and outcome of discharge against medical advice from the psychiatric units of a general hospital. *Psychiatric Services, 98,* 1187–1192.

[25] See footnote #22.

[26] Appleby, L., & Desai, P. (1985). Documenting the relationship between homelessness and psychiatric hospitalization. *Hospital and Community Psychiatry, 36,* 732–737. Caton, C. L. M. (1995). Mental health service use among homeless and never-homeless men with schizophrenia. *Psychiatric Services, 46,* 1139–1143.

[27] See footnote #24.

[28] Helba, C., Moran, G. E., Luckey, B., O'Brien, J., Kawata, J., & Leahy, P. (2003, August). *Comparing natural history data with contemporaneous self-report and administrative data*. Paper presented at the Annual Meeting of the American Statistical Association.

Certain groups of youth have been shown to be more likely to run away from foster care, such as youth of color and females.[29] In addition, youth in foster care pose a different issue in terms of early discharges. Many youth who are aging out of foster care tend to just "take off" before their actual date of discharge. These youth likely miss out on critical independent living services and discharge planning activities and are more difficult to track to see how they fare.

Civil commitment statutes may also cause early discharges. Although there is considerable variability in specific provisions from state to state,[30] a fairly typical scenario is presented here for illustrative purposes. In many states, the structure of the civil commitment process involves an initial certification that a person has a mental illness or addiction and presents a current danger to himself or others. This certification allows the authority to detain the person in a psychiatric treatment facility for a relatively brief period, often 72 hours, for observation. At the end of the observation period, there must be a full hearing, with legal counsel, to determine whether there is evidence of a mental illness or addiction and evidence that the person presents a current danger to himself or others. If the burden of evidence for current danger is not met, the person typically must be released immediately, sometimes to the surprise of treatment staff and without time for adequate discharge planning.

Qualifications and Experience of Staff Responsible for Discharge Planning

The level of staff training can affect the adequacy of discharge planning. Nurses and licensed social workers are the most common backgrounds for discharge planning staff at psychiatric inpatient units. Discharge planning may also be performed by staff with fewer credentials and less education.

Interviews by the study team with several program staff indicate that more experienced staff are more familiar with and able to develop relationships with community organizations. These more experienced staff appear to be ultimately more effective in collaborating among providers and participating in a continuum of care planning.

Level of Resources Dedicated to Discharge Planning

The monetary and staff resources for discharge planning can affect the level of effort. Determining the level of resources is often difficult since institutions are usually paid a bundled

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[29] Courtney, M., Skyles, A., Miranda, G., Zinn, A., Howard, E., Goerge, R. (2005). Youth who run away from substitute care. Chicago: Chapin Hall Center for Children.

[30] Swartz, M. S., & Monahan, J. (2001). Special section on involuntary outpatient commitment: introduction. *Psychiatric Services, 52,* 323–324.

daily rate for all services provided, including discharge planning. The staff responsible for discharge planning may also perform multiple functions. Other factors influencing the level of resources include staff credentials, staff turnover, and caseloads. Organizations with a low pay scale often face high staff turnover. Discharge planners with smaller case loads have more time to deal with complex cases, including locating appropriate housing.

Characteristics of the Target Population

Characteristics of the population served can also affect the ease of locating housing. A history of substance use, physical abuse, running away, or being in state custody are risk factors for homelessness among youths and adolescents.[31] Factors common to adults with homeless histories include having some type of disability (physical, substance use related, psychiatric), having poor social networks, being a member of an ethnic or racial minority, and having multiple problems.[32] Olfson et al. found that a combination of three characteristics—drug use disorder, persistent psychiatric symptoms and impaired global functioning at the time of discharge—predicted short-term homelessness in individuals who have schizophrenia and are discharged from general hospitals.[33]

Homelessness History

The frequency of homelessness spells and length of time a person is homeless affect efforts to find permanent housing for individuals being discharged. In 1988, the Institute of Medicine noted important distinctions among individuals who are homeless and identified three subgroups:

- **Temporarily homeless**—persons who experience only one spell of homelessness, usually short, and who are not seen again by the homeless assistance system;
- **Episodically homeless**—persons who use the system intermittently but usually for short periods; and

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[31] Embry, L. E., Stoep, A. V., Ryan, K. D., & Pollock, A. (2000). Risk factors for homelessness in adolescents released from psychiatric residential treatment. *Journal of the Academy of Child and Adolescent Psychiatry, 39,* 1293–1299; FYSB, 1995)

[32] Christ, W. R., Clarkin, J. F., & Hull, J. W. (1994). A high-risk screen for psychiatric discharge planning. *Health and Social Work, 19,* 261–270. U.S. Department of Health and Human Services (DHHS). (2003). *Ending chronic homelessness—Strategies for action: A report from the Secretary's Workgroup on Ending Chronic Homelessness.* Washington, DC: Author. Gantt, A. B., Cohen, M. L., & Sainz, A. (1999). Impediments to the discharge planning effort for psychiatric inpatients. *Social Work in Health Care. 29,* 1–130. Goering, P., Tolomizenko, G., Sheldon, T., Boydell, K., & Wasylenki, D. (2003). Characteristics of persons who are homeless for the first time. *Psychiatric Services, 53,* 1470–1474. Olfson, M., Mechanic, D., Hansell, S., Boyer, C. A., & Walkup, J. (1999). Prediction of homelessness within three months of discharge among inpatients with schizophrenia. *Psychiatric Services. 50*(5), 667–673.

[33] Olfson, M., Mechanic, D., Hansell, S., Boyer, C. A., & Walkup, J. (1999). Prediction of homelessness within three months of discharge among inpatients with schizophrenia. *Psychiatric Services. 50*(5), 667–673.

- **Chronically homeless**—persons with a protracted homeless experience, often a year or longer, or whose spells in the homeless assistance system are both frequent and long.

One study examined shelter use data from New York City and Philadelphia and concluded that approximately 80 percent of individuals using the homeless assistance system are temporarily homeless, 10 percent are episodic, and 10 percent are chronic.[34]

Need for and Availability of Treatment Services and Supports

The four settings differ in the need for services by the discharged populations. Young adults leaving foster care have the greatest heterogeneity in terms of the need for mental health and other health care services. By contrast, individuals discharged from psychiatric or substance abuse programs have those needs in common. Individuals who are homeless or at the highest risk for homelessness also tend to have the most complex need for services.[35] Furthermore, the availability of health care, mental health, substance abuse treatment, and case management varies widely among communities. Some discharge planners are faced with the challenge of developing discharge plans for individuals who may need multiple complex services within the context of scarce resources. Many discharge planners do not have the ability to develop resources based solely on the individual needs of persons discharged from their programs. With the limited availability of resources, an institution's linkages and partnerships with community service programs are often a factor shaping the level of access to these services.

Developing Linkages Between Institution/State System and Community

Discharge planning involves an individual's transition from one care setting to another, and coordination between settings is a crucial element. A critical factor that helps determine the effectiveness of discharge planning in obtaining housing and community services is the quality of the linkages and partnerships between residential/custodial and community organizations, such as housing and service providers. SAMHSA's ACCESS (Access to Community Care and Effective Services and Supports) Study devoted a great deal of attention to measuring the characteristics of

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[34] Kuhn, R., & Culhane, D.P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of public shelter utilization. *American Journal of Community Psychology, 26*(2), 207–232.

[35] U.S. Department of Health and Human Services (DHHS). (2003). *Ending chronic homelessness—Strategies for action: A report from the Secretary's Workgroup on Ending Chronic Homelessness.* Washington, DC: Author.; Gantt, A. B., Cohen, M. L., & Sainz, A. (1999). Impediments to the discharge planning effort for psychiatric inpatients. *Social Work in Health Care. 29,* 1–130.; Goering, P., Tolomizenko, G., Sheldon, T., Boydell, K., & Wasylenki, D. (2003). Characteristics of persons who are homeless for the first time. *Psychiatric Services, 53,* 1470–1474.

interagency linkages and their effects on client outcomes.[36] Secondary analysis of the ACCESS study data by Orwin, Myers, and Sonnefeld concluded that more effective linkages were achieved when they were established with other units of the same parent organization than when they were between two independent organizations.[37] Martin et al. have also described a partnership model that characterizes the conditions necessary for two organizations to collaborate effectively to provide necessary services to clients.[38]

Individuals who are homeless or are at risk of homelessness may become estranged from community services when there is poor sharing of information and other communication with the community programs responsible for implementing the discharge plan. Boyer et al. identified two discharge planning activities that increased successful linkages to community services for individuals released from psychiatric inpatient units.[39] The rate of kept appointments more than doubled (43 percent vs. 19 percent) when a discussion took place between inpatient staff and outpatient clinicians, compared with the rate when there was no discussion. The second strategy of arranging for individuals to visit or start attending the outpatient programs before discharge also increased kept appointment rates (47 percent vs. 29 percent) compared with the rate when the client did not attend outpatient programs.

Availability of Affordable Housing

The availability of affordable housing relative to demand in a geographic area will affect a program's ability to locate housing.[40] O'Hara & Cooper stated in *Priced Out in 2002* in their ongoing study that a Supplemental Security Income (SSI) check would not be sufficient to pay for housing in *any* of the nation's 2,702 housing market areas.[41]

Some argue that it is not effective discharge planning that matters, but rather the provision of housing with supports. For example, Tsemberis and Eisenberg found that a housing-

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[36] Morrissey, J. P., Calloway, M. O., Thakur, N., Cocozza, J., Steadman, H. J., Dennis, D., et al. (2002). Integration of service systems for homeless persons with serious mental illness through the ACCESS program. *Psychiatric Services*, *53*(8), 949–957.

[37] Orwin, R. G., Myers, M. A., & Sonnefeld, J. (2003, November). Secondary analysis of the CMHS ACCESS Multisite Program for Homeless Mentally Ill Persons. Presented at the Annual Meeting of the American Evaluation Association, Reno, NV.

[38] Martin, W. W., Hobson, W., Myers, M. A., & Wolfe, P. (2003, July). Ending chronic homelessness: strategic partnering for state and local administrators. Presented at the Annual Meeting of the National Alliance to End Homelessness in Washington, DC.

[39] Boyer, C. A., McAlpine, D. D., Pottick, K. J., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *American Journal of Psychaitry*, *157,* 1592–1598.

[40] Wright, J. D., & Rubin, B .A. (1991). Is homelessness a housing problem? *Housing Policy Debate, 2,* 937–956. Koegel, L. K., Koegel, R. L., & Dunlap, G. (1996). *Positive behavioral support: Including people with difficult behavior in the community.* Baltimore, MD: Brookes Publishing Co.

[41] O'Hara, A. & Cooper, E. (2003). *Priced out in 2002.* Technical Assistance Collaborative, Retrieved from http://www.tacinc.org/cms/admin/cms/_uploads/docs/PO2002.pdf

first approach was more effective than a more traditional linear continuum of housing services[42] in producing longer term housing stability over a 5-year period.[43] In a study of housing support services and case-management-only programs, Clark and Rich found that persons with high psychiatric symptom severity who participated in housing support services programs had longer stays in stable housing than persons who received only case-management services.[44] Those committed to the housing-first approach might argue that a focus on the immediate provision of housing with supports is the way to disrupt the institutional circuit and that any other approach is a diversion that lessens effectiveness.

Length of Followup

Followup after discharge, whether provided through aftercare, continuing care, case management, or community supports, has been found to prevent recurrent homelessness.[45] The Critical Time Intervention (CTI) Program in New York City provided staff to follow people with serious mental illnesses for 9 months after discharge from shelters.[46] Prior to discharge, a community support plan was tailored to the person's needs and the staff worked to build durable ties between the person and his or her long-term supports. Support typically included home visits, accompanying individuals to appointments, and providing advice during crises. Unlike most traditional case management models, nonprofessional workers provided community support. Other approaches to community support and continuing care may be even more open-ended based on the duration of followup time periods.

State Regulations Governing Discharge Planning

The requirements for discharge planning differ by setting partly because of state regulations and accreditation requirements. State laws vary in terms of the requirements for discharge planning from general hospitals, psychiatric hospitals, and residential treatment centers

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[42] Housing programs that model a linear approach assist clients through a step-by-step progression of services that begins with outreach, includes referral to transitional housing and treatment services, and results in permanent housing. Clients are required to participate in treatment services to retain their housing, which is often a group arrangement.

[43] Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services, 51,* 487–493.

[44] Clark, C., & Rich, A. R. (2003). Outcomes of homeless adults with mental illness in a housing program and in case management only. *Psychiatric Services, 54,* 78–83.

[45] See footnote #42.

[46] Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W., & Wyatt, R. J. (1997). Preventing recurrent homelessness among mentally ill men: A "critical time" intervention after discharge from a shelter. *American Journal of Public Health 87,* 256–262.

for children and adolescents. For instance, the State of Maryland requires that a discharge planning staff member notify an individual's next of kin, the core service agency (the county mental health service system responsible for the individual's care), and community-based treatment and support providers from whom the individual received services prior to his or her admission. Maryland staff are responsible for an aftercare plan that includes a continuing treatment plan (outpatient mental health treatment services, somatic care, psychiatric rehabilitation and support services, substance abuse services, case management) and additional referrals to public service agencies, legal aid, educational services, housing services, vocational services, peer support services, and available crisis services.

Ohio, on the other hand, has adopted less specific discharge planning requirements for drug and alcohol treatment facilities. Ohio discharge plans are required to have "recommendations and/or referrals for additional alcohol and drug addiction treatment or other services."[47] Detoxification programs are also required to make "telephone contact with client and program to which client is referred to ensure that client followed through with referral." It is worth noting that the Ohio substance abuse treatment program regulations do not mention housing.

Federal Laws Governing Discharge Planning for Youth in Foster Care

The Federal legislation (Pub. L. 99–272) that initially established the Independent Living Program (ILP) in 1986 specifically required discharge planning to help youth age 16 and older live on their own. It called for youths' case plans to include "a written description of the programs and services which will help such children prepare for the transition from foster care to independent living" (Section 477(i)(b)). The *Standards for Independent Living* of the Child Welfare League of America, currently under revision, reflected this requirement by specifying that an independent living plan must be in writing, requires youth involvement, and should begin as early as possible.[48]

The most recent legislation on the ILP, however, the Foster Care Independence Act of 1999 (Pub.L. 106–169), was silent on written transition plans, although it opened up independent

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[47] State of Ohio Department of Alcohol and Drug Addiction Services, (n.d.). *Standards for alcohol and drug addiction treatment programs.* Columbus, OH. Author.

[48] Child Welfare League of America (CWLA). (1989). *Standards for independent living.* Washington, DC: Author.

living services to youth ages 18 to 21 who were discharged from foster care, thus addressing a critical need in the prevention of homelessness. And there is little information available about the extent to which states followed the 1986 requirement for transition plans. A review of 10 years of states' reports on their independent living services did not address transitional independent living plans, although it did include information on aftercare services provided by states and referral services to community resources.[49]

The next section lists the key research questions and describes the methods used for site selection, documentary analysis, site visits, and the Analytic Findings Report.

[49] U.S. Department of Health and Human Services (DHHS). (1999). *Title IV-E independent living programs: A decade in review*. Washington, DC: U.S. Government Printing Office.

II. Methods

Key Research Questions

In this report, we address the central question of whether the discharge planning processes in each of the four designated settings are evaluable. What is meant by the term *evaluability?* First described by Joseph Wholey in 1979.[50] Kaufman-Levy and Poulin have more recently defined an *evaluability assessment* as "a systematic process that helps identify whether program evaluation is justified, feasible, and likely to provide useful information."[51] According to Kaufman-Levy and Poulin, the two key issues that must be addressed in any evaluability assessment are the *adequacy* of a program design or model and the *consistency* of the program's implementation of the model.[52] To be evaluable, a program must have an implicit or explicit model that makes clear its goals and objectives and their relationship to program activities. The model must also have realistic, achievable goals and plausible objectives that can be measured.

In sum, a program is evaluable only if (a) the underlying model is adequate and (b) the program has been implemented in a manner consistent with the model. These are the two criteria we applied in the current study to determine the evaluability of discharge planning processes in four settings as strategies to prevent subsequent homelessness.

To answer this question of evaluability, we developed numerous research questions in four key areas: setting and program characteristics, client characteristics, community and interorganizational context, and measurement and data issues. A list of the set of key research questions follows.

Setting and Program Characteristics:

- What are the characteristics of each setting in terms of size, length of stay, early terminators, and program completers? How does this affect discharge planning activities, outcomes, and evaluability?

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[50]Wholey, J. S. (1979). *Evaluation: Promise and performance*. Washington, DC: The Urban Institute.

[51] Kaufman-Levy, D., & Poulin, M. (2003). *Evaluability assessment: Examining the readiness of a program for evaluation*. Washington, DC: Juvenile Justice Evaluation Center, Justice Research and Statistics Association, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

[52] See footnote #49.

- How are the programs in each setting funded and what are the implications for evaluability, if any?
- What are key differences among the programs within settings in institutional and program resources, constraints, and staff? What effects do these have on discharge planning characteristics and evaluability?
- Do the programs within each setting have each of the elements of exemplary discharge planning? Which elements appear to be missing and with what effects on outcomes and evaluability?
- Can discharge planning be disentangled from other program activities in and across settings? If not, what are the implications for evaluability?

Client Characteristics:

- What individual characteristics of the target population need to be considered, and how might they be measured?
- What target population(s) in relation to homelessness could be evaluated, and how do these vary by program?

Community Characteristics and Interorganizational Context:

- How available are the key community resources and what are the implications for evaluability?
- What other community agencies are involved in discharge planning? What is their role? Does this differ by setting or by subpopulations within settings?
- What is the impact of state and national policies on the discharge planning process?

Measurement and Data Issues:

- What are the relevant independent, dependent, and mediating variables that should be studied in each setting, and how could they be defined and operationalized?
- What types of data are available from what sources, how adequate is the data quality, and what are the implications for evaluability?
- Is the type of outcome data recommended by the expert panel available, including homelessness indicators?
- What is the appropriate followup period after discharge to determine clients' housing status and other outcomes, and what are the implications for evaluability?

- What alternative research designs could be considered for evaluating or studying discharge planning in relation to preventing homelessness in each of these settings, and what would their costs be?

As mentioned earlier, our study methods involved reviewing the relevant discharge planning literature, carrying out a documentary analysis, conducting site visits, writing an analytic findings report, and developing alternative research design options. This section provides a summary of the research methods used in each of these tasks.

Literature Review

As a first step in reviewing the literature, the study team conducted comprehensive searches of MedLine and other on-line databases for research studies pertaining to discharge planning or any article about discharge planning that included the terms *discharge planning* and *homeless* crossed with the four settings; *foster care* crossed with *aging out, independent living, transition,* and *"homeless prevention";* and *criminal justice* crossed with *discharge planning.* From these searches, we retrieved full text for 90 articles. Several of the retrieved studies were found to be relevant for this study and are discussed in this report. We also searched the Internet and collected other articles listed as references in the retrieved sources.

The search revealed a lack of quantitative studies on discharge planning in the four settings. Very few empirical studies had evaluated the effectiveness of different discharge planning approaches or identified essential components of successful discharge planning. Most articles examined discharge planning from general hospitals and psychiatric facilities and were primarily descriptive in nature. References indicating relevant articles obtained during the literature review are included in the bibliography at the end of this report.

Documentary Analysis

Members of the expert panel nominated several exemplary programs in each of the four setting types. In addition, Westat and ASPE staff made requests to knowledgeable persons for the names of additional exemplary programs in settings with few nominees.

The intention of the nomination process had been to select programs with exemplary discharge planning procedures. From what we learned about the programs in the documentary analysis and site visits, it would not be accurate to characterize the programs identified as having "exemplary" discharge planning. Neither we nor the expert nominators had enough detailed information about the discharge planning practices of these programs to reliably characterize them as "exemplary." Instead, the programs that were nominated were ones that nominators believed were noteworthy for their general program design, data systems, or outcomes. An implicit assumption was that very good programs are likely to have good discharge planning practices as part of their broader interventions.

From the names submitted from the TEP and the contacted experts, ASPE approved a final list of 20 programs (5 per setting) and alternates to be contacted for this component of the study, based on program variation in geographic and urban/rural considerations. Alternates were contacted when four recommended programs actively and several programs "passively" refused by simply not returning calls. Nineteen of the twenty program positions were filled, leaving the recruitment one short in the area of substance abuse treatment programs. Documentary analysis was done on those 19 programs.

The documentary analysis involved reviews of existing written policies and procedures related to the program's discharge planning standards, procedures, staffing, data, and outcomes, and phone interviews were conducted to fill in missing information. The final products for the documentary analysis were a preliminary logic model of the program's discharge planning process and a narrative summary for each program that described the strengths and weaknesses of the discharge planning process in relation to the key research questions. The completeness of the narratives and logic models was largely dependent on the level of detail provided in each program's written materials and the additional information obtained from subsequent telephone discussions with program staff.

During the documentary analysis, logic models were developed for each of the 19 programs to assist in answering the research questions and as a way to graphically capture the key elements of each program's discharge planning process. In addition, our liaisons at each program—typically, senior staff members or program directors—reviewed and approved each of those models.

Site Visits

Westat and ASPE selected 8 programs for site visits out of the 19 programs included in the documentary analysis component of the study. The programs were selected to represent geographic, urban/rural, and program type variation and included only those that were willing and able to participate in a site visit. Site visit schedules were formulated, and a detailed discussion guide organized around the key research questions was developed and sent in advance to each of the programs.

Two staff persons conducted the 2-day site visits. Discussions at each site were held with various types of staff involved in administration, clinical services, discharge planning, and information management. These discussions were flexible, building on the analysis of existing site-specific documentary materials, clarifying information gaps, and capturing the unique aspects of each site as well as variation among the sites. Site visit staff reviewed three cases selected by the program to determine data availability and the quality of variables needed for a future study. In addition, site visit staff reviewed any available electronic medical record systems. Discussions with two community agencies selected by the program were conducted during the site visit or via telephone after the visit. These discussions were focused on the role of these agencies in the discharge planning process, preparation of program clients released to these agencies, and the data available at these agencies.

After the site visits, detailed site visit reports were written and organized around three general areas: (a) program characteristics (e.g., philosophy, community resources, funding), (b) discharge planning process (e.g., personnel, timing of discharge planning, impact of policy), and (c) research issues (e.g., sample size, target population, followup with clients, data issues, early terminators). After the eight site visits, the program-specific logic models were revised. While we found these models useful in terms of presenting a graphic picture of a program's characteristics, discharge planning activities, outcomes, and external/mediating influences, the models tended to oversimplify a program's theory and practice. For example, during the site visits, we learned that the logic models did not represent the multiple and distinct discharge planning procedures that programs implemented for their different client populations (e.g., Medicaid, juvenile justice, foster care). Thus, evaluators must be careful to capture the nuances and details of a program through repeated contact and discussion with program staff. Because of the inability of the models to capture the complexity of discharge planning pathways, we decided not to include the program-specific logic models in this report.

Analysis of Site Visit and Documentary Analysis Data by Setting

For this component of the study, we combined the information collected on the 19 programs in the documentary analysis and site visit components. We used intracase and cross-case qualitative analytic methods to identify patterns, common themes, and significant deviations within and between the settings. Setting-specific tables for each of the key research questions were completed with information from the two site-visit programs and two or three additional documentary analysis programs. We examined quantitative information on program size, length of stay, dropout rates, discharge planner case loads, and discharge planner turnover. In addition, we examined qualitative data on discharge planning and client characteristics, funding sources, availability of community resources, followup after discharge, and data availability. In summary, our analysis resulted in setting-specific findings pertaining to the research questions, including implications for discharge planning and program outcomes as well as evaluability, and facilitated the formulation of cross-setting findings in these same areas.

Study limitations: Sites for both the documentary analysis and site visits were not randomly selected. Only a limited number of sites from each setting (four to five for the documentary analysis, two for the site visit) were studied, thus limiting the generalizability of the findings. Site visits revealed that the documentary analysis was inadequate in providing a complete and accurate description of the discharge planning process.

Development of Alternative Research Designs

After reviewing the findings by and across settings, the study team identified a number of topics that could fruitfully be studied to make a contribution to knowledge on the relationship between discharge planning practices and preventing homelessness. In addition, we examined the variables that would be needed for those studies and the availability of measures and data in the relevant domains. We prepared a memorandum that outlined these issues and proposed nine different specific studies, presenting for each the rationale, research questions, methods, and products. The final version of this memorandum was distributed to the members of the Technical Expert Panel (TEP) and a conference call was held to elicit their reactions and suggestions. Written feedback was also solicited, both from those on the call and from TEP members unable to participate on the call. The four study designs included in section III of this report are more

detailed elaborations of the most promising of the designs included in the memorandum and reflect the comments and suggestions from the TEP.

III. Analytic Findings by Setting

Introduction

This section summarizes combined findings from the documentary analysis and site visits for each of the four settings examined in this study: (1) adult inpatient psychiatric units, (2) residential treatment centers serving children and youth with serious emotional disturbances and/or substance abuse disorders; (3) residential treatment programs for adults with substance abuse disorders and (4) foster care independent living programs. A separate section is used to present the findings for each setting. Text and tables outline the answers to each research question, and there is a concluding subsection that summarizes the key findings for that setting. Following the sections for each setting there is a separate section that presents cross-cutting findings that apply to all four settings.

We used intra-case and cross-case qualitative analytic methods to identify patterns, common themes, and significant deviations within and between the settings. Setting-specific tables for each of the key research questions were completed with information from the two site visit programs and two or three additional documentary analysis programs. The analysis examined quantitative information on program size, length of stay, dropout rates, discharge planner case loads, and discharge planner turnover. In addition, the analysis examined qualitative data on discharge planning and client characteristics, funding sources, availability of community resources, followup after discharge, and data availability. In summary, this analysis resulted in setting-specific findings pertaining to the key research questions, including implications for discharge planning and program outcomes as well as evaluability, and facilitated the formulation of cross-setting findings in these same areas.

Adult Residential Substance Abuse Programs

Researchers gathered information from the documentary analysis and site visits to four residential programs providing substance abuse treatment services to adults. Those programs are dispersed geographically across the U.S.

A few broad characteristics are common across the four programs. All four programs offer residential services to persons who have been dually diagnosed with substance abuse and mental health disorders. Two programs serve only individuals who are dually diagnosed. The other two primarily serve persons without dual diagnoses and have secured Federal grant funding that enables them to extend their treatment services to persons who are dually diagnosed. (It should be noted that persons with dual diagnoses of serious mental illnesses and substance use disorders are especially challenging to serve and typically require much longer lengths of stay than do those who have only substance use disorders.)[53] The two programs visited by project staff represented each of these types of arrangements. All four programs encourage their clients to become involved in a Twelve Step program to sustain their recovery. All of the programs follow a social rehabilitation approach to treatment and individualize treatment planning to meet the client's specific needs.

The tables that appear in this and the remaining sections of the report include complete data for the two programs (Program A and Program B) visited by project staff. Data for the two nonvisited programs (Program C and Program D) are provided as they were available from materials collected during the documentary analysis.

A. Program Descriptions

Analytic Questions: What are the characteristics of this setting in terms of size, length of stay, early terminators, and program completers? How does this affect discharge planning activities, outcomes and evaluability?

Table 1 describes details of the size and length of stay across the four programs. The size of three of the programs ranges from 15 to 40 residential beds. This is reflective of the varying communities and physical structures that house these programs. Program A, which has the fewest beds, is located within a large, historical home in a suburban community residential neighborhood. Program C, the largest, is housed in a renovated military housing facility in a large metropolitan area. Program B is housed in a refurbished motel in a commercial district in a large metropolitan area. All four of the residential programs are components of larger, not-for-profit treatment agencies that offer inpatient and outpatient services in their respective communities.

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[53] U.S. Department of Health and Human Services. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Annual rates of admissions to these programs are influenced by the number of residential beds and length of stay. During the two site visits it became apparent that program length of stay is jointly determined by treatment program design and the client's funding source. Program C, which has the shortest length of stay, is specifically designed to serve as a short-term transitional facility to prepare clients for halfway house placement following acute treatment or detoxification. Program A, which served only persons with dual diagnoses and expected a long (up to 12 months) length of stay, could retain clients that long only if they had Medicaid and county-level mental health funding. Probation departments using Program A authorized stays up to 6 months. Private insurance typically allows for the shortest residential stays, with limits as short as 7 days. Program A receives funding from a not-for-profit health maintenance organization that permits stays of up to 60 days for persons with dual diagnoses; however, this is not typical for most insurance companies. Program B relied primarily on state funding, supplemented by SAMHSA grants and a variety of other public and private sources. All lengths of stay in Program B tended to be shorter, although the clients with dual diagnoses served in the program with SAMHSA grant funding stayed longer than those funded by other sources. Review of program documentation for Programs C and D indicate that a mixture of various funding sources was also common among their clients.

TABLE 1: PROGRAM SIZE AND LENGTH OF STAY (FY 2003)

PROGRAM VARIABLE	VISITED PROGRAMS		NONVISITED PROGRAMS	
	A	B	C	D
Beds	15	36	40	Not Ascertained
Admissions	53	240	728	45
Discharges:				
Program completers	27 (51% of admits)	111 (46% of admits)	342 (47% of admits)	Not Ascertained
Early terminators	26 (49% of admits)	40 (17% of admits)	386 (53% of admits)	
Maximum length of stay (cap)	12 mo	9 weeks	"… until a satisfactory referral can be made."	6 mo
Average/median length of stay	5 mo	7 weeks	30 days	4 mo

Table 1 shows high rates of early termination in two of the three programs for which these data were available. Total discharges reported for Program B do not equal 100 percent. This is because approximately 37 percent of admitted clients step down from full residential care

to an "intermediate" level of care in which they receive a residential bed at night, and outpatient services during the day. This 37 percent was not included among the data that Program B provided for "Program Completers." It was learned during the site visits that early termination is not unusual among clients who are dually diagnosed. Staff in those programs explained that multiple treatment episodes are common with this population since many clients struggle with the challenge of maintaining sobriety in conjunction with symptoms of severe mental illness. Persons who are dually diagnosed are considered at high risk for homelessness.[54]

Early termination has implications for discharge planning and program outcomes. Discharge planning activities are often limited, and sometimes not conducted, for persons who terminate early from a residential program. Factors that influence the kinds of activities that can be conducted following early termination include length of stay in the program prior to termination, identification of a discharge target during treatment planning, sufficient time to make referrals to community resources, and accessibility of the program to the client after he or she leaves. Staff in the visited programs described trying to do as much as was possible to connect an early terminator with community resources. However, they are unable to do much when a client cannot be located, or cuts off all contact with the program. The longer period of time a client spends in a program, the more time staff have to identify and secure the resources needed to support outpatient living.

Program size and length of stay also have implications for evaluability. An evaluation design should account for the varying lengths of stay among residential programs. The sample frame could be defined to include residential programs that have a specified minimum client length of stay (e.g., minimum of 90 days of residential care). However, the problem remains that those who terminate early are likely to be at greatest risk of homelessness and should be included in any evaluation study.[55] They are also likely to be the most challenging to engage in a followup study. The high risk of homelessness associated with persons with dual diagnoses makes this a population of great interest for an evaluation. However, the sample design will need to account for the high rates of early termination among this group. The substantial variation in program size, with annual admissions ranging from 45 to 728, will be a significant consideration for design of any study. Other factors being equal, a study of a larger program could more quickly

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[54] Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist, 46*(11), 1149–1158.

[55] Sowers, W. E., & Rohland, B. (2004). American Association of Community Psychiatrists' principles for managing transitions in behavioral health services. *Psychiatric Services, (55)*, 1271–1275.; U.S. Department of Health and Human Services. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

enroll a sample of sufficient size to obtain the statistical power needed to answer key research questions in a rigorous quantitative study.

Analytic Question: How are the programs in this setting funded and what are the implications for evaluability, if any? What are key differences among the programs in institutional and program resources, constraints, and staff? What effects do these have on discharge planning characteristics and evaluability?

Major sources of program funding vary by program (see Table 2). County mental health dollars contribute largely to funding care for persons with dual diagnoses in Program A, while Programs B and C rely heavily on state drug and alcohol program funding. Programs A, B, and D have secured Federal grant funding to support provision of services to clients with dual diagnoses; this is a primary source of funding for Program D. Programs A, B, and C do not bill separately for discharge planning activities; discharge planning is considered part of the treatment planning and services. Staff in Programs A and C describe funding as sufficient to conduct discharge planning activities during a client's residential stay. In Program B, the approach to discharge planning differs depending on whether a person is in the standard program or the grant program for persons with dual diagnoses. For the standard program, the pattern is much like that in Programs A and C. Clients enrolled in the dual diagnoses program for Program B are each assigned an on-site case manager. This case manager is able to link clients to medical, dental, housing, counseling, and other services funded by the Federal grant at collaborating community agencies, and remains involved with the client for up to a year. Administrative staff in Program B hope to continue these services to clients with dual diagnoses after the grant period ends in a year, and are seeking additional sources of funding (e.g., grants, donations).

TABLE 2: PROGRAM FUNDING				
FUNDING CHARACTERISTIC	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Major funding sources	County mental health dollars Medicaid Federal Dept. of Justice Private insurance	State drug and alcohol dollars Federal grants Clinical trials Private insurance	Dept. of Public Health	Federal grants
Funding adequacy	Sufficient for discharge planning (DCP) activities conducted during residential stay	Federal grant enables discharge planning and aftercare to clients with dual diagnoses Traditional funding (non dually diagnosed) supports only DCP conducted during residential stay	Sufficient for discharge planning activities conducted during residential stay	Not Ascertained
Separate DCP billing?	No	No	No	Not Ascertained

Program funding has implications for discharge planning and program outcomes. None of these programs has the resources to conduct followup activities after a client has left residential care, unless they have special time-limited grant funding to do so (e.g., Program B). Provision of case management services following residential treatment is also contingent upon alternative sources of funding (e.g., Federal grant dollars). Healthcare for the Homeless grant funding from the Health Resources and Services Administration in the U.S. Department of Health and Human Services enables some programs to link indigent clients with outpatient resources, such as medical and dental care, that may not otherwise be available to this population. Program B is part of a relatively large umbrella agency with a range of treatment programs and, of particular importance, a broad range of affiliated housing options. The program has endorsed a "housing first" philosophy and made a strong resource commitment to development of housing options that are available to clients on discharge. By contrast, Program A has a less diverse network of housing options available for clients.

Program funding also has implications for evaluability. Client followup after discharge would have to be funded by any evaluation study;[56] the programs lack the technical knowledge and resources to do that followup without assistance. Differences in program funding sources introduce differences in discharge planning activities and clients' access to outpatient resources. These potential differences should be identified early and accounted for in the research design. Ignoring such differences can lead to invalid comparisons among sampled persons. Agency commitment to providing a range of housing options for clients at discharge has important implications for discharge planning outcomes and should be carefully considered in any study design.

Analytic Questions: Do the programs have each of the elements of exemplary discharge planning? Which elements appear to be missing and with what effect on outcomes and evaluability? Can discharge planning be disentangled from other program activities in this setting? If not, what are the implications for evaluability?

Table 3 describes elements of exemplary discharge planning for each program. All four of the adult residential programs include discharge planning activities among their admission and treatment planning practices. All programs conduct some form of comprehensive assessment that includes a diagnostic history and evaluation of mental and social functioning. This information serves as a foundation for initial treatment planning. All programs collect information about the client's housing history; however, the level of detail varies by program. Activities that are included in treatment and discharge plans are designed to reflect each client's preferences, skill levels, and capabilities; this is particularly important in planning for persons who are dually diagnosed. Treatment and outpatient service needs are reassessed during case meetings and revised as the client moves through the treatment process. While all programs seek client input during initial development, reassessment, and revision of the treatment plan, Programs B and D actually invite the client to attend case staffing meetings. Three of the four programs indicated that they encourage participation from the client's family, as appropriate, in treatment and discharge planning. During the two site visits, staff at these programs described treatment and discharge planning activities as so intertwined that they thought it would be difficult to examine one without including elements of the other.

In all four programs, the counselor or residential case manager who is responsible for treatment planning activities also oversees discharge planning. All four programs try to include

[56] Scott, C. (2004). A replicable model for achieving over 90% followup rates in longitudinal studies of substance abusers. *Drug and Alcohol Dependence, 74*, 21–36.

input about the discharge planning process from other case managers (e.g., from a county mental health department), probation officers, and other community providers that work with the client. According to staff from Programs A and B, the input they receive from representatives of other agencies varies by program; some agencies do not have the time or resources to participate in this process and rely upon the residential program to work out all of the details. Collaboration on discharge planning activities appears to be most successful with community programs with which the residential program has developed the strongest linkages. Factors supporting successful discharge planning include communication among community providers, county-level mental health case management, and availability of housing and independent living resources in the community. Programs A, B, and D describe housing and Independent Living (IL) resources tailored to the needs of persons with dual diagnoses as key to helping prevent homelessness in this special population.

None of the four programs conducts consistent followup with all clients after discharge. Any followup efforts are contingent upon the client's enrollment in affiliated aftercare programs or participation in research efforts. In Program B, clients with dual diagnoses who are enrolled in a federally funded grant program are assigned a dedicated case manager who coordinates and tracks their residential and outpatient service needs for a year. Clients in Program D are tracked monthly if enrolled in a special housing and health care program and/ or every 6 months if participating in a federally funded research study to prevent homelessness.

TABLE 3: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS

DCP COMPONENT	VISITED PROGRAMS		NONVISITED PROGRAMS	
	A	B	C	D
Early initiation of DCP	Begins at intake; part of treatment planning process	Begins at intake; part of treatment planning process	DCP part of initial service plan; within 72 hr of admission	During admission; part of assessment of client's service needs
Comprehensive assessment	Individualized bio-psychosocial assessment	Individualized bio-psychosocial assessment	Comprehensive psychosocial assessment; BASIS-32[1]	Assess independent living skills at admission Homeless clients given Government Performance Results Act (GPRA) measures at admission

[1]The BASIS-32® is a patient self-report rating scale of symptom and problem difficulty. It is administered at the beginning of a treatment episode to provide a baseline assessment of the client's perspective of his or her symptoms and problems, and again at discharge to determine outcomes of treatment. More information is available at www.basis-32.org.

TABLE 3: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS (Continued)				
DCP COMPONENT	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Housing assessment	At intake and as part of treatment (Tx) planning	A component of bio-psychosocial assessment; "Housing First" is program philosophy	Included in psychosocial assessment	Intake interview asks about all residencies in halfway houses, board & cares, foster homes, or juvenile facilities over past 3 yr
Identification of responsible individual	Primary Residential Counselor (PC)	Primary Residential Counselor (PC) for traditional residential program clients Grant-funded case manager for dually diagnosed clients enrolled in Federal study	Program Case Manager (CM)	Service Coordinator (SC)
Team approach	PC invites clinical & supervisory staff, & any assigned case manager(s) to weekly case staffing	PC, clinical, and supervisory staff conduct case staffing every 2 weeks. Client and community program reps invited	Tx team includes CM, clinical director, program director, senior case aid, nurse, & intake coordinator	Collaboration on DCP by SC, client, county mental health CM, and community service providers
Community collaboration	Most successful w/ affiliated supported independent living (SIL) case management (CM) team, and certain county CM teams Less success with Federal probation dept. and private insurance	With local multi-service outreach center and university on Federal grant to provide case management and aftercare services to individuals with dual diagnoses With area homeless coalition to construct supportive housing 12 Step programs	Affiliation agreements with halfway houses (primary housing placement for clients after discharge)	With local agencies & homeless prevention advocates to address barriers faced by persons with dual diagnoses when accessing care

TABLE 3: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS (Continued)				
DCP COMPONENT	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Comprehensive DCP	PCs get to know clients well through Tx planning; identify (ID) client preferences; transitions group prepares client for next placement	Guided by Tx plan; clients enrolled in federal study also have access to federally funded services for dually diagnosed persons	Guided by client's service plan; plan reviewed weekly during case review; plan includes recommendations from referring acute treatment agency or shelter	Guided by client's Tx plan and independent skill level; SC and client work together to develop discharge plan
Appropriate DCP to fit client needs	Client participation; based on client's Tx needs & goals, preferences, capabilities and eligibility SIL program assesses client ability to live independently	Client participation; based on client's Tx needs & goals, preferences, capabilities, and eligibility	Client reviews halfway housing preferences w/ case manager; flexible discharge planning policy allows client to stay until satisfactory housing arrangements can be made	Client's level of independence is assessed prior to discharge; information used to guide planning for next living situation
Client/family involvement	Encouraged; family group sessions	Encouraged; children can live with parent at residential facility	Encouraged; based on client's definition of "family"	Not Ascertained
Postdischarge followup	Only if client is assigned to CM services through SIL program	Only for clients enrolled in federally funded program for persons who are dually diagnosed; they receive CM services for up to 1 yr	Postdischarge services not provided	Clients enrolled in Health, Housing & Integrated Services Network (HHISN) are tracked monthly to assess changes in community functioning Data (not specified) collected at admission and every 6 mo for clients enrolled in federally funded research to prevent homelessness

TABLE 3: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS (Continued)				
DCP COMPONENT	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Supportive external factors	Close-knit network of community providers County mental health case management system	Federal grant funding for community services and CM to clients who are dually diagnosed	"Homeless certificate" helps client access community housing options[1]	Subsidies for low income housing; housing & independent living resources for dually diagnosed

[1] A homeless certificate is a voucher that can be redeemed to pay for temporary accommodation in a hotel, motel, board and care, or similar facility.

The characteristics of each program's discharge planning activities influence processes and outcomes. It would appear that including discharge planning as part of the treatment planning is a regular practice in these types of programs. This process ensures that discharge planning activities can evolve and change as the client moves through different phases of treatment. While collaborating with community agencies on discharge planning is reported as a goal among these programs, participation by those community agencies is variable, and at times limited. None of the programs conducts consistent followup or tracking of clients after discharge. Those that do conduct followup rely on external funding. None of these programs employed highly structured approaches to client assessment.

The evaluability of discharge planning is also affected by several of the characteristics of discharge planning. Treatment and discharge planning activities are closely linked in these programs and not readily separable. Comprehensiveness and appropriateness of discharge plans may be difficult to evaluate given the lack of structured assessment protocols in most programs. Community agencies participate in discharge planning, but this varies within and between these programs. This makes identification of "key participants" a variable of interest for an evaluation. Data on most postdischarge outcomes is very limited in this setting. When available, it is typically because the client is participating in research, or is in a particular funding track. Any available postdischarge data should be examined carefully to see which clients are included and which excluded. For example, community agency data on followup treatment will include only those participating in treatment. Furthermore, the Homeless Management Information System (HMIS) data may exclude those not receiving any services from agencies that do not receive McKinney-Vento Homeless Assistance funds from HUD.

Analytic Questions: What characteristics of the discharge planner need to be considered, and how might they be measured? What characteristics could be evaluated, and how do these vary by setting?

In all four programs, the staff member (typically a primary counselor or case manager) who is responsible for treatment planning is also responsible for ensuring the completion of discharge planning activities (see Table 4). These staff often rely on assistance from other residential program staff with coordinating outpatient services. In Program B, residential operations staff who deal with the day-to-day dealings in the facility assist clients with completion of applications, housing, entitlements, and community services, and provide transportation to community program interviews and screenings. This role is filled by supervisors and day staff in Program A and case aides in Program C. Training in discharge planning practices appears to be relatively informal in these programs. There is some introduction to the process during orientation, but for the most part, staff learn the details of the process from experienced staff. Documentation from Programs C and D suggest there may be some standard training, but it was unclear what that training entailed. Professional qualifications for discharge planners vary by program. Program A requires a minimum of a master's degree in public health or a related field, while Programs B and C require a bachelor's degree. Experience working in the field of addictions is key among the three programs; all require at least 3 years of professional experience in the field. All three also report low turnover among their staff.

TABLE 4: CHARACTERISTICS OF DISCHARGE PLANNER				
CHARACTERISTIC	**PROGRAM A**	**PROGRAM B**	**PROGRAM C**	**PROGRAM D**
Who does discharge planning (DCP)?	Primary residential counselor; Case Manager (CM) participation invited	Primary Residential Counselor (PC) for traditional residential program clients Grant-funded case manager for clients with dual diagnoses enrolled in Federal study Residential operations staff assist with coordination of outpatient services	Program CM with assistance of case aids	Service Coordinator (SC)
Training	At orientation and by shadowing experienced counselors	Not formalized; learned over time	At sessions offered by Dept. of Public Health, on the job, and in weekly meetings	Weekly supervision with clinical and program administrators; regular training from regional supervisors
Credentials/ qualifications	3 yr of experience in field and/or master's	PCs: min. bachelor's degree Grant-funded CMs: master's degree	CMs have bachelor's degree in human services, or 4 yr of experience in the field	Not Ascertained
How long in job?	Low staff turnover; min 3 yr	PCs: Over 20 yr in substance abuse (SA) Tx Grant-funded CMs: Min 8 yr in SA Tx	Staff turnover minimal; Staff tenure not ascertained	Not Ascertained

Characteristics of the discharge planner have several implications for discharge planning and program outcomes. Low staff turnover among these programs would suggest staff familiarity with discharge planning practices and consistency in planning activities. It is unclear how representative the staff turnover rates provided by three programs are of the typical staff turnover for these kinds of residential programs. Training on discharge planning seems to be informal for these programs. This would suggest a potential for inconsistency in planning activities.

However, this inconsistency may be tempered by the relatively high staff tenure, since staff have been on the job long enough to become familiar with the process.

Characteristics of the discharge planners in these programs also raise several issues of interest in terms of evaluability. Staff tenure is a variable of interest for an evaluation. It would be difficult to evaluate discharge planning training without detailed documentation about a program's training process. Education levels of discharge planners appear to vary across programs, with higher education levels perhaps being required for programs that serve people with co-occurring serious mental illness and substance use disorders. The relevance of these differences in discharge planner education should be considered as a factor in any study design since it appears to co-vary with subpopulation and risk of homelessness.

B. Client Characteristics

Analytic Questions: What individual characteristics of the target population need to be considered, and how might they be measured? What target population(s) in relation to homelessness could be evaluated, and how do these vary by setting?

All programs offer residential treatment services to males and females ages 18 years of age and older (see Table 5). All four provide services to persons who are dually diagnosed with mental and substance use disorders. Programs B and C also provide residential services to persons who are not dually diagnosed. Characteristics common among clients with dual diagnoses include long histories of psychiatric hospitalizations and histories of homelessness.[57] Most clients in all four programs, whether or not they are dually diagnosed, have criminal histories. Clients' financial resources vary, and this is used to determine program eligibility. All four programs accept Medicaid and private insurance. Many clients enrolled in Programs A and D are funded by the county mental health system. Clients in Programs A, B, and D can be receiving Social Security Disability benefits (SSI or SSDI), but those enrolled in Program C must be able to work. Programs A, B, and D allot a specific number of treatment beds to different funding sources; it was not clear from the information provided if Program C also did this. Histories of homelessness are not uncommon among clients of all four programs. Persons who are dually diagnosed are deemed at the greatest risk for future homelessness; it is not uncommon

[57] Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist, 46*(11), 1149–1158.

for members of this population to terminate early from treatment, and some have difficulties interacting socially with others in a residential environment.

TABLE 5: CLIENT CHARACTERISTICS (FY 2003)				
CLIENT'S:	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Age	18–59	18+	18+	18–59
Gender	Approx. 50/50 males and females	Approx. 50/50 males and females	69% male 31% female	Male/Female (percentages not ascertained)
Diagnosis	Dually diagnosed; 70% schizophrenic, 25% bipolar/major depression plus a substance abuse disorder	ASAM criteria for residential substance abuse Tx, and/or DSM IV criteria for substance dependence[1] Those in dual diagnoses track have co-occurring mental disorder	Substance abuse; about 60% have co-occurring disorders	Dually diagnosed
Previous system involvement	Most have long history of psych hospitalizations; high dollar users of county mental health system	Most have criminal history; many known to child protective services system	Most clients have outstanding arrest warrants	History of treatment for severe & persistent mental disabilities
Financial resources	County mental health funds, Medicaid, private insurance, SSI, SSDI	Medicaid, private insurance, SSI, SSDI	Must be able to work; cannot be receiving SSI or SSDI Some have homeless certificate	Public assistance, Medicaid, private insurance, SSI, SSDI
Prior homelessness	Most homeless prior to admission	Some homeless prior to Tx	25% meet state's definition of homeless; 50% have no permanent address	Some homeless prior to Tx
Risk of homelessness	High risk	Some risk for all clients. Highest for dually diagnosed and women with children	High risk	High risk

[1]American Society of Addiction Medicine

Characteristics of the clients in these programs have important implications in terms of discharge planning and program outcomes. The tendency for persons with dual diagnoses to terminate treatment early makes it challenging for these programs to conduct thorough discharge planning for this group. This contributes to the high risk of homelessness associated with this group. Clients with criminal histories of felony commission face challenges in being accepted into housing. Most HUD-funded housing programs do not accept former felons.

Client characteristics also play a significant role in the evaluability of discharge planning in these programs. There is substantial variation in the degree of risk of homelessness across clients served by these programs. Thus, any study design would need to address the risk of homelessness among each program's sample of clients in order to fairly compare the impact of discharge planning on clients' housing status.

C. Community Descriptions

Analytic Question: How available are the key community resources and what are the implications for evaluability?

Data supporting this question are provided in Table 6. All four programs describe a need for affordable independent housing in their communities. Supportive housing options for persons who are dually diagnosed are particularly limited. Programs A and B are able to refer some clients to housing options through affiliated independent living programs. Wait lists for these housing programs can be long, and the accommodations do not always support the needs of persons who are dually diagnosed. Program B maintains "master leasing agreements" with area landlords; these types of agreements have helped expand housing options for some clients since the program is named on the lease along with the client. Program B is also collaborating with other agencies to build supportive housing units in the community; this effort was inspired by the need for housing for persons with dual diagnoses and women in recovery with children. All four residential programs are part of larger umbrella agencies that offer outpatient substance abuse and mental health services. There are also other community providers that meet these service needs in their communities. Staff from Programs A and B described a need in their communities for substance abuse and mental health professionals who work with persons who are dually diagnosed. The availability of case management services varies. Clients in Programs A and D can receive case management services through these residential programs as long as they qualify for such services through their county mental health departments. Clients with dual diagnoses

participating in the federally funded study in Program B are assigned a case manager who tracks them for a year. Clients not enrolled in these special programs do not receive case management services through the residential programs.

TABLE 6: AVAILABILITY OF COMMUNITY RESOURCES				
RESOURCE	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Housing	For persons dually diagnosed through affiliated SIL program; otherwise few affordable independent housing options; crisis beds, board and care homes, SRO units, shelter plus care.	Limited avail. for dually diagnosed and women in recovery w/children Supportive housing avail. through local multiservice outreach center, affiliated independent living program Program has master leasing agreements w/ area landlords Building supportive housing units in community	Halfway houses, shelters, sober housing. Few halfway houses accept clients taking benzodiazepines, sleeping meds, or methadone. Few take clients under age 24. Some require homeless certificate.	Health Housing and Integrated Services (HHIS), community living programs, board and care homes
Mental health services	Need for providers who follow evidence-based practices and who work with persons dually diagnosed. Need for day Tx programs for persons dually diagnosed, and for psychotherapists who accept Medicaid	Via affiliated outpatient program, two similar Tx programs in area, local multiservice outreach center, and faith-based and other independent community programs Need for more providers who work with persons who are dually diagnosed	Not Ascertained	Three multi-service centers in county including affiliated outpatient program
Substance abuse (SA) treatment	Through this program and county mental health programs	Via affiliated outpatient program, two similar Tx programs in area	Acute SA Tx providers in community refer clients to this program for help transitioning clients to halfway houses	Three multi-service centers in county including affiliated outpatient program
Case manage-ment (CM) services	Available to those who meet reqs. for assignment to a county CM team; otherwise not widely available	Available to non dually diagnosed through local multiservice outreach program Clients enrolled in grant program for dually diagnosed receive CM services for up to 1 yr	Provided during residential stay only	Available to clients enrolled in county's CM program

The availability and quality of community resources has significant implications for discharge planning and program outcomes. Linking clients with affordable and appropriate housing is a challenge for discharge planners. Housing can be particularly difficult to secure for persons with dual diagnoses and women in recovery with children. Programs differ dramatically in the extent to which they have emphasized developing a range of housing options for client use on discharge. Some programs have adopted a "housing first" philosophy which some in the substance abuse treatment community may see as running counter to traditional Twelve Step principles since it implies acceptance of some continued use of substances ("wet" or "damp" housing). In some instances, discharge planners are able to access planning support and resources upon discharge from a client's county mental health case manager or grant-funded case manager.

Similarly, community resources affect the evaluability of discharge planning. Some client subgroups will have access to case management services after discharge while others will not. An evaluation could explore differences in postdischarge outcomes for different subgroups, but note that this may reduce effective sample sizes and limit statistical power. The availability of affordable and supportive housing in the community will be a key variable to explore in any outcome evaluation.[58] The implications of adopting a "housing first" philosophy (allowance of "wet" or "damp" housing) should be examined in any study of discharge planning outcomes following substance abuse treatment.[59]

Analytic Question: What other community agencies are involved in discharge planning? What is their role? Does this differ by setting or by subpopulations within settings?

As described in Table 7, some clients enrolled in Programs A and D have a county mental health case manager who is involved to some degree in coordinating and tracking their outpatient care. Programs A and B rely heavily on housing resources and life skills training available through affiliated supported independent living programs. Programs C and D work closely with halfway houses and shelter programs to coordinate postdischarge housing. Program B can refer clients to a multiservice outreach center that offers supported, independent housing. Program B is also currently collaborating with this multiservice outreach program on a Federal grant to prevent homelessness among persons with dual diagnoses. Funding from this grant

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[58] Sowers, W. E., & Rohland, B. (2004). American Association of Community Psychiatrists' principles for managing transitions in behavioral health services. *Psychiatric Services, (55)*, 1271–1275.

[59] Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R. Jimenez, L. Duchon, L., & Krantz, D. H. (1998). Predictors of homelessness among families in New York City: From shelter request to housing stability. *American Journal of Public Health, 88*(11), 1651─1657.

enables provision of medical, dental, and optical care and housing and counseling services that meet the special needs of clients who are dually diagnosed; these services are also available to persons without dual diagnoses. Program C works closely with acute substance abuse treatment facilities and area halfway houses; the residential program is designed to help clients transition between these two facilities. Agreements that a residential program has in place can vary by community provider. Formalized agreements tend to be used when special funding will be shared between agencies, or when one program is providing a specialized service to another.

All four programs encourage clients to become involved with a local Twelve Step program. Programs B, C, and D include the Twelve Step model in the treatment process. Early on in treatment, clients begin attending Twelve Step meetings at the residential facility and select a Twelve Step "sponsor." The sponsor is an abstinent volunteer also in recovery from substance use who provides emotional support to the client during the recovery process. This sponsor can be a key source of support for clients as they leave the structure of a residential facility and return to the community.

TABLE 7: COLLABORATIVE AGENCIES

	VISITED PROGRAMS		NONVISITED PROGRAMS	
	PROGRAM A	**PROGRAM B**	**PROGRAM C**	**PROGRAM D**
Referrals	Local psychiatric hospitals: refers to residential program; provides crisis beds as needed for clients who destabilize during treatment (Tx)		Acute substance abuse Tx facilities: refers clients to this program for transition services and placement in halfway house or other Shelter programs: source of program referrals; provides accommodations for early program terminators	
Housing	Affiliated SIL program: coordinates housing, skills training, provides ongoing client follow-up after discharge from residential program	Affiliated SIL program and halfway house: key housing resources for former residential clients	Sober housing Halfway houses: targeted housing placement for most clients after discharge from this program	Health Housing and Integrated Services (HHIS), community living programs, board and cares: serve as key housing resources for clients discharged from residential program

TABLE 7: COLLABORATIVE AGENCIES (Continued)				
	VISITED PROGRAMS		NONVISITED PROGRAMS	
	PROGRAM A	PROGRAM B	PROGRAM C	PROGRAM D
Case management (CM) & other services	County CM teams: ongoing client followup after discharge from residential program ACT program: ongoing CM after discharge for persons with severe mental illness	Faith-based community: offer series of programs for special populations (e.g., pregnant women, HIV+ persons, and women in recovery w/children) Local multiservice outreach program: Collaborates with this program and local university on Federal grant to provide residential Tx, CM, and outpatient services to persons with dual diagnoses; multiservice outreach program also a resource for outpatient medical, dental, and housing resources for all residential clients		County CM program: refers client to program, conducts ongoing CM for client
12 Step programs		12 Step program community: begin working with clients during residential stay and remain involved after discharge to support client's recovery	12 step program community: clients encouraged to work with AA or NA during residential stay and to remain involved after discharge to sustain recovery	12 step program community: clients encouraged to work with AA or NA during residential stay and to remain involved after discharge to sustain recovery

The nature and extent of the involvement of collaborative agencies in the discharge planning process impacts the discharge planning and resulting program outcomes. Staff from community agencies that will be working with the client after discharge from residential care may become involved in discharge planning as time and resources allow. Much of the communication between residential staff and community providers takes place through phone calls. Often at the point of discharge there is a "hand-off" of the case between agencies with client information being communicated through a summary treatment report.

Involvement of collaborative agencies also affects evaluability. The quality and effectiveness of interagency relationships were quite variable and independent of the presence of memorandums of agreement or other formalized agreements. Formalized agreements tend to be used when special funding will be shared between agencies, or when one program is providing a specialized service to another. Interagency relationships are an important consideration for an evaluation, but may be challenging to measure. Because communication between agencies tends to take place via telephone, it may be difficult to accurately assess the role each provider plays in discharge planning without detailed documentation of the process.

D. Research Issues

Analytic Question: What is the appropriate followup period after discharge to determine clients' housing status and other outcomes, and what are the implications for evaluability?

Table 8 shows that none of the programs consistently follows up with all clients after they are discharged from residential care. Those that do any followup are able to do so because they are receiving special funding that provides for the time and resources needed to do followup for specified clients. Program A is able to track clients who enroll in an affiliated supported independent living program through the agency's electronic management information system. Clients with dual diagnoses in Program B who are enrolled in the federally funded study are tracked for a year by their grant-funded case manager. Program C does not provide followup services to clients, but tracks the number of clients who remain in area halfway houses 30 days after discharge. Program D tracks changes in community functioning monthly for clients enrolled in the HHISN, and collects SAMHSA GPRA measures every 6 months for clients enrolled in a federally funded homeless prevention project.

TABLE 8: CLIENT FOLLOWUP AFTER DISCHARGE				
FOLLOWUP DESCRIPTION	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**	
	A	**B**	**C**	**D**
Program follows client	Only if client enrolled in affiliated SIL program for outpatient case management (CM) services	Clients in traditional residential program do not currently receive consistent followup Clients with dual diagnoses enrolled in Federal grant program receive followup CM and aftercare services for up to 1 yr	Conducts record checks with halfway house to track number of clients who remain there 30 days after discharge. Program discontinues referrals to halfway houses that show poor client retention/other outcomes	Clients enrolled in HHISN and/ or federally funded homelessness prevention grant
Nature of followup	In person and phone through SIL program	In person and phone contact by grant-funded CM	Not ascertained	Not ascertained
For how long	Until client terminates services	Up to 1 year for dually diagnosed in Federal grant program	30 days after discharge from residential program	HHISN: monthly Federal grant: every 6 months
Services provided	Outpatient CM (as a county CM team provider), housing, skills training	CM and aftercare for dually diagnosed in Federal grant program	None	Not ascertained
Data collected	All inpatient admits & dischgs; referrals to (MH) services; CM team assignment; diagnosis & med. histories; financial information	Data collected from Federal study were not described; but these data would span a year of services for each client and may be of interest for an evaluation. Limited data for early terminators.	Number of clients who remain in halfway house 30 days after discharge	HHISN: changes in community functioning Federal grant: GPRA measures Content and format not ascertained

Client followup of patients following discharge and the resulting data enables measurement of program outcomes. Followup is not conducted regularly with clients discharged from these programs. When it is conducted, it is at a time period specified by a particular program or funding source. Early terminators are at the greatest risk of homelessness, and are unlikely to receive any followup.

There are significant implications for evaluability as a result of these followup patterns. Because client followup data are lacking for these types of programs, any evaluation study design would have to include the cost of followup data collection. Followup periods of 90 days for

linkages, as recommended by the expert panel, may be inadequate to assess the effectiveness of discharge planning as a strategy to prevent subsequent homelessness. It could be difficult to disentangle the effects of the discharge planning process from the relapse-prone course of the chronic substance use disorder.

Analytic Question: What types of data are available and from what sources? What is the data quality and what are the implications for evaluability? Is the type of outcome data recommended by the expert panel available, including homelessness indicators?

Intake and treatment data, including discharge planning notes, are available from all four programs. Most of this information appears to be in hardcopy form and is maintained in various sections of the client record. All four programs have electronic management information systems. Types of pre- and postdischarge data typically included in the electronic records include client demographics, living situation, diagnoses, medication histories, employment status, substance abuse history, reason for discharge, and referrals made by program staff. Program A has access to client data through the county's mental health data management system, which tracks all admits and discharges to inpatient care, referrals to mental health services, diagnosis and medications histories, and financial information. Program B maintains some hardcopy and electronic data for clients enrolled in the Federal study; however, we did not probe in detail for types of data collected. Program B is participating in a consortium that is in the process of developing a Homeless Information Management System (HMIS) to track data on clients receiving homelessness-related services. Program C tracks the number of clients that remain in halfway houses 30 days after discharge from residential care. Program D collects data on a client's community functioning for clients enrolled in the HHISN, and administers Government Performance Results Act (GPRA) measures for clients enrolled in a Federal homelessness prevention study. Details about data collection procedures were not provided.

TABLE 9: DATA AVAILABILITY				
TYPE OF DATA	**PROGRAM A**	**PROGRAM B**	**PROGRAM C**	**PROGRAM D**
Predischarge: **Client assessments** **Services** **Outcomes** **Data format** **Data quality**	Most residential program data in hard copy in client case record. Some intake and discharge data are entered into the county's electronic mental health data system (admit & discharge dates, age, length of stay, discharge living situation, employment status, diagnosis, & reasons for discharge)	Most residential data in hardcopy. Data entered into program's electronic management info system includes reason for discharge (DC), employment status, services provided during resident's. stay, substance use in 30 days pre-DC, housing status at DC, & outpatient referrals made	BASIS-32 assessments; format not specified Psychosocial assessment; format not specified Individualized Service Plan; format not specified Electronic format: client demographics, disabilities, treatment/service history, drunk-driving arrests, pattern of substance abuse, social/health services, goal achievement	Electronic data on client demographics; education, preliving arrangement, income, insurance status, employment status, diagnoses at admission; living situation, financial situation, insurance info, day activity, employment status, income, diagnoses, meds, reason for leaving, living situation, and advocacy services provided at discharge
Postdischarge: **Who collects?** **Services** **Outcomes** **Data format** **Data quality**	SIL program case managers enter case data into county's electronic mental health data system. Includes inpatient admits & discharges. referrals to mental health (MH) services, case management CM team assignment; diagnosis & medication histories, financial information	Data collected by CM for clients dually diagnosed who are enrolled in Federal study; some data in electronic form Homeless Management Information System (HMIS) data for clients' receiving homeless services	Number of clients who remain in halfway house 30 days after discharge; details about data collection process not provided	HHISN: changes in community functioning Federal grant: GPRA measures Content and format not ascertained

The availability of program data has implications for evaluability. Much of the client treatment and discharge planning activity data maintained by these programs is in hard copy and of varying quality. Information related to discharge planning that may be available electronically is expected to be limited to data collected for financial reporting and audit purposes. Few standardized assessment or data collection instruments are used, so data may not be comprehensive or consistent and are likely to be highly variable, of questionable quality, and

difficult to access electronically. These factors have significant impacts on the evaluability of these programs. Uniform data collection methods would need to be established as part of any study design.

Analytic Question: What are the relevant independent, dependent, and mediating variables that should be studied in each setting? How could they be defined and operationalized?

Table 10 describes potential research variables for this program setting and the measures that would be used to evaluate them. The independent variable of interest for an evaluation is the discharge planning process, which would be measured using the multiple components of exemplary discharge planning. Dependent variables are housing status and linkages to services after discharge. An evaluation of this program setting needs to consider potential client and community mediating factors. At the client level, an evaluation design should consider how housing and service outcomes can be affected by the client's functionality as related to mental health and substance abuse diagnoses, criminal history, and funding eligibility. The treatment services received in the inpatient program may also affect how a client will respond to community housing and services. At the community level, outcomes may be affected by the availability of appropriate housing in the region, outpatient mental health and substance abuse treatment for persons dually diagnosed and non-dually-diagnosed, the strength of collaborations between the residential treatment program and key community agencies, and local resources for persons who are homeless or at risk of homelessness.

TABLE 10: POTENTIAL RESEARCH VARIABLES AND MEASURES

VARIABLE	MEASURES
Independent	
Discharge planning process	Initiation, comprehensive assessment, housing assessment, ID of responsible individual, team approach, community collaboration, comprehensiveness of plan, appropriateness to individual needs, client & family involvement, postdischarge followup
Dependent	
Housing status	Housing status at discharge (where discharged to) and followup
Service linkages	Linkages in place to services needed after discharge
Mediating	
Client characteristics	Mental health and substance abuse diagnoses; funding stream eligibility; criminal history
Treatment program	Treatment services received while at inpatient setting that may affect client's ability to function in community housing and service context
Community resources	Availability of affordable, safe, & supportive housing; outpatient mental health & substance abuse treatment services for individuals non-dually diagnosed and dually diagnosed; collaboration between the Tx program and community agencies; resources for individuals who are homeless

E. Summary and Conclusion

Each of the adult residential substance abuse programs described in this section incorporates most of the key components of discharge planning. However, the presence of those components does not ensure the evaluability of discharge planning in this setting. As described in Tables 1 through 9 in this section, there are multiple differences among these programs related to the characteristics of the programs and their environments, as well as the individual components of discharge planning. The following points describe key issues and their potential impact on the design of an evaluation.

The following observations can be made with regard to discharge planning in the context of this program setting. The goal of these programs is to treat substance use disorders, either alone or in combination with co-occurring serious mental illnesses. Discharge planning as a process is enmeshed with treatment planning activities in these programs, and the two do not appear to be readily separable. Despite the fact that these programs were selected on the basis of having strong discharge planning, there was little evidence of well-articulated discharge planning processes in any of the four programs. None of the programs employed highly structured approaches to assessment of discharge needs or had quality assurance procedures that were intended to strengthen the discharge planning processes. The comprehensiveness and appropriateness of discharge plans may be difficult to evaluate given the lack of structured assessment protocols in most programs.

Low staff turnover among these particular programs would support staff familiarity with community resources and discharge planning practices. However, discharge planning training seems to be informal for these programs and suggests a possibility of inconsistency in discharge planning activities. The low staff turnover reported for these programs may or may not be typical, and makes staff tenure a variable of interest for an evaluation. It would be difficult to evaluate staff training as a variable without detailed documentation about a program's training process.

Differences in program funding sources introduce differences in discharge planning activities and clients' access to outpatient resources. These potential differences will need to be identified early and accounted for in any research design. Ignoring such differences can lead to invalid comparisons among sampled persons

Client characteristics significantly affect the evaluability of programs in this setting. Length of stay in these programs is often contingent upon clients' funding streams. Clearly, the longer the period of time clients stay in a program, the more time staff have to investigate outpatient resources and establish linkages. Discharge planning activities may be limited, or not conducted at all, for persons who terminate early from these residential programs. Early termination rates were approximately 50 percent in two of the three programs for which data were available. Those who terminate early, particularly persons who are dually diagnosed, tend to be at greatest risk of homelessness.[60] An evaluation design will need to account for variables associated with the varying lengths of stay among residential programs and address the loss of participants resulting from early program termination. Housing seems to be especially difficult to find for those with felony histories, women with children, and those with co-occurring serious mental illnesses. Any study design will need to take account of risk factors associated with subgroup membership. All clients in these settings are at risk of homelessness; however, the high risk of homelessness associated with persons who are dually diagnosed makes this group of particular interest for an evaluation. Furthermore, this group's tendency to be noncompliant with treatment and terminate treatment early could make it difficult to attain a sufficient sample size and to follow them after they leave the program.[61]

There are several variations across the programs in this setting in terms of access to and collaboration with community resources. The quality and effectiveness of interagency relationships among these programs are variable and appear to be independent of the presence of memorandums of agreement or other formalized agreements. Formalized agreements tend to be used when special funding will be shared between agencies, or when one program is providing a specialized service to another. The quality and effectiveness of interagency relationships are important considerations for an evaluation, but may be challenging to measure. Because communication between agencies tends to take place via telephone, it may be difficult to accurately assess the role each provider plays in discharge planning without detailed documentation of the process.

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[60] Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist, 46*(11), 1149-1158.

[61] U.S. Department of Health and Human Services (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Insitutes of Health, National Insitute of Mental Health. Olfson, M., Mechanic, D., Hansell, S., Carol, A. B., Walkup, J., & Weiden, P. J. (2000). Predicting medication noncompliance after hospital discharge among patients with schizophrenia. *Psychiatric Services, 51*(2), 216–222. Tsuang, J. W., Fong, T. W., & Andrew, P. H. (2003). Dual diagnosis and treatment compliance. *Psychiatric Services, 54*(4), 574–576.

Most programs report a need for affordable, safe, and supportive housing options in their communities. There are sharp interprogram differences in their commitment to developing a range of housing options for clients on discharge, and also in the philosophy of programs with regard to tolerance for continuing substance use when housed ("wet" or "damp" housing). Linking clients with affordable and appropriate housing is a challenge, particularly for persons with co-occurring disorders and women in recovery with children. Clients with criminal histories of felony commission may face challenges in being accepted into housing. Programs reported that some local public housing authorities they dealt with have restrictive rules about accepting former felons into housing. Local housing authorities have great discretion in setting local rules on admission to public housing, and some may also have appeals mechanisms that can grant waivers in individual cases. In some instances discharge planners are able to access planning support and resources from a client's county mental health case manager or grant-funded case manager. Provision of case management services following discharge from residential treatment is often contingent upon alternative sources of funding (e.g., Federal grant dollars). An evaluation design needs to account for the fact that clients will have access to varying types of outpatient services and housing *within and across* these programs.

Several issues related to client followup and client data are noted with regard to programs in this setting. None of the programs described in this section has the resources to conduct followup activities after a client has left residential care, unless they have special time-limited grant funding to do so. Client followup after discharge would have to be funded by any evaluation study since the programs lack the resources or infrastructure to conduct that followup without assistance.

Much of the client treatment and discharge planning activity data maintained by these programs is in hard copy and of varying quality. Information related to discharge planning may be available electronically, but is expected to be limited to data collected for financial reporting and audit purposes. Few standardized assessment or data collection instruments are used, so data may not be comprehensive or consistent and are likely to be highly variable, of questionable quality, and difficult to access electronically.

In summary, it is not clear that these programs currently have an evaluable model for discharge planning. It would also be very challenging to compare programs in a rigorous experimental design given the number of dimensions on which they differ and the extent to which discharge planning practices are bound to client and context variables. The availability of

housing and other community resources is highly variable across programs and, to a lesser extent, across clients depending on their eligibility for differing funding streams (e.g., Medicaid or SSI/SSDI) or research grant enrollment criteria (e.g., co-occurring serious mental illnesses). Client early termination rates may be high in some programs and associated with heightened risk of subsequent homelessness. This factor may make the enrollment of an adequately sized sample and followup over time a challenge. While there is much to be learned about effective practices to prevent homelessness in this setting, a rigorous quantitative evaluation study of discharge planning programs as a strategy to prevent homelessness seems like it would be difficult and costly.

Residential Treatment Centers for Youth

The five residential treatment center programs examined in the documentary analysis provide intensive clinical treatment for either emotional or substance use disorders. The goal of this treatment is to improve youths' clinical and social functioning in their family and community. Average treatment stays range from 43 days to 10 months. The arrangement of a permanent placement is an integral goal of each youth's clinical treatment and discharge plan. In every case, these programs provided a comprehensive set of services from which discharge planning could not be easily disentangled.

The youth treated in all these programs are under the legal custody of their parents or the state, or they are on their own in the case of youth who have reached the age of majority. All of the programs treat youth from a wide geographic area. Four of the five programs are part of umbrella agencies that also provide an array of community mental health or substance abuse services. Therefore, four programs have the option of referring discharged youth to another program operated by the same agency, so long as they live within the agency's service area. Programs consistently reported that it was easier to make arrangements for postdischarge services if the referral was to another program within the same umbrella agency.

State Medicaid agencies, state child welfare departments, and state general funds are the major funding sources for four of the programs. The two programs for substance abuse also have Federal grants as a major source of funding. In addition, one program relies on charitable donations and another treats a sizable number of privately insured youth.

Two of the five programs in the documentary analysis were selected for site visits, in part because of their comprehensive electronic record systems that document service provision and the

discharge planning process. Program A provides treatment primarily for youth with serious emotional disturbances and Program B provides treatment for youth with substance use disorders. One program is located in an urban area and the other program is located in a small city within a predominately rural area.

The residential treatment centers (RTCs) for youth that we visited differ widely in the services they provide, the areas they serve, the funding sources they rely on, and their connections to postdischarge housing options. For example, Program A offers a range of housing options, including an affiliated transitional living program and group and foster care situations. Program B relies on only one nonfamily option—an independent transitional living program. Program A serves youth in three states, whereas Program B serves youth only from its home state. Program B has developed commercial insurance as an important funding source, whereas most of Program A's funding is from state Medicaid agencies. Program A conducts a 2-year followup survey of all program participants. Program B conducts a followup survey only of individuals who are in a federally funded grant program. Clearly, there are substantial differences in the way RTCs operate, factors that could have major implications for the design of any study of the discharge planning processes in these settings.

A. Program Descriptions

Analytic Questions: What are the characteristics of this setting in terms of size, length of stay, early terminators, and program completers? How does this affect discharge planning activities, outcomes, and evaluability?

As shown in Table 11, the bed size for residential treatment centers varies widely from the smallest program of 8 beds to the largest program of 64 beds. There is considerable variation in the average length of stay (ALOS) across programs. Program B's ALOS was only 43 days, while the rest of the programs had ALOSs that ranged from 5 to 10 months. The number of people discharged each year ranges from a low of 18 to a high of 356, a range explained by both the number of beds and the ALOS.

The early termination rates experienced by the programs vary widely, from 8 percent to 61 percent. The two programs with the highest early termination rates (61 percent and 30 percent) both primarily treat youth with substance use disorders. Possible explanations of the

difference in termination rates include treatment model, effectiveness in engaging clients, and client characteristics.[62]

Program size and length of stay have several implications for evaluability.[63] First, the programs with fewer annual discharges would need to have longer client enrollment time periods to produce an adequate sample size for a quantitative evaluation. The range of ALOS from 43 days to 10 months is also significant. Programs with longer lengths of stay are able to provide more extensive discharge planning because of the additional time available to locate new living situations, arrange services in areas with scarce resources and wait lists, and work with families to improve the possibility of the youth's return. The limitations on the extent of discharge planning activities are even more extreme in the case of early terminators. If a client elopes or leaves hastily against medical advice (AMA), there is even less time to conduct a deliberate discharge planning process. Programs with higher rates of early terminators have more clients who are unlikely to receive a full "dose" of discharge planning. What's more, the noncompliant clients who terminate early are also likely to be at greatest risk of homelessness, and to be most difficult to follow in any study.[64]

Any future study would need to take these differences in early termination rates and length of stay into account. Clearly, the quality of discharge planning received is likely to be affected by these factors, as may be client outcomes and the ability to enroll and retain clients in any study. While it is unwise to generalize from our cluster of five programs, the RTCs that primarily treated youth with substance use disorders had shorter ALOSs and higher early termination rates than did the RTCs that treated youth with serious emotional disturbances. If this pattern held more broadly, it might be important to have adequate representation of these two types of programs in a future study.

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[62] DeLeon, G., Melnick, G., Kressel, D., & Jainchill, N. (1994). Circumstances, motivation, readiness and suitability (The CMRS Scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse, 20*(4), 495–515.

[63] Simpson, D. D., Joe, G. W., Broome, K. M., Hiller, M. L., Knight, K., & Rowan-Szal, G. A. (1997). Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 279–293.

[64] Tsuang, J. W., Fong, T. W., & Andrew, P. H. (2003). Dual diagnosis and treatment compliance. *Psychiatric Services, 54*(4), 574–576.

TABLE 11: PROGRAM SIZE AND LENGTH OF STAY (FY04)					
PROGRAM VARIABLE	VISITED PROGRAMS		NONVISITED PROGRAMS		
	A	B	C	D	E
Beds	64	52	25	Not Ascertained	8
Discharges Per Yr: **Program completers** **Early terminators**	184 Not Ascertained 15 (8%)	356 139 (39%) 217 (61%)	18 Not Ascertained Very Low	36 Not Ascertained Very Low	30 21 (70%) 9 (30%)
Average length of stay (ALOS) **ALOS for early terminators**	5 mo Not Ascertained	43 days 5 to 50 days	9 mo Not Ascertained	10 mo Not Ascertained	Not Ascertained 30 days
Maximum treatment (mo)	Not Ascertained	6	Not Ascertained	12	3

Analytic Questions: How are the programs in this setting funded and what are the implications for evaluability, if any? What are key differences among the programs in institutional and program resources, constraints, and staff? What effects do these have on discharge planning characteristics and evaluability?

Table 12 shows that residential treatment centers primarily serve youth funded by Medicaid, state funds, and child welfare. There are five primary payment combinations: Medicaid only, Medicaid and child welfare, Medicaid and state funds, juvenile justice, and Federal grants. The payment source affects the discharge planning processes that are followed. For example, child welfare case workers may take the lead on obtaining a foster care placement, while program staff may have this responsibility in other cases. Different agencies also pay for different portions of the full service package; the Medicaid agencies can pay only for the treatment component of the residential program, and the state mental health or the child welfare department will reimburse the program for all room and board expenses.

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) located within DHHS is a major funding source for the two programs that treat youth with substance use disorders. Because the Federal Government requires the use of standardized assessment and outcome instruments and the collection of postdischarge data, SAMHSA grantees tend to conduct more rigorous initial and postdischarge assessments of youth than do other programs.[65]

[65] Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson J., Liddle, H., Titus, J. C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*(3), 197–213.

The source of program funding has several important implications for discharge planning. We learned that instead of one discharge planning process at a program, there may be multiple discharge planning tracks depending on which agency is funding the youth's treatment and what that agency requires. There are substantial differences in treatment and discharge planning procedures that may be driven by funding sources (e.g., Medicaid, child welfare, juvenile justice, and SAMHSA grants), or the state of residence of the youth in the case of programs that serve a multistate area. For example, in Program B, only the youth who are participating in the SAMHSA-funded research study are followed after discharge and receive case management services. Another example is that in Program A, the parents of youth who were court ordered into treatment from two states were required to participate in family treatment (presumably increasing the likelihood of family reunification), while there were no comparable requirements from the other state that Program A serves. In selecting a program for study, it would be critical to consider the implications of these differences in treatment and discharge planning tracks and whether it was reasonable to aggregate youth from different tracks in a single sample. This could limit which programs are suitable to include in a study, since those with low numbers of annual discharges in a given track might need very long enrollment periods to obtain sufficient numbers of clients for a rigorous quantitative study.

Researchers also inquired about the adequacy of program funding for discharge planning. Four of the five programs reported that they consider their funding adequate for discharge planning. Payment for discharge planning is usually included in the inpatient treatment rate. The exception is Program B, which is able to bill Medicaid for the nonclinical aspects of discharge planning such as completing applications and arranging community-based services. If it becomes necessary to estimate the cost of the discharge planning process, the absence of separate billing for discharge planning might make it more difficult.

The relatively large service areas of these programs have implications for staff knowledge of local resources in the client's home community. Program A serves a three-state area, so it is unlikely that program staff could be familiar with local resources in many of their clients' home communities. In one of the three states that Program A serves, staff members are based in that state to assist in the discharge planning process, but challenges remain for the other two states. Similarly, Program B reported clear differences in its ability to develop effective discharge plans depending on whether the client was from an area nearby or a more distant part of the state. Both programs reported that community resources also tended to be relatively scarce in more rural areas.

TABLE 12: PROGRAM FUNDING					
FUNDING CHARACTERISTIC	**VISITED PROGRAMS**		**NON-VISITED PROGRAMS**		
	A	**B**	**C**	**D**	**E**
Major funding sources	Medicaid State funds Child welfare	Medicaid State funds Child welfare State alcohol & drug Federal grant	Medicaid State funds	Medicaid State funds Child Welfare Juvenile Justice	Federal grant
Funding adequacy	Adequate	Adequate, except for complicated cases	Inadequate	Adequate	Adequate
Separate DCP billing	No	Yes	No	No	No

Analytic Questions: Do the programs have each of the elements of exemplary discharge planning? Which elements appear to be missing and with what effect on outcomes and evaluability? Can discharge planning be disentangled from other program activities in this setting? If not, what are the implications for evaluability?

As initially mentioned in the discussion of Table 12, the discharge planning process depends not only on the funding stream(s) for which youth are eligible but also on who has legal custody of the youth. The most straightforward discharge planning process is for youth who will be returning to their families. No other public agencies are usually involved in these situations. For youth who are in state custody, the child welfare department is involved, which means membership on the discharge planning team and may include responsibility for selecting and approving the foster placement and approving the discharge plan. For youth involved in juvenile justice, their probation officer is involved, which also means membership on the discharge planning team and may include responsibility for arranging the aftercare services. In cases where courts have ordered treatment, the court receives regular updates on the youth's progress and may require that parents participate in family treatment.

There are some key differences between Programs A and B. Program A conducts a more thorough housing assessment, develops two or more housing options, and collaborates with providers in three states. Program B serves youth only in a single state and appears to be more attuned to substance-use-related behaviors than to posttreatment residential placement.

Across programs, two key aspects of discharge planning—the identification of a living situation and aftercare services—occur within the clinical context as integral parts of the assessment and treatment. In addition, the preparation of the youth for aftercare services and the

next housing situation are consistently performed by clinical staff. This alignment of responsibility seems reasonable, but may further complicate disentangling discharge planning from other aspects of the treatment program.

As shown in Table 13, the RTCs use a number of well-established clinical assessment instruments for service planning; housing assessments are done more informally without the use of instruments. Program A conducts a more thorough housing assessment, including home visits, of the child's initial living situation and other possible living situations. Program B uses the findings from the Global Assessment of Individual Needs (GAIN), a highly structured and well-established comprehensive assessment protocol, to guide the discussion about the best living situation for the youth. In terms of matching community resources with the youth and their families, the counselors at both programs rely on their own professional experience. Staff at these programs thought that discharge planning quality would benefit from a more detailed procedures manual than their programs currently have.

Any future study would have to address the issue of differences in discharge planning process tracks associated with state of residence and funding source. The interprogram differences in the discharge planning process due to these factors, and particularly the differences in approaches to arranging postdischarge housing, could limit program comparability. It also appears that it would be challenging to disentangle discharge planning from other program activities.

TABLE 13: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS		
DCP COMPONENT	**PROGRAM A**	**PROGRAM B**
Early initiation of DCP	Begins before or upon admission.	Begins the first week of residential treatment.
Comprehensive assessment	Each youth undergoes an initial 21-day assessment which includes: Housing - Screen for runaway incidences - Develop a permanency plan Substance use assessment Psychological evaluation Nursing assessment Psychosocial assessment Recreation therapy assessment Education assessment Dietetic assessment, if needed Psychiatric evaluation, if needed <u>Standardized Assessments:</u> Child Behavioral Checklist Youth Self Report Family Adaptability and Cohesion Scale Family Assessment Measure General Scale	Determine discharge target Cognitive functioning Demographic data Legal status Treatment history Alcohol and drug use Physical health Risk behaviors and disease prevention Mental and emotional health Environment and living situation before treatment Legal history Vocational history <u>Standardized Assessment:</u> Global Appraisal of Individual Need (GAIN-I) GAIN-I Recommendation and Referral Summary (G-RRS).
Housing assessment	During the initial assessment, the program completes a thorough evaluation, including home visit, to determine whether the child will be able to return to his or her family. The program or child welfare agency assesses each potential placement.	During the development of the initial treatment plan, informal staff discussions take place about youth and family needs.
Identification of responsible individual	Yes. The counselor is responsible for discharge planning.	Yes. The primary counselor is responsible for discharge planning.
Team approach	Yes. Direct care staff, psychiatrist, nurse, child welfare case worker, probation officer, and school representative.	Yes. Primary counselor, case manager, child welfare case worker, and probation officer.
Community collaboration	Some collaboration with community providers by telephone. Schools are involved in 50% of cases.	Community providers are not usually involved in the discharge planning meetings.

TABLE 13: PROGRAMS' DCP CHARACTERISTICS (Continued)		
DCP COMPONENT	**PROGRAM A**	**PROGRAM B**
Comprehensive DCP	Strong housing assessment. Develops two or more housing options. Provide family treatment. Prepares youth for next living situation. Refers youth to services. Develops linkages.	Weak housing assessment Develops housing options, except for youth in child welfare and probation Provides family treatment. Prepares youth for next living situation. Refers youth to services. Develops linkages.
Appropriate DCP to fit client's needs	Programs say that they individualize services.	Programs say that they individualize services.
Client/Family involvement	State #1 and #2: Parents under court-ordered treatment are required to participate in family therapy twice a month. Families are invited to attend family therapy. The program provides transportation assistance. Youth are extremely involved.	Families are invited to attend family therapy. Youth are extremely involved. The youth contact some of their outpatient providers and develop a personal recovery plan.
Independent living services	The program has developed its own independent living program.	The program is able to refer youth to an independent living program in the community.
Postdischarge followup	2-yr followup survey of all youth. Youth on Medicaid in state #1: With its own funds, program offers community integration staff who follow the youth and family for 12 weeks and assist with resource access.	The program conducts followup surveys on all youth. Followup case management and service delivery is limited to youth in a Federal study.
Supportive external factors	The Medicaid Programs in States #1 and #2 offer case management.	Transitional Living Program in the Community.

Analytic Questions: What characteristics of the discharge planner need to be considered, and how might they be measured? What characteristics could be evaluated, and how do these vary by setting?

Table 14 indicates that counseling staff are primarily responsible for discharge planning. In four of the five programs, the counseling staff have bachelor's degrees, usually in psychology. Several programs reported low staff turnover rates, with no staff turnover in the preceding year. Most of the programs provide only informal training on discharge planning, such as on-the-job training and job shadowing. Program A is the only program to provide formal training and to conduct any routine quality assurance efforts. The program's monthly reviews of discharge plans

are limited to timeliness (i.e., within 3 days of case meetings) and completeness. The completeness review examines whether current information is listed for the type of living situation, vocational information, aftercare information, date and time of aftercare appointment, medical provider listed, education information listed, other needs listed, necessity for continued stay documented, justification for changes in plan, expected next level of care, and discharge dates.

The generally poor documentation of standard discharge planning activities is one of the most serious impediments to studying the discharge planning processes at these programs. All programs had largely open-ended forms for discharge planning. Most programs lacked a detailed discharge planning manual and formal training on discharge planning. Most programs reviewed the quality of discharge plans in weekly case and supervisory meetings. The lack of standardized staff training would be expected to result in inconsistency across the staff performing discharge planning functions. This absence of formal procedures and inconsistency in staff practices would limit the ability to generalize the conclusions of any study of these programs; it would be difficult to know what practices had led to any results observed.

While high turnover is a potential problem in many human service programs,[66] there is little evidence of turnover problems in these programs. Staff education requirements were either for bachelor's or master's degrees. A higher level of discharge planning competency would be expected in programs with lower staff turnover and higher levels of education and/or experience. In addition, it would be easier to implement a discharge planning protocol in a program with lower turnover because of the less frequent need to conduct staff training on the protocol.

[66] Burton, J. C. (2002). Alternative organizing principles for the design of service delivery systems. *Administration in Social Work, 26*(2), 17–39. Libretto, S. V., Weil, J., Nemes, S., Linder, N. C., & Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs, 36*(4), 489–495.

TABLE 14: CHARACTERISTICS OF DISCHARGE PLANNER					
CHARACTERISTIC	**A**	**B**	**C**	**D**	**E**
Who does DCP at program?	Counselors Community integration staff (only for State #1)	Primary Counselor Case Manager	Care Manager Customer Care Specialists (CCS)	Lead Clinician	Residential Counselor
Training	Formal & ongoing	No formal training Job shadowing	Not Ascertained	On the Job Continuing Education	Not Ascertained
Credentials/Qualifications	M.A.	B.A.	CM: B.A. 8 yr of experience CCS: B.A.	M.A. Experience preferred	B.A. Experience Alcohol and drug counselor certification
Job tenure/Turnover	18 mo	Not Ascertained	None in past year	None in past year	Not Ascertained

B. Client Characteristics

Analytic Questions: What individual characteristics of the target population need to be considered, and how might they be measured? What target population(s) in relation to homelessness could be evaluated, and how do these vary by program?

Table 15 summarizes key client characteristics at the five residential treatment programs. Two of the residential programs treat only female youth. The other three programs treat both genders, with two programs treating more males than females. Three of the programs treat youth with emotional disorders or conduct disorders. Two of the programs primarily treat youth with substance use disorders. The programs admit youth ages 8 to 18. Only one program treats youth younger than 12.

A few programs specialize in the treatment of specific populations. For instance, one program will accept only adolescent females who are either pregnant, have children, or are at a high risk of pregnancy. Another program specializes in treating youth who are sex offenders, developmentally delayed, or both. These individual characteristics would be important to take into account as mediating variables in a future study, especially those characteristics that may increase the difficulty of locating placements and arranging services.

Because RTCs serve youth who have not reached the legal age of majority, very few clients are discharged without appropriate housing. The most common goal of the discharge plan is for the youth's return to his or her family or a foster family, although some plans call for placement in another care setting. In addition, all RTCs contacted have policies against the discharge of youth to a state of homelessness. However, there are subpopulations that are at high risk for homelessness, including youth who terminate treatment early, run away, or age out of foster care. There are also youth who have committed sex offences and set fires that are extremely difficult to place.

Individual characteristics that would need to be considered as possible mediating variables in a future study include serious emotional disturbances, substance use disorder, co-occurring disorders, age (and particularly age of emancipation), gender, legal status, repeat visit to program, and juvenile justice involvement.

TABLE 15: CLIENT CHARACTERISTICS (FY 2003)

	VISITED PROGRAMS		NONVISITED PROGRAMS		
CHARACTERISTIC	**A**	**B**	**C**	**D**	**E**
Age	12–17	15–18	12–18	8–18	12–18
Gender	Male (82%)	Male (63%)	Female (100%)	Female (73%)	Female (100%)
Diagnosis	Emotional disorders	Substance abuse disorders Emotional disorders	Conduct disorders	Emotional disorders	Substance abuse disorders
Previous system involvement	Not Ascertained	100%	Not Ascertained	Not Ascertained	Not Ascertained
Prior homelessness	Not Ascertained	18%	25%	Not Ascertained	Not Ascertained
Risk of homelessness	8% run away Older youth Sex offenders	Older youth Early terminators	Older youth	Older youth	Older youth Early terminators

C. Community Descriptions

Analytic Question: How available are the key community resources and what are the implications for evaluability?

RTCs provide services to youth from large geographic areas spanning sizable regions within states or multiple states in some cases. The availability of community services varies widely with fewer resources consistently reported in rural areas (Table 16). Programs examined in the documentary analysis also indicated shortages of specific services such as intensive in-home treatment, support services, outpatient substance abuse treatment, school services, and child psychiatrists. All five programs indicated there were severe affordable housing shortages in their communities. To address this gap, four programs developed transitional living programs, most of which offered housing. Since many of the youth treated at residential programs are too young to be able to legally live independently, the availability of foster families and group homes are additional housing alternatives for this population. A future study should include as variables whether a program has an affiliated transitional living program or whether there is a transitional living program in the area.

Community resources have several implications for evaluability. Since residential treatment programs serve youth from broad geographic areas, resource availability would be more appropriately measured for each youth's planned discharge community (rather than for the community in which the RTC is located). In addition, the common shortage of services in rural areas suggests the need for the inclusion of a mediating variable measuring the level of urbanicity of each youth's planned discharge community. As discussed previously, discharge planning staff are also less likely to be aware of what resources are available in large or distant service areas and this too can affect the quality of a discharge planning process.

TABLE 16: AVAILABILITY OF COMMUNITY RESOURCES		
RESOURCE	**PROGRAM A**	**PROGRAM B**
Housing	Umbrella agency runs a group home for older youth with developmental delays. Community housing varies widely across the three-state region served.	Transitional Living Program in the immediate area. Program serves a large state and staff knowledge of community resources is more limited in distant areas.
Community-based Mental Health Services	Home state: Broad array of services available State #1: Outpatient mental health services available, in-home services unavailable, limited services in rural areas State #2: Medication management and outpatient therapy are easy to find. In-home services are available	Limited availability for outpatient services and medication management More limited in rural areas
Outpatient Substance Abuse Treatment	Not Ascertained	Limited availability More limited in rural areas
Case Management Services	Inadequate in States #1 and #2	Not Ascertained

Analytic Questions: What other community agencies are involved in discharge planning? What is their role? Does this differ by setting or by subpopulations within settings?

Table 17 shows that program staff have fewer discharge planning responsibilities for youth in child welfare and criminal justice. For youth who are in state custody, the child's welfare case manager is a member of the discharge team and usually is responsible for locating a foster family and approving the discharge plan. Youth in juvenile justice also have different discharge planning procedures. The youth's probation officer is part of the discharge planning team and often locates housing and arranges services after discharge. Because youth in state custody or in juvenile justice have different discharge planning processes, a future study would have to carefully consider whether it is appropriate to aggregate these distinct subpopulations. If the subpopulations were studied separately, then it would be necessary to obtain an adequate sample size for each.

Community collaboration is a challenging dimension to measure. We learned that four of the five programs have informal relationships with community providers. One program systematically evaluates its informal relationships with other agencies and ceases collaboration with poor performers. We learned that even when a program has a written agreement with another agency, the actual relationship may be quite different. Other indications of special

relationships include lending staff and serving on each other's boards. In sum, the quality of relationships with collaborative agencies is revealed in the working relationships rather than the existence of formal agreements. The effectiveness of the interagency collaborations will vary among the RTCs, depending on their management approach. The collaborations will also vary between each RTC and its external partners, depending on the management approach of the partners. Furthermore, with youth coming from such dispersed geographic areas, the quality of collaborative relationships between residential treatment programs and community agencies varies widely.

TABLE 17: COLLABORATIVE AGENCIES	
PROGRAM A	**PROGRAM B**
Juvenile Justice: Probation officer is part of discharge team. Court receives monthly treatment updates. Court requires that family attend family therapy and treatment.	**Juvenile Justice:** Probation officer is part of discharge team. Probation officer arranges aftercare.
Child Welfare: Caseworker is part of discharge team. Caseworker conducts own search for foster families. Caseworker approves the final placement and discharge plan.	**Child Welfare:** Caseworker is part of discharge team. Caseworker conducts own search for foster families. Caseworker approves the final placement and discharge plan.
Community Agencies: Schools are frequently members of discharge team. Other agencies rarely involved in discharge planning.	**Community Agencies:** Rarely involved in discharge planning.
Type of Relationship with Community Agencies	
Informal Relationships: This program treats youth in three states. Program staff were unable to name any particular organizations with which they have a special relationship.	**Formal Relationships:** Due to a JCAHO accreditation requirement, this program has over 100 MOUs. Despite written agreements, the program has the strongest relationship with agencies in the city and neighboring counties.
	Resource Sharing: To strengthen relationships, the umbrella agency provides staff who offer substance abuse screening and treatment groups at community agencies. An important partner was identified as the local Supportive Independent Living Program (SIL). Umbrella agency professional staff serve on the SIL program board.

D. Research Issues

Analytic Question: What is the appropriate followup period after discharge to determine clients' housing status and other outcomes, and what are the implications for evaluability?

As shown in Table 18, all five programs conduct some type of followup survey to learn about the youth's experience after discharge. Most followup surveys have a customer satisfaction orientation and therefore fail to ask questions about postdischarge service use and the permanency of the housing placement (instead they ask about the youth's living situation at the time of the survey). However, three of the programs collect the other variables of interest on service use, medication, school attendance and employment. All the surveys include questions on the youth's current living situation.

The followup response rates are known for Programs A and B. Program A's followup rates are respectable, but do decline to marginal levels over time: 80 percent follow up at 2 weeks, 74 percent at 6 months, 67 percent at 18 months, and 60 percent at 24 months. Ideally, any future study would need to improve the followup rates. Recent research has shown that misleading conclusions can be reached when followup rates are 70 percent or below.[67] With low followup rates it is likely that the program is failing to reach youth at the highest risk and could have inaccurate outcome findings. Possible evidence of this is the fact that children who had been in state custody were the most difficult to track. Program B's followup survey effort, which is funded by a SAMHSA grant, achieved a 3-month followup rate of 100 percent, although longer term followup rates were not ascertained. The high rate for Program B shows that with enough funding and effort, a very high followup rate can be obtained for this population. It should also be noted, however, that Program B has an early termination rate of 61 percent and it is not clear to what extent those who leave the program early are included in the followup survey. Typically, those who terminate program participation early may be at greater risk of homelessness. Judging from our prior experience, the followup rates achieved by both Programs A and B are unusually high.

The implication for evaluability is that all the programs examined have some form of followup survey efforts that a future study could improve. It would be necessary to make sure all

[67]Scott, C. (2004). A replicable model for achieving over 90% followup rates in longitudinal studies of substance abusers. *Drug and Alcohol Dependence, 74*, 21-36.

youth admitted to the program (including early terminators) were followed, that response rates were high, and that the survey questions include all the outcomes of interest. All the program's existing efforts would be able to track youth for the 90-day period that the expert panel recommended to measure service linkages. However, it may be appropriate to extend the followup period for this population of youth who are involved in intensive treatment and whose programs typically measure 1–2 year outcomes. Youth programs are always addressing maturation factors in addition to other presenting problems. The risk of homelessness is relatively small as long as the youth are in the custody of the state or others, although the phenomenon of runaway and throw-away youth homelessness is not to be discounted.[68]

It would be particularly important to follow a subpopulation of discharged youth who had reached the age of emancipation since this is when the risk of homelessness becomes much higher. The need to have an adequate sample size of youth who have reached the age of emancipation may make it necessary to extend the client enrollment period since not all those discharged are of age.

Another consideration is that two of the five programs provide postdischarge services, usually case management or outpatient services, as part of their residential service package. The provision of some type of postdischarge service by the program, usually case management, after discharge should enhance the likelihood that the discharge plan would be successfully implemented. A future research study would need to adjust for programs that provide postdischarge services such as case management or counseling. Again, those who terminate early would not be likely to receive postdischarge services.

[68] Brown, S. A. (1993). Recovery patterns in adolescent substance abuse. Baer, J. S., Marlatt, G. A., & McMahon, R. J. (Eds.), *Addictive behaviors across the life span* (pp. 161–183). London: Sage Publications. DeLeon, G., Melnick, G., Kressel, D., & Jainchill, N. (1994). Circumstances, motivation, readiness and suitability (The CMRS Scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse, 20*(4), 495–515.

TABLE 18: CLIENT FOLLOWUP AFTER DISCHARGE					
FOLLOWUP DESCRIPTION	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**		
	A	**B**	**C**	**D**	**E**
Program follows client	Yes	Yes (only for youth in grant-funded study)	Yes	Yes	Yes
Nature of followup	Survey Care Specialists (CS)	Survey Case Management Services (Early terminators may not receive followup)	Survey Staff available to answer questions	Survey Case Management	Survey
Length of followup	Survey: 2 yr CS: 3 mo	Survey: 1 yr	Survey: 1 yr Staff: 30 days	Survey: NA CM: 30 days	1 yr
Data Collected					
Living situation	Yes	Yes	Yes	Yes	Yes
Outpatient mental health services	Yes	Yes	No	No	Yes
Psychiatric medication	Yes	Yes	No	No	Yes
School attendance	Yes	Yes	No	No	Yes
Employment	Yes	Yes	No	No	Yes

Analytic questions: What types of data are available from what sources, what is the data quality, and what are the implications for evaluability? Is the type of outcome data recommended by the expert panel available, including homelessness indicators?

As shown in Table 19, the two site-visited programs have a large amount of electronic data on client characteristics and some followup data. The existing postdischarge survey instruments could readily be expanded to collect all the data recommended by the expert panel.

An interesting observation regarding the postdischarge data is that four of the five RTC programs are parts of umbrella agencies that also provide outpatient services. In two cases, the umbrella agencies are the largest providers in their service areas and many youth are referred to their outpatient services. During the site visits, we learned that it would be relatively easy to obtain data from these programs. One program believed that a blanket consent to research would apply to any future study. Designers of any future study should consider the implications of having the same program providing residential and postdischarge services. It is likely to increase the probability that the discharge plan will be executed as planned, and also makes outcome data

more readily available. As mentioned previously, those who terminate early would be less likely to receive postdischarge services.

Obtaining postdischarge service use data for the large number of youth on Medicaid would probably be possible, but time-consuming. All state Medicaid agencies collect claims data on enrollees in fee-for-service and managed care arrangements. We were unable to explore the availability and quality of the Medicaid claims data during the site visits. However, other research studies on Medicaid claims data have found the need for data cleaning and that there is a lag before a service claim enters the MIS system. The research has also found variable quality and completeness of service data from managed care Medicaid plans.[69] We did not explore whether the child welfare or juvenile justice data on living situation would be available to a potential study. It is always critical to remember that service data may be unavailable for those who are noncompliant and not participating in voluntary services. This means that some of those at greatest risk of homelessness may not appear in the services data.

TABLE 19: DATA AVAILABILITY		
TYPE OF DATA	**PROGRAM A**	**PROGRAM B**
Predischarge:		
Client assessments	Psychiatric evaluation Psychological evaluation Child Behavioral Checklist Youth Self Report Family Adaptability and Cohesion Scale Family Assessment Measure General Scale Psychosocial assessment Nursing assessment	Global Appraisal of Individual Needs (GAIN) GAIN-I Recommendation and Referral Summary (G-RRS).
Services outcomes	Survey	Survey
Program's data format	Electronic includes faxes, emails, and phone contact	Electronic

[69] Woolridge, J. H. (2000). Perils of pioneering: Monitoring Medicaid managed care. *Health Care Finance Review, 22*(2), 61–83.

TABLE 19: DATA AVAILABILITY (Continued)		
TYPE OF DATA	**PROGRAM A**	**PROGRAM B**
Program's data quality	High quality: Most items are selected from a drop-down menu. Program identifies and fixes missing data.	Variable: GAIN data is of high quality. The electronic record system is new. Program has not conducted systematic quality reviews. Information required by the state is the best. Staff receive training on proper data entry. Staff tends to input data in open-ended notes rather than selecting fixed menu options.
Postdischarge: **Services & outcomes**	Medicaid agency would have postdischarge service data for youth on Medicaid. Medicaid-funded case managers would have data on housing situation. Probation officers and courts would have data on youth's service use and housing situation. Child welfare would have postdischarge data on housing situation of youth in state custody. The program would have data in terms of housing situation and service use on Medicaid youth in organization's home state. Data on followup-services use would be available directly from other agencies. No data may be available for those who have reached maturity and do not receive services.	Medicaid agency would have postdischarge service data only for youth on Medicaid. Medicaid-funded case managers would have data on housing situation. Probation officers and courts would have data on youth's service use and housing situation. Child welfare would have postdischarge data on housing situation of youth in state custody. Data on followup-services use would be available directly from other agencies. No data may be available for those who have reached maturity and do not receive services.

Analytic Question: What are the relevant independent, dependent, and mediating variables that should be studied in each setting? How could they be defined and operationalized?

Table 20 shows variables that might be included in a study of housing outcomes associated with residential treatment centers. Independent variables would measure various

aspects of the discharge planning process including the efforts of the program, juvenile justice, child welfare and other involved agencies. Dependent variables would measure housing, mental health, substance abuse, and linkages to services. Mediating variables would capture youth characteristics, the program's relationship with community agencies, and the availability of community resources that influence the ability of the program to achieve outcomes.

TABLE 20: POTENTIAL RESEARCH VARIABLES AND MEASURES	
VARIABLE	**MEASURES**
Independent	
Discharge planning received	Early initiation Comprehensive assessment Housing assessment Identification of responsible individual Team approach Community collaboration Comprehensive DCP Client/family involvement Independent living services Postdischarge followup Supportive external factors
Dependent	
Housing	At discharge At followup
Linkages	Linkages in place to services needed after discharge
Mediating	
Treatment	Type of residential treatment and service dosage
Other agencies involved	Child Welfare Juvenile Justice
Mental health	Mental health assessment at discharge
Substance abuse disorder	Substance abuse assessment at discharge
Youth characteristics	Age Mental health diagnosis Substance abuse diagnosis Dual diagnosis Foster care experience Juvenile justice Education Employment Special characteristics (sex offender, developmental disability)
Relationship with community agencies	Refers youth to umbrella agency for outpatient services Special relationship with community provider
Community resources	Urbanicity Availability of mental health services Availability of substance abuse services Availability of Supported Independent Living Program Housing costs

E. Summary and Conclusion

Through the site visit, we learned that Program B's informal discharge planning documentation resulted in infidelity to the program's intent. The program was not consistently providing youth with recovery planning forms and sharing discharge records with one community provider. A more general challenge to evaluability in these settings is the general lack of standardization of training and procedures. With one exception, the discharge planners at each program underwent only informal training on the job and through ongoing supervision. None of the programs had a detailed procedural manual which described discharge planning in sufficient detail to assure consistent practice.

We learned that each residential treatment program has multiple discharge planning processes which are shaped by the respective funding sources (Medicaid, child welfare, juvenile justice, or Federal grants). Most of the RTCs also tend to serve large geographic areas, so there can be considerable variation from client to client in what postdischarge resources are available in their scattered home communities. Staff are limited in the extent to which they can know about the resources available in all the different communities, and the rural communities in particular are likely to have limited service availability. The challenge of developing and maintaining strong interorganizational relationships with the housing and service agencies in all these scattered communities presents another challenge.

It also appears that it would be difficult to disentangle the discharge process from other aspects of the program. Discharge planning is not financed separately. The discharge plan is developed as part of the clinical treatment plan. The same clinical staff that are responsible for treatment also develop the discharge plan, identify the next housing options, prepare the discharge plan, and arrange the aftercare services.

Another considerable challenge to a future quantitative study of discharge planning is the small number of youth who are at high short-term risk for homelessness. One study has estimated that 12 percent of youth will have an episode of homelessness within 12–18 months of exiting from foster care.[70] A study by Embry[71] et al. (2000) found that about one-third of youth

[70] Courtney, M. E., Piliavin, I., Grogan-Kaylor, A., & Nesmith, A. (2001). Foster youth transitions to adulthood; A longitudinal view of youth leaving care. *Child Welfare. 80*(6), 685–717.

[71] Embry, L. E., Stoep, A. V., Ryan, K. D., & Pollock, A. (2000). Risk factors for homelessness in adolescents released from psychiatric residential treatment. *Journal of the Academy of Child and Adolescent Psychiatry, 39,* 1293–1299.

exiting psychiatric residential treatment would become homeless within *5 years*, but provides no estimate of the homeless rate for the first 12 months. This study does suggest that the rate may be somewhat lower for youth with mental disorders. Because most youth served are under the age of emancipation, all programs have policies prohibiting the discharge of youth without an appropriate living situation. As a result, in order to examine homelessness as a key outcome, a future study would need to have a long followup period and/or target programs that serve older youth and youth at higher risk, particularly those who have homeless histories, depart the program prematurely, become emancipated during treatment, or are difficult to place.

As discussed earlier, a future study may want to disaggregate residential treatment centers that primarily treat youth with serious emotional disturbances from centers that primarily treat youth with substance use disorders. As shown in Table 11, these programs appear to differ in program ALOS and completion rates. As noted above, the youth may also have differential risk of subsequent homelessness.

In summary, the social problem of youth homelessness following discharge from these settings is a serious one and deserves thoughtful attention and rigorous study. However, it is not clear that these programs have a well-developed model of discharge planning that could be readily evaluated in a rigorous quantitative study

Inpatient Adult Psychiatric Setting

Researchers collected and analyzed documents related to discharge planning from five adult inpatient psychiatric programs, which were described in the documentary analysis. Three of the sites are public hospitals, and two are psychiatric units within larger private hospitals. Each of these programs provides acute care to adults with severe psychiatric disorders at a level of acuity requiring inpatient treatment. A wide range of psychiatric illnesses is treated in each of the five sites. Co-occurring substance use diagnoses (a key factor in risk of homelessness) are common to the patients served across all sites, and significant co-occurring medical problems are addressed at all but one state hospital, which refers those cases to another state facility. At all of these sites, discharge planning is embedded in the treatment planning process, which is executed by an interdisciplinary team. Funding comes from the state in the case of public hospitals and from third-party payers, including Medicare and Medicaid, in the case of the private hospitals. Each of the programs serves significant numbers of patients who are homeless or at risk of homelessness, and focuses on housing needs as part of the discharge planning and treatment process. All of the programs cite lack of housing options as a major barrier to effective discharge planning.

The two programs we visited were, in some ways, strikingly different. One was a private hospital located in a large urban area, and the other was a public hospital located in a very rural area. These two programs were selected on the basis of their diverse characteristics, recommendations from stakeholders regarding their promising discharge planning practices, and their willingness to participate as expressed during the documentary analysis process.

While both sites we visited have promising practices in discharge planning and are able to articulate them, the public hospital has a detailed discharge planning protocol, written agreements defining the roles of the hospital, the state Department of Mental Health (DMH), and the local Mental Health Authorities (MHAs), and detailed forms and processes that help ensure consistency. In contrast, the private hospital has little in the way of agreements, procedures that are well defined in writing, or forms and processes to ensure consistency. At the private hospital, discharge planning is primarily the responsibility of the hospital staff, who work with community-based programs. At the public hospital, discharge planning is primarily the responsibility of community-based agencies (local MHAs), which work with the hospital social workers.

There were, however, also striking similarities between these two sites. Both programs have principle-centered leadership at institutional and departmental levels, and researchers found staff members of both programs to be knowledgeable and very dedicated. While the community settings were very different, housing resources were inadequate in both settings, though the choice of housing options was practically nonexistent in the rural setting.

It became clear early on that there are differences between public and private hospitals that would make it very difficult to evaluate discharge planning in these settings in the same study. Moreover, the two institutions we visited both had unique characteristics that would make it challenging to identify appropriate comparison sites for an evaluation of discharge planning in either.

A. Program Descriptions

Analytic Questions: What are the characteristics of this setting in terms of size, length of stay, early terminators, and program completers? How does this affect discharge planning activities, outcomes, and evaluability?

In the documentary analysis, we looked at adult acute care units within three state-operated mental health facilities (Programs B, C, and E) and within two private general hospitals (Programs A and D). Public hospitals consistently had a higher number of beds than private ones. Program A, a public hospital site visit program, had more than twice as many adult acute care beds as Program B, a private hospital site visit program.

The average length of stay (LOS) ranged from 7–14 days across facilities. The shortest LOSs often occurred when a patient left against medical advice (AMA) and/or at the end of a 72-hour temporary detention order. The private facility we visited reported only 1 percent to 2 percent of patients leaving AMA. The public facility reported that 10 percent of all discharges are from the commitment hearing, which must take place within 72 hours of admission.

In all programs reviewed, acute inpatient care is intended to be short-term. The average LOS in psychiatric inpatient settings is significantly shorter than in the other three settings examined in this study (foster care, substance abuse treatment, and residential treatment centers for youth). Private hospitals are under intense pressure from insurers and managed care

organizations to minimize patient LOS. State mental health systems have a goal of providing as much care as possible in the community and also try to minimize LOS.[72]

The short LOS poses a great challenge to discharge planners in these acute care settings, especially for those patients who are homeless or at risk of homelessness. While staff attempt to follow the same steps in discharge planning for all patients, there is obviously a limit to what can be accomplished in a few days. This is particularly problematic with regard to securing appropriate housing for those who are homeless or at risk of homelessness. While the range of housing options was much broader in the urban setting (Program A) we visited than in the rural setting (Program B), the scarcity of housing units and the need for careful matching of patient to housing was the same. Program A documented in an internal study done in 2001 that homeless patients had an average LOS that was 3 days longer than all other patients—a reflection of the challenge of locating placements and the willingness to extend the LOS.

A key exemplary practice of the two hospitals we visited is their willingness and ability to extend the LOS (sometimes significantly) when necessary to obtain an appropriate housing match. The public hospital (Program B) is able to do this through state funding. The private hospital (Program A), under increased pressure from managed care to shorten LOS, has gone so far as to raise charitable funds for this purpose. However, it is noteworthy that Program A has been threatened with closure because it is not recovering the cost of operation. Staff there were uncertain how long they would be allowed to continue measures such as extending the LOS of difficult-to-place patients. Staff at both sites view the ability to extend the LOS as necessary to achieving a satisfactory housing outcome in certain challenging cases. The shorter the LOS, the more compressed the discharge planning activities and the more difficult it is to achieve positive outcomes. Across the three sites not visited, extending the LOS to achieve a housing match is used at the other public hospitals (much more at Program C than at Program E), but the private hospital (Program D) lacks the ability to do so.

The patients with the shortest stays are often those who refuse treatment and leave against medical advice (AMA). This group of patients is more likely to have co-occurring substance use disorders and is at very high risk of homelessness.[73] They are, therefore, of particular interest in a

[72] Mark, T. L., & Coffey, R. M. (1999). What drove private health insurance spending on mental health and substance abuse care, 1992–1999? *Health Affairs, 22,* 165–172.

[73] Drake, R. E., Osher, F. C., Wallach, M. A. (1991). Homelessness and dual diagnosis. The *International Journal of Psychosocial Rehabilitation, 46*(11), 1149─1158. Folsom, D. P., Hawthorne, W., Lindame, L., Gilmer, T., Bailey, A., Golshan, S., Garcia, P., Unutzer, J., Hough, R., & Jeste, D. V. (2005). Prevalence and risk factors for homelessness and utilization of mental health

study such as this. Discharge can also be quite sudden following detention order hearings, where it is not uncommon to reach a finding that a person is mentally ill but does not currently present a danger to self or others. Discharge planners are faced with trying to provide the patient with some housing option, with little time to achieve the best match. Shelters are often the only option in these cases. It should be noted that Program A was in a state with a policy against discharge to shelters, but staff reported that they had no choice but discharge to shelters in a small but significant number of cases in spite of the policy.

As illustrated in Table 21 below, the variation in the number of inpatient beds in the five units examined (from 25 to 60) was moderate. (Certainly, many other psychiatric inpatient units are larger than these are, particularly at public psychiatric hospitals.) The number of monthly discharges, a function of the number of beds and length of stay, was about 60 for Program A and 122 for Program B. The early termination rate for Program B, at 10 percent, was much higher than the rate in Program A. The short average stays at both programs can make discharge planning difficult, and this is especially true for those who terminate treatment early. The higher early termination rate at Program B, the rural state hospital, could result in lower likelihood of a successful housing placement and, possibly, greater difficulty in obtaining client participation in followup after discharge. These factors would be significant challenges in trying to involve this program in an evaluation.

TABLE 21: PROGRAM SIZE AND LENGTH OF STAY

PROGRAM VARIABLE	PROGRAM				
	A	**B**	**C**	**D**	**E**
Beds (adult acute)	25	60	74	22	60
Discharges/Mo	60	122	Not Ascertained	Not Ascertained	Not Ascertained
Early terminators	1–2%	10%	Not Ascertained	Not Ascertained	1%
Maximum LOS	45–60 days	Yr	30–45 days	30 days	30 days
Ability to extend LOS	Yes	Yes	Yes	No	Limited
Average/Median LOS (days)	12	7–10	7–14	8–12	10

services. among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, 162(2), 370-376. Olfson, M., Mechanic, D., Hansell, S., Carol, A. B., Walkup, J., & Weiden, P. J. (2000). Predicting medication noncompliance after hospital discharge among patients with schizophrenia. *Psychiatric Services, 51*(2), 216─222.

Analytic Question: How are the programs in this setting funded and what are the implications for evaluability, if any?

Table 22 demonstrates that funding of sites within this setting vary depending upon whether the hospital is public or private. Private hospital services are funded mainly through third-party payers and a very few patients as self-pay. Public hospitals are funded almost solely through the state Department of Mental Health (DMH). Any third-party reimbursement goes to the state DMH. Funding for discharge planning comes from per diem charges for the patient's hospital visit for the private hospitals and from global hospital budgets in the case of the three state psychiatric hospitals. In all cases, there was no funding dedicated specifically to discharge planning.

Regardless of funding sources, all the programs included in the documentary analysis have inadequate funding. While Program A is part of a wealthy teaching hospital, the psychiatric inpatient unit fails to recover its costs and has been threatened with closure. All of the public hospitals have taken multiple cuts in funding over the last several years because of state budget crises. Although staff at all five sites expressed willingness, in principle, to participate in an evaluation, they made it very clear that the program would have to be compensated for costs incurred in conducting any evaluation study.

TABLE 22: PROGRAM FUNDING

FUNDING CHARACTERISTICS	**PROGRAM**				
	A	**B**	**C**	**D**	**E**
Major funding sources	Third-party payers Donations	State DMH	State DMH	Third-party payers	State DMH
Funding adequacy	Costs exceed revenues, but the unit is part of a wealthy university-based medical system.	No. The hospital budget has been cut repeatedly in recent years.	No. The hospital budget has been cut in recent years.	No	No. The hospital budget has been cut in recent years
Separate DCP billing?	No	No	No	No	No

Analytic Questions: What are key differences among the programs in institutional and program resources, constraints, and staff? What effects do these have on discharge planning characteristics and evaluability?

The two sites we visited (Programs A and B) differ markedly in terms of institutional resources. Both benefit from principled leadership and committed staff who place a high priority on discharge planning and avoiding homelessness. Program A is part of a wealthy university-affiliated teaching hospital system that has decided, for now, to continue operation of the money-losing program as a public service, and that has ample resources to do so. It is located in an affluent state that has a tradition of generous funding for health and human services, although this state too has tightened purse strings in recent years. This state's Medicaid program, a key funding source for many poor psychiatric patients, is relatively generous in eligibility and service funding.

The public hospital is located in a state that has traditionally been less generous in funding mental health care. The Medicaid program in Program B's state is one of the most restrictive in terms of eligibility. Program B is located in the poorest region of the state, where unemployment rates are chronically high, health status is poor, and public housing is nearly nonexistent.

The urban location of the Program A results in the need for dealing with a culturally diverse patient population, and this hospital provides interpreter services in 28 languages. Program B serves a much more homogeneous patient population. The characteristics of the patient populations served present different, but equally challenging problems for discharge planning.

A number of external forces affect discharge planning in both these hospitals. Program A, the private hospital, is subject to the constraints of doing business with multiple managed care programs. The hospital reports increasing pressures from managed care programs to decrease LOS as a cost control measure. The public hospital, operated by the state DMH, operates within the bounds of state code and regulations, as well as detailed written agreements which define its relationship to DMH and to the local Mental Health Authorities (MHAs) and a detailed discharge planning protocol. Discharge planning models in public hospitals are not easily portable because they involve state law and policy.

Both of the hospitals visited give attention to recruiting and retaining good staff, but the two differ markedly in terms of staffing resources. Because of its affiliation with a major teaching hospital, Program A maintains a high doctor-to-patient ratio and is part of the medical school's psychiatric residency program. Staffing is rarely a problem. Program A is located within a major university-affiliated medical center, which provides access to physicians in every medical specialty for consultation on the many patients with co-occurring medical problems.

Program B, the rural public hospital, on the other hand, has great difficulty recruiting staff of all kinds. Nearly half of the areas served by this hospital have been declared medical manpower shortage areas. There are few private providers of mental health care and a very limited number of psychiatric beds in the rural region. Program B has worked over the years to develop staff resources and has collaborated with local community colleges and other institutions of higher education to develop programs and provide advanced training for existing staff.

The differences noted in the two programs we visited demonstrate the variability of programs in this setting. Institutional resources, geographic location, payer sources, and institutional and systems policies all impact discharge planning. Site visits to these hospitals provided a sense of the many distinctions between public and private hospitals. These patterns were supported in the documentary analysis. Our visit to the private hospital pointed out many advantages which set it apart even from other private hospitals. This teaching hospital has higher doctor-to-patient ratios and, as a tertiary care center, the expertise to deal with co-occurring medical problems. In terms of evaluability these differences raise significant issues about selecting programs for inclusion in a future study.

Analytic Questions: Do the programs have each of the elements of exemplary discharge planning? Which elements appear to be missing and with what effect on outcomes and evaluability? Can discharge planning be disentangled from other program activities in this setting? If not, what are the implications for evaluability?

Discharge planning is integral to the treatment plan in the each of the five inpatient psychiatric programs we studied. Without exception, interviewed staff stated that discharge planning was closely linked to treatment. While researchers and program staff at the two sites we visited agree that discharge planning activities could be separated out and measured, discharge planning and treatment planning go hand in hand in these programs as they currently operate.

Table 23 summarizes how the elements of exemplary discharge planning are practiced at these sites. With the exception of postdischarge followup, both Program A and Program B have many of the elements of exemplary discharge planning and are able to articulate them. Program A, the private hospital, has little in the way of formal discharge planning procedures. It lacks well-defined, written policies, has little in the way of quality improvement review to ensure consistency in discharge planning practices, and uses rudimentary forms and notes to record discharge planning activities.

In contrast, Program B, the public hospital, has a detailed discharge planning protocol, written agreements defining the roles of the hospital, the DMH, and the MHAs, and detailed forms and processes that help ensure consistency. In fact, Program B's discharge planning procedures were the most highly developed among all the 19 programs examined in this study. Lead responsibility for discharge planning is clearly placed with the local MHA serving the patient's home region, with hospital staff in a supportive and assistive role. There are protocols on how to address disagreements between the hospital and the MHA regarding discharge plans (the state MHA mediates). In addition to a comprehensive standard form discharge plan that is given to the client and the MHA staff, there is a provision for a "crisis plan" that provides the patient with relapse prevention strategies and contacts for use in emergencies. There is a high-level review committee, including the hospital administrator, which helps to ensure discharge planning consistency and must sign off on any discharge planning that might result in a patient's discharge to a shelter or other undesirable outcome. Training on the discharge planning protocols is provided for new staff at each program, and televised systemwide training is offered whenever substantial revisions are made to discharge planning policies. One area of concern about the practices in Program B is the absence of formal assessment instruments, although the forms used are at least reasonably specific. The discharge planning protocol used by Program B is the clearest articulation of a model for the discharge planning process that we have found. Across the five sites studied, the three public hospitals all had more written policies, procedures, and agreements than the two private hospitals. However, none of the other programs had a protocol articulated as well as Program B's.

The discharge planning protocols developed by the state DMH and used by Program B may approach the level of consistency needed to effectively evaluate discharge planning. They are, however, highly context bound within the integrated state public mental health system in which they operate. They are specified in state law, regulation, and policy, and build on the

particular structure of local mental health authorities in that state. This would make it a challenge to locate an appropriate comparison group for an evaluation study.

Neither of the private psychiatric hospital units appear to have a well-developed model for discharge planning. They lack a discharge planning design that makes clear their goals and objectives and how those relate to program activities. While they do have standard procedures and forms, there is no written protocol to specify how to respond to commonly occurring problems, nor is there standardization of client assessment and measurement. Quality assurance and improvement procedures for the discharge planning process are not established. Insufficient information was obtained to assess whether the other state hospital units have well-structured discharge planning protocols, although Program C appeared to have some promising features and may be worthy of closer examination.

TABLE 23: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS		
DCP COMPONENT	**PROGRAM A**	**PROGRAM B**
Early initiation of DCP	Upon admission.	During prescreening by the MHA prior to admission or upon admission for the very few patients who are not prescreened.
Comprehensive assessment	Yes. While there appears to be a thorough assessment, including medical, mental health, substance use, psychosocial history, family and cultural issues, resources/eligibility status, housing, education work history, and functional ability capacity formal instruments are not used. There are relatively weak structural processes in place to assure consistency.	Yes. There is a thorough assessment. The MHA serves as a single point of entry for patients residing in that catchment area. The prescreening assessment includes patient history, evaluation, provider information, and treatment and discharge planning info. On admission a nursing assessment, brief physical and risk assessment, psychological and psychosocial assessments, and substance use and housing assessments are completed. Occupational therapy and rehabilitation assessments are performed, as indicated, during hospitalization. While formal instruments are not used in the assessment process, a detailed DCP Protocol and forms are in place and provide a measure of consistency.
Housing assessment	Yes. However, no formal instrument is used to determine the risk of homelessness.	Yes. However, no formal instrument is used
Identification of responsible individual	Yes. The assigned social worker is primarily responsible.	Yes. The Hospital Liaison from the local MHA is primarily responsible and within the hospital, the assigned social worker has primary responsibility. These roles are spelled out in Discharge Protocols promulgated by the DMH.
Team approach	Yes. An interdisciplinary team is involved in DCP.	Yes. An interdisciplinary team is involved in DCP. The MHA hospital liaison is a member of this team, and may also involve other MHA staff in the process, as needed.
Community collaboration	Yes. Unit has an unusually strong relationship to community resources, particularly DMH programs. No formal Memoranda of Understanding (MOUs), nor do community agencies participate directly in the DCP team.	Yes. The relationship of the hospital to local MHAs, structured by state policy, is very strong overall with some variance across MHAs.

TABLE 23: PROGRAMS' DISCHARGE PLANNING (DCP) CHARACTERISTICS (Continued)		
DCP COMPONENT	**PROGRAM A**	**PROGRAM B**
Comprehensive DCP	Yes. DCP highly individualized, based on thorough assessment, and considers various needs of patients at discharge. Linkage made to psychiatric and medical followup. Hospital staff evaluates potential eligibility of patients for entitlements and initiates enrollment process as applicable. Hospital provides medications to patients without prescription coverage, and provides prescriptions to covered patients.	Yes. DCP process is highly individualized, based on thorough assessment, and considers the various needs of patients at discharge. Linkage made to psychiatric and medical followup. Hospital staff evaluates potential eligibility of patients for entitlements and initiates enrollment process as applicable. Hospital provides medications to patients without prescription coverage, and provides prescriptions to covered patients.
Appropriate DCP to Fit Client Needs	To the extent scarce resources permit. DCP is culturally competent. DCP part of individualized treatment plan, considers patient needs and preferences. Translators in many languages available.	To extent scarce resources permit. DCP is part of individualized treatment plan designed to lead to discharge. It considers patient needs and preferences and is culturally competent.
Client/Family involvement	Yes. The patient, legally authorized representatives, and family members and friends, with patient consent, are included in the DCP process. Those involved are asked to sign the discharge plan.	Yes. The patient, legally authorized representatives, family members and friends, with patient consent, are included in the DCP process. When present at treatment team meetings, they are asked to sign the plan. If unable to attend these meetings, video conferencing is available.
Postdischarge followup	No. Only monitors readmission.	No. Only monitors readmission. Most discharged patients are eligible for MHA case management and other services.
Supportive external factors	Strong relationship with community agencies, particularly DMH.	Excellent regional collaboration around unmet needs. Good relationship with MHAs.

Analytic Questions: What characteristics of the discharge planner need to be considered, and how might they be measured? What characteristics could be evaluated, and how do these vary by setting?

Table 24 below summarizes the characteristics of those who are primarily responsible for discharge planning at the sites we visited. Training and credentials are similar for these two sites. Both facilities have reasonable tenure of staff and make a significant effort to attract and retain qualified staff. However, only Program B provides specific training on discharge planning protocols. The formal training in discharge planning practiced at Program B may enhance the likelihood of consistency in postdischarge outcomes and make this program more amenable to meaningful evaluation. It is also noteworthy that the role of primary discharge planner is within the hospital for Program A, while in the case of Program B, that role resides in a community

agency that also has primary responsibility for followup. These community agency MHA staff, who divide their time between the community and the hospital setting, may be more informed about local resources and better able than hospital staff to assess what housing and service arrangements are most workable. This is a significant difference in practices that might also be associated with differences in client outcomes and needs to be accounted for in any evaluation.

TABLE 24: CHARACTERISTICS OF DISCHARGE PLANNER		
CHARACTERISTIC	**PROGRAM A**	**PROGRAM B**
Who does DCP?	Assigned social worker primarily responsible. Often, nurse case manager and nursing staff assist.	Hospital liaison from local MHA primarily responsible and, within the hospital, assigned social worker has primary responsibility.
Training	DCP training largely on-the-job and focuses on learning community resources, making optimal patient housing matches, and establishing relationships in the community. Social workers and nurses are supervised and receive training both within the unit and from respective professional departments in larger medical center.	Social workers and MHA hospital liaisons trained in the State DMH Discharge Protocol when hired. Beyond this, there is a mentoring process for new social workers as they learn DCP process and available resources. Some ongoing training of hospital and MHA personnel, done in part through video conferencing.
Credentials/Qualifications	Social workers: B.A. or M.A. with LICSW.	Social work staff: B.A. or M.A. MHA hospital liaisons: B.A. or higher.
HOW LONG IN JOB?	3–5 yr	Social work staff: Varies widely: few years to 10 yr. MHA hospital liaison: Varies widely.

B. Client Characteristics

Analytic Questions: What individual characteristics of the target population need to be considered, and how might they be measured? What target population(s) in relation to homelessness could be evaluated, and how do these vary by program?

Characteristics of patients in this setting are summarized by site in Table 25 below. All patients in this setting have severe psychiatric disorders with a level of acuity requiring inpatient treatment. A substantial number of them have substance use disorder or significant medical problems or both. Program B reported a high rate of co-occurring developmental disorders and

serious mental illnesses. Many of the patients served have a history of homelessness or are at risk of homelessness.

Across programs, the target populations to be evaluated would be those with a prior history of homelessness and those at risk of homelessness. None of the programs used standardized instruments to collect housing history or assess the risk of subsequent homelessness. Program B did have a reasonably well-developed form to collect housing-relevant data. Sometimes patients are hesitant to admit to being homeless or having a history of homelessness. A significant number of patients at each of the sites studied are found to be at risk of homelessness during hospitalization. Hospital admissions not infrequently occur in response to crises that may necessitate a change of residence upon discharge. It is often determined that returning home is not an option or is not in the best interest of the patient and/or family or significant other/friend. In each site, many patients have histories of multiple hospital admissions. One hospital has documented that two-thirds of patients have been admitted more than once. Such a statistic is not atypical and brings home the importance of using unduplicated patient counts rather than numbers of admissions or discharges when determining how long it will take to achieve the desired sample size for a study.

Mental illness is a key risk for homelessness, as is a diagnosis of substance abuse.[74] Those patients with dual diagnoses who are homeless or at risk of homelessness tend to have multiple severe problems. As Table 25 shows, treatment of psychiatric disorders may be complicated by co-occurring developmental disabilities or medical illnesses. Discharge planning for these subgroups is extremely complex because of the number and severity of problems to be addressed, as well as to the complexity of the service delivery system in the community.

Another layer of complexity is associated with patient eligibility for community-based housing and services. Staff at Program A described very different discharge planning tracks depending on whether a patient was eligible for Medicaid, for DMH-funded services, both, or neither. Those who lacked eligibility for either Medicaid or DMH services were left with very few options for housing or postdischarge treatment. Similarly, a substantial proportion of clients in both programs visited had histories of prior criminal convictions that may make them ineligible for HUD-sponsored housing. Program B also reported limited service availability for the non-Medicaid eligible and particular problems in locating services for persons with co-occurring

[74] Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve. Highlight report. Findings of the National Survey of Homeless Assistance Providers and Clients U.S.* Washington, DC: The Urban Institute Press.

psychiatric and developmental disorders. Clearly, any evaluation of discharge planning must take into account a range of patient demographic and clinical characteristics as well as eligibility for services and entitlements. The need to recognize and possibly control for these interpatient differences could affect the effective sample sizes and the required duration of the client enrollment process.

TABLE 25: CLIENT CHARACTERISTICS

CHARACTERISTIC	PROGRAM				
	A	**B**	**C**	**D**	**E**
Age	≥ 18 years	≥ 18 years	≥ 18 years	≥ 18 years	≥ 18 years
Gender	More male than female	More female than male	More male than female	50% male; 50% female	57% male
Diagnosis, primary	Range of severe psychiatric problems	Range of severe psychiatric problems; high rate of co-occurring develop-mental disabilities	Range of severe psychiatric problems	Range of severe psychiatric problems	Range of severe psychiatric problems
Co-occurring medical (significant)	>33% have co-occurring medical disorders.	A significant number of patients have co-occurring medical disorders.	Patients with significant medical disorders are referred to the psychiatric unit of a state university-based hospital.	A significant number of patients have co-occurring medical disorders.	A significant number of patients have co-occurring medical disorders.
Co-occurring substance use	A significant number of patients have co-occurring substance-use disorders.	At least 80% of patients have co-occurring substance use disorder.	A significant number of patients have co-occurring substance-use disorders.	A significant number of patients have co-occurring substance-use disorders.	32% have a primary substance-use disorder; 18% are dually diagnosed with mental illness/ substance abuse
Previous hospital admission	Many have had prior admissions, and homeless patients have readmission rates twice that of other patients.	Many patients have had prior admissions.	66% have had more than one admission.	Many have had prior admissions.	Many have had prior admissions.

TABLE 25: CLIENT CHARACTERISTICS (Continued)					
CHARACTERISTIC	**PROGRAM**				
	A	**B**	**C**	**D**	**E**
Age	≥ 18 years	≥ 18 years	≥ 18 years	≥ 18 years	≥ 18 years
Financial resources	Varies. Urban setting makes this hospital a primary resource for the poor, homeless, uninsured, and underinsured.	Largely poor	Largely poor	Varies	Largely poor
Prior homelessness	8.5% admit to being homeless on admission. More are found to be homeless during hospitalization.	15% of patients have a history of prior homelessness.	Many with prior homelessness	Many with prior homelessness	33% are homeless on admission.
Risk of homelessness	10%–12% are at risk.	Many are at risk.	Many are at risk.	Many are at risk.	Many are at risk.
Eligible for entitlements	Many are eligible.	40% are enrolled and 10% more are likely eligible	Most are eligible.	Many are eligible.	Most are eligible.
Eligible for community-based services	Eligibility for DMH services and Medicaid Managed Behavioral Health Care System is key to receiving community-based services.	Access to community-based services is limited for the non-Medicaid eligible.	Eligibility is a factor.	Eligibility is a factor.	Eligibility is a factor.
Other relevant characteristics	Very culturally diverse clients. An increasing number of violent patients.	Most meet civil commitment standards. An increasing number of violent patients, most of whom have history of incarceration.	An increasing number of violent patients, most of whom have history of incarceration.	Not Ascertained.	Not Ascertained.

C. Community Descriptions

Analytic Question: How available are the key community resources and what are the implications for evaluability?

The key community resources for this setting are housing, outpatient mental health treatment, and for many patients, substance abuse treatment services. Medical care and services for persons with developmental disabilities are also required for many. The availability of community resources is key to the ability of the patient to transition successfully into the community and to recover after discharge.[75] The availability of community resources also directly affects the discharge planning process, and in some cases the LOS.

The five sites studied reported a significant lack of adequate housing in terms of both type and quantity. Waiting lists are long in both site visit settings, and in the rural setting there are very few options in terms of types of housing available. In both the sites we visited, discharges to shelters sometimes occur as a result.

Outpatient mental health services are more readily available than housing, but do not usually offer the full range of treatment options desirable. Substance abuse treatment services, particularly residential treatment programs, are even more difficult to locate. State policy governing Program B makes psychotropic medications available to anyone who has been resident in a state psychiatric hospital. Service options for integrated mental health and substance abuse treatment are especially limited in the region served by Program B. Both housing and treatment resources differed across catchment areas within the broader rural geographic area served by Program B, but transportation to and from community programs was a common problem across areas.

In both of the settings we visited community resources differed substantially depending upon the individual resources of the patient and the patient's eligibility for various programs, particularly DMH services, Medicaid, and HUD housing. These dramatic interindividual differences pose significant challenges for evaluation of discharge planning. In general, housing and service availability for those served by Program B was strikingly limited and directly

[75] Chinman, M. J., Rosenheck, R., & Lam, J. A. (2000). The case management relationship and outcomes of homeless persons with serious mental illness. *Psychiatric Services, 51*(9), 1142–1147. Clark, C. & Rich, A. (2003). Outcomes of homeless adults with mental illness in a housing program and in case management only. *Psychiatric Services, 54*(1), 78–83. Mojtabai, R. (2005). Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness. *Psychiatric Services, 56*(2), 172–178.

restricted the outcomes that could be achieved by effective discharge planning. Both the availability of services in the community and the eligibility of the patient to receive them affect discharge planning and would need to be considered in its evaluation.

TABLE 26: AVAILABILITY OF COMMUNITY RESOURCES		
RESOURCE	**PROGRAM A**	**PROGRAM B**
Housing	Variety of housing options available in community. Wait can be up to a year, and options differ across catchment area and are dependent upon patient eligibility.	Housing resources are very sparse overall and differ across local MHAs. There are long waiting lists for what is available. Choices are extremely limited.
Employment	While employment is available, supported employment is limited. Cost of living in this urban area is so high that the low wages offered in many jobs are not adequate.	Unemployment in this region is highest in state. Supported employment programs extremely limited.
Mental health (MH) services	MH services adequate for those patients eligible for DMH, Medicaid, or otherwise insured. Some patients can receive limited pro-bono services through this hospital outpatient service. No outpatient services available for most noneligible persons.	MH services limited but available for low-income and Medicaid-eligible patients. Travel to remote sites often required and public transportation is almost non-existent. Private MH services in this rural area extremely limited. Psychotropic meds available for those who have been hospitalized.
Substance abuse (SA) treatment	SA treatment is provided through the Department of Public Health (DPH). DMH and DPH have separate eligibility processes and different criteria. Furthermore, these departments do not work well together. This imposes barriers for patients who are dually diagnosed.	Most patients are eligible for limited services available through local MHAs, which also provide SA treatment.
Case management (CM) services	CM services are available only for those patients eligible for DMH services or Medicaid-managed behavioral health care.	Most patients are eligible for services through local MHAs. CM becomes the responsibility of the MHA upon discharge from hospital, but services very limited for non-Medicaid eligible.

Analytic Questions: What other community agencies are involved in discharge planning? What is their role? Does this differ by setting or by subpopulations within settings?

The involvement of community agencies differs substantially between the two sites we visited. No community agency actually participates in discharge planning at the private hospital we visited. There is, however, a long-standing cooperative working relationship between the hospital unit and the DMH programs to which patients are often referred upon discharge. In

contrast, at the public hospital we visited, the local MHA actually bears primary responsibility for discharge planning and a representative is a member of the treatment team.

The involvement of community agencies in discharge planning differs across the other three sites studied as well. Across these sites, there is more involvement of community agencies in discharge planning at the three state psychiatric hospitals, all of which are part of integrated state behavioral health systems. Across all five programs, involvement of community agencies in discharge planning may vary by subpopulation, related to patient eligibility for programs such as Medicaid and DMH services. These differences in roles and patterns of community agency involvement will be important to incorporate in the design of any future evaluation study. The innovation of having the community MHA staff take lead responsibility for discharge planning seems particularly promising and worthy of examination.

TABLE 27: COLLABORATIVE AGENCIES	
PROGRAM A	**PROGRAM B**
There is no direct involvement of community agencies in actual DCP process. There is an effective patient referral collaboration with the state DMH. Hospital has long-standing close relationship with DMH programs to which patients are often referred upon discharge.	Local MHAs are primarily responsible for DCP in this setting. They serve as a single point of entry for patients in their jurisdiction and prescreen them prior to admission. Exceptions are the few patients who present at the hospital and transients who are taken to the hospital on temporary detention orders. In these cases the MHA in the area to which the patient will be discharged becomes involved sometime during the process.

D. Research Issues

Analytic Question: What is the appropriate followup period after discharge to determine clients' housing status and other outcomes, and what are the implications for evaluability?

The Technical Expert Panel (TEP) felt that for adult settings housing status should be looked at on day 1 and day 7, noting that it is difficult to relate housing stability directly to discharge planning beyond that. In the case of Program A, we were told that many patients who were at risk of homelessness prior to discharge would be living at DMH-run transitional shelter programs for 90 days, receiving continuing treatment and awaiting suitable housing. Those not eligible for DMH or Medicaid services would likely be in generic homeless shelters where only very limited mental health services may be available, and where high stress may increase the likelihood of relapse. In Program B, where the range of housing options was so limited, housing

at 90 days would likely be relatively permanent. The most common option for Medicaid-eligible clients would be in large personal care homes, living in undesirable conditions but receiving medications and participating in the single type of community treatment program available, if the travel distance was not too great. For non-Medicaid-eligible clients, the setting might be in a shelter that has a maximum 6-month stay.

In the course of conducting the documentary analysis and site visits it became clear that many of the patients in this setting cycle through the continuum of care, often transitioning repeatedly though inpatient and outpatient treatment settings over long periods of time. Those patients who are readmitted to inpatient settings often have severe, co-occurring psychiatric and substance use disorders, and may be noncompliant with treatment. These characteristics may also place them at high risk of homelessness. When we spoke to hospital and community agency staff members during site visits, they indicated that it was unrealistic to expect a single brief period in an inpatient hospital to resolve problems of such acuity, nor did they think it fair to expect a single discharge plan to lead to stability in housing and functioning. Instead, they felt they are often successful in achieving housing stability and recovery with these patients, but over time, and often after repeated hospitalizations and other interventions. One community agency representative said what would be most useful would be a longitudinal study of homeless clients showing if and how they move through the system, because it takes a long time to obtain the type of housing they need and to move from one level of housing to another.

Although the TEP's recommendations to follow up on housing status at 1 and 7 days and on service linkages at 90 days may be appropriate when examining discharge planning as a one-time intervention, the more common reality among those who are homeless and have co-occurring psychiatric and substance use disorders is of multiple transitions (i.e., discharges) from programs and levels of care. A study design might examine transitions from a variety of settings (not just psychiatric inpatient units) or follow a person for a much longer period of time (perhaps several years) to better capture the factors that are important in preventing subsequent homelessness. It is also clear that client-level eligibility and community resource issues must be factored into any study design, since the outcomes of discharge planning can only be understood within their context.

Table 28 below clearly shows that none of the hospitals studied collects postdischarge data on patients, other than to track readmissions. The table also indicates where patients receive

followup mental health treatment, particularly noting those eligible for Community Mental Health Center (CMHC) services.

TABLE 28: CLIENT FOLLOWUP AFTER DISCHARGE					
FOLLOWUP DESCRIPTION	**PROGRAM**				
	A	**B**	**C**	**D**	**E**
Program follows client? (Inpatient)	No	No	No	No	No
Services provided (Community setting)	Some followed in outpatient clinic and many through DMH or Medicaid.	Most followed by local MHA if compliant.	Most followed by local CMHC if compliant.	44% are CMHC eligible; many insured see private providers; a few indigent are eligible for special care.	Most are followed by local CMHC if compliant.
Data collected by hospital	Place discharged to; readmissions.	Place discharged to; readmissions.	Place discharged to; readmissions.	Place discharged to; readmissions.	Place discharged to; readmissions.

Analytic questions: What types of data are available from what sources, what is the data quality, and what are the implications for evaluability? Is the type of outcome data recommended by the expert panel available, including homelessness indicators?

Some of the data necessary for an evaluation of discharge planning are not available for the patients at either of the sites we visited. Neither of these hospitals systematically tracks any postdischarge data other than readmission to the same hospital. In both cases, patient charts are maintained manually. Both hospitals put information from the patient record into a database at the time of discharge. Data availability is summarized in Table 29 below.

To track patients discharged from Program A, it would be necessary to tap two hospital databases and six additional information systems in the community. Each agency would require its own Internal Review Board (IRB) process. All patients would not be captured because some, among them the most chronically homeless, are lost to followup.

Most patients discharged from Program B will be eligible for MHA services. State reporting requirements for MHAs ensure availability of data on consumer contacts. While requirements are the same across MHAs, data systems vary. Although this information is helpful and reliable, it is available only for patients eligible for services (most) and those who are compliant and actually continue to seek care. Data are not available on the approximately 1 to 10

percent of the consumer population who refuse treatment.[76] These treatment refusers are among those at highest risk of homelessness and of particular interest in an evaluation.

None of these data systems was designed for the purpose of tracking outcomes after discharge. To obtain the outcomes data recommended by the expert panel, the programs would need to put data collection and followup processes in place. It would be necessary to rigorously pursue information on known relatives and contacts at the time of discharge from the hospital. Staff would need to be recruited and trained to track consumers lost to followup in community treatment. This would be time-intensive, costly, and possibly unsafe in situations when staff are dealing with consumers who have behavioral issues.

TABLE 29: DATA AVAILABILITY		
TYPE OF DATA	**PROGRAM A**	**PROGRAM B**
Predischarge: **Client assessments** **Services** **Outcomes** **Data format** **Data quality**	Inpatient record maintained manually except physician orders, which are computerized and fed into a complex database shared by a 5-hospital system. Currently no homeless identifier in that database, though that and other data are captured in a small hospital database maintained by the Quality Improvement (QI) specialist.	Inpatient medical records are maintained manually. Data from record is entered into the state DMH database by the hospital at discharge. Data available in that system are very reliable.
Postdischarge: **Who collects** **Services** **Outcomes** **Data format** **Data quality**	The hospital collects no followup information, with the exception of tracking readmissions. Six additional information systems are possible sources of community agency outcome data. Data in these systems are inconsistent in content, reliability, and accessibility. Data available only on those participating in treatment.	The hospital collects no followup information, with the exception of tracking readmissions. MHAs are required to report on continuity of care within 7 days and on housing status at 7 and 30 days. Data available only on those participating in treatment.

Analytic Questions: What are the relevant independent, dependent, and mediating variables that should be studied in each setting, and how could they be defined and operationalized?

Independent, dependent, and mediating variables to be studied in this setting are summarized in Table 30 below. Designing such an evaluation will certainly be complex, and there are many dependent and mediating variables that would need to be controlled for. Careful

[76] Olfson, M., Mechanic, D., Hansell, S., Carol, A. B., Walkup, J., & Weiden, P. J. (2000). Predicting medication noncompliance after hospital discharge among patients with schizophrenia. *Psychiatric Services, 51*(2), 216-222.

definition of these variables and a clearly articulated discharge planning protocol would be necessary.

TABLE 30: POTENTIAL RESEARCH VARIABLES AND MEASURES	
VARIABLE	**MEASURES**
Independent:	
Discharge planning process	Early initiation, comprehensive assessment, housing assessment, identification of responsible individual, team approach, community collaboration, comprehensiveness, appropriateness, patient/family involvement
Dependent:	
Housing	Housing status at discharge (where discharged to) and followup.
Linkages	Linkages in place to services needed after discharge
Mediating:	
Patient characteristics	Psychiatric (DSM IV) diagnoses; co-occurring substance abuse diagnosis and status; co-occurring medical (ICD 9) diagnoses; funding stream; eligibility for services and entitlements;; history of homelessness; history of previous mental health/substance abuse treatment; ability to perform activities of daily living and instrumental activities of daily living; and ties to social network.
Community resources	Availability of appropriate, affordable and sustainable housing; case management; mental health services; medication access; substance abuse treatment services; health care; supportive employment, education /training or day treatment availability; and transportation.
Institutional and systems resources and constraints	Hospital budgets, staffing, policies, and systems issues.
Laws, regulation, policies	Discharge planning; program financing; patient eligibility.

E. Summary and Conclusion

This section will provide a summary of discharge planning in the context of the inpatient psychiatric setting and discuss its evaluability and the challenges that may be encountered in designing an evaluation study. The preliminary logic models developed for the two inpatient psychiatric sites visited were not changed substantively when we revised them; rather, the changes captured nuances, placed emphasis, and added description. In neither program did the practice of discharge planning seem to differ substantially from intent. However, having completed the documentary analysis of five programs and site visits to two, it appears that discharge planning might be better represented in a logic model that more clearly illustrates the relationship between discharge planning and the treatment process in which it is embedded. A more accurate model might also show that treatment, discharge planning, and community resources must all be present to achieve residential stability and other desired client outcomes.

When considering the appropriate followup period for a study, placing the study within the longer term course of recovery from serious mental illnesses and co-occurring substance use disorders may be helpful. People with these conditions often cycle through the continuum of care, with repeated transitions to and from inpatient settings and a range of outpatient settings. Discharge planning rarely represents an end, but rather a transition to another level of care.

In terms of assessing evaluability of discharge planning in this setting, the following points summarize findings cited above:

- Discharge planning is integral to the treatment plan in the each of the five inpatient psychiatric programs we studied. Without exception, staff we spoke with view discharge planning as closely linked to treatment. Although researchers and program staff at the two sites we visited agree that discharge planning activities could be separated out and measured, discharge planning and treatment planning go hand in hand in these programs as they currently operate.
- While the five programs studied within this setting have some characteristics in common, the significant differences among them make it difficult to compare them. Of the five programs studied, three were public hospitals and two were psychiatric units within larger private hospitals. The differences between public and private hospitals are striking. Moreover, the private hospital visited had several unique characteristics that would make finding a comparison site difficult.
- Beyond the institutional differences in resources and constraints, one must look at larger systems in which the institution operates and at the impacts these systems have on discharge planning (e.g., state Departments of Mental Health, hospital systems). Even where a structured protocol for discharge planning exists, as it may at Program B (the rural state hospital), the model is not readily transferable to other settings given the extent to which it is rooted in state law, regulation, and policy.
- The discharge planning practice in Program A could be more consistent with intent if written procedures and assessment tools were in place to ensure consistency of practice. This lack of structure to ensure fidelity to a model was also a problem in the other private hospital. The three public hospitals all appeared to have more highly structured models for discharge planning, though neither of the others was as well developed as Program B.
- Although there are a substantial number of discharges at individual programs each month, the appropriate target population for an evaluation of discharge planning as a

strategy to prevent subsequent homelessness is the much smaller number of patients who are homeless or at risk of homelessness. Subgroups of particular interest for a study of discharge planning as it relates to subsequent homelessness include those who frequently refuse treatment and those who are early terminators—groups that are especially likely to be lost to typical followup procedures.

- Characteristics of patients served in this setting include severe psychiatric disorders. Symptoms of some severe psychiatric disorders, (e.g., paranoia) cause some patients to be unlikely to consent to records release or to maintain contact, or both. A high proportion (50 percent to 80 percent) of those with severe psychiatric disorders have co-occurring substance use disorders. These dual diagnoses are highly correlated with homelessness or risk of homelessness. Within that homeless subgroup, this dually diagnosed population has a relatively poor prognosis and is difficult to follow up. Other common co-occurring disorders in some of the psychiatric inpatient units include medical illnesses and developmental disabilities, each of which provides additional complications for the discharge planning process.
- Interindividual variability of patient eligibility for services and entitlements further complicates discharge planning. Community resources—particularly appropriate, affordable, and sustainable housing; case management; and community-based mental health and substance abuse treatment programs—are critical for patients being discharged from this setting. These services vary significantly by the patient's home location and by the patient's eligibility status. Effectively, there are different tracks for the discharge planning process, depending on entitlement eligibility and community of residence, with resulting differences in likely housing and other outcomes.
- Client followup after discharge is not done by any of the hospitals studied; however, many clients in public mental health systems are followed by a community-based program, usually DMH related. This service too depends on Medicaid and/or DMH eligibility, both of which are tightly restricted in some states.
- The kind of postdischarge data necessary for a study would most likely need to be collected by the study at considerable expense. While community treatment data are available, such systems are limited to clients who remain in treatment. In all sites studied, data would be needed from the hospital, as well as community agencies, each possibly requiring a separate IRB process. None of these data systems was designed for the purpose of tracking outcomes after discharge, and they differ in terms of content, format, and reliability. An effective followup tracking system

would require extensive contact data for known relatives and associates at the time of discharge from the hospital. Staff (or study researchers) would need to be recruited and trained to track consumers lost to followup in community treatment. This undertaking would be time intensive, costly, and possibly unsafe in situations when staff are dealing with consumers who have behavioral issues.

In summary, each of the above elements poses a significant challenge to designing a rigorous experimental evaluation of discharge planning across sites within this setting. Such a study would further require partnering with hospitals and community agencies to develop systems for patient followup and data collection. Research methodologies would have to control for numerous variables. Designing and implementing such a study would undoubtedly be lengthy and expensive.

That said, the problem of homelessness among this vulnerable population requires a careful study designed to improve outcomes. We found interesting practices that merit study and that might well result in findings worthy of dissemination and replication. Program B may have a discharge planning protocol in place that is sufficiently structured to serve as the basis for a study, although the spartan resource environment in which it operates limits its opportunity for effectiveness. It would be a challenge to devise a rigorous quantitative study that could provide a definitive answer to the question of whether such a discharge planning protocol can make an important difference. Effective treatment and appropriate housing and other community resources would almost certainly have to be part of the operating context in which the question is answered.

Foster Care

The five foster care programs examined in the documentary analysis all provide services to help teenage youth achieve positive outcomes (including stable housing) after discharge. Each of the programs goes beyond traditional independent living services, which generally involve workshops and training in daily living skills, educational support, and job-hunting assistance. They provide substantial additional assistance, such as supported housing, case management, counseling, financial subsidies, matched saving programs, and aftercare services. In every case, these programs provide a comprehensive set of services from which discharge planning cannot be disentangled. Rather, program staff state that everything they do is discharge planning, beginning when the youth first enters the program.

Three out of five of the programs (including both programs visited) focus to a great extent on housing status of youth. These programs provide youth with housing and prepare them to live on their own through life skills training, academic support, employability counseling, and apartment searches. One nonvisited program focuses on housing status for clients that plan to live on their own after discharge from the program. However, many of its clients plan to be reunified with their families; consequently, the program focuses more on family issues than on housing status for those youth. (This program also accepts younger clients than the other programs.) Another nonvisited program focuses more on mental health assessments and services, with support also provided to link youth with community resources.

The two programs that we visited both focus a large part of their efforts on providing supported housing to youth in foster care, helping youth learn to live on their own while they are still in foster care, offering a range of services tailored to each youth's specific needs, and providing stable relationships between youth and their caseworkers. These programs were selected for site visits because of their strong focus on preventing homelessness, as well as recommendations from stakeholders regarding their promising practices. Both visited programs provide life-skills and job-readiness assessment and training, individualized case management, round-the-clock support and crisis intervention, and financial assistance.

Aside from their similarities in program focus, there were some major differences between the two programs visited. One is the age of emancipation from foster care in their locations (18 years for Program A and 21 for Program B), which has major implications for a youth's developmental level at discharge and outcomes that the programs can accomplish with their clients. Another difference is the range of housing options provided. Program A provides

an extensive housing continuum, ranging from highly structured group homes to independent living in youths' own apartments, while Program B provides only semi-independent apartment living, with some gradation in amount of supervision based on a youth's ability to manage responsibility. The more extensive the continuum, the more the program can provide backup options for youth who find they are not able to succeed in more independent living situations. Another benefit of extensive housing options is the wide range of incentives they offer youth in structured placements to gain the skills to become more independent.

A. Program Descriptions

Analytic Questions: What are the characteristics of this setting in terms of size, length of stay, and numbers of early terminators and program completers? How do these characteristics affect discharge planning activities, outcomes, and evaluability?

The two visited programs had about the same number of referrals in FY 04 (82 and 90), as shown below in Table 31. However, Program A (in which the age of emancipation is 18) accepted all its referrals, while Program B (in which the age of emancipation is 21) selected a little over half (52). Program A could accept all its referrals because it offers a wide continuum of housing options and so is able to match youth with appropriate housing even if the youth are not yet ready for apartment living. Program B, on the other hand, carefully assesses all its referrals for likelihood of success in its semi-independent apartments, and rejects youth who do not seem ready. But even with this screening process, in FY 04 (as in previous years) more youth dropped out of Program B without graduating (25) than graduating (17), as shown in Table 31. Program A does not structure its program so that youth graduate; rather, they categorize discharges as either "planned" or "unplanned," with unplanned discharges happening when youth run away, are jailed, or age out of foster care with no place to live. Clearly, these two programs differ greatly in ways that affect any potential study design. Program B's highly selective screening process may preselect youth who are most likely to achieve positive housing outcomes, while Program A has no such preselection process. Information on referrals, admissions, discharges, and waiting lists was not ascertained for the nonvisited programs.

TABLE 31: PROGRAM SIZE AND LENGTH OF STAY (FY 2004)					
PROGRAM VARIABLE	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**		
	A	**B**	**C**	**D**	**E**
Referrals	82	90	Not Ascertained	Not Ascertained	Not Ascertained
Admissions	82	52	Not Ascertained	Not Ascertained	Not Ascertained
Discharges	83 (planned) 11 (unplanned)	17 (graduated) 25 (not graduated)	Not Ascertained	Not Ascertained	Not Ascertained
Total clients served	160	93	Current caseload 32	70	Not Ascertained
Average length of stay	424 days (completers) 164 days (non-completers)	742 days (completers) 242 days (non-completers)	12–18 mo	1 yr	Phase I: 2 yr Phase II: 18 mo Phase III: 2 yr
Waiting list	None for apartments; up to 2 weeks for other housing	4–6 weeks	Not Ascertained	Not Ascertained	Not Ascertained

Compared with the other three settings that were the focus of this study, the five foster care programs all provide relatively long lengths of stay, reflecting the age (teenagers) and developmental status of the clients as well as the gains the programs strive to achieve with their clients. As shown in Table 31, clients generally stayed in the foster care programs for at least a year, although in the two visited sites, noncompleters left before completing a year. In one of the visited sites (Program B), the average length of stay (ALOS) for youth who completed the program was more than 2 years; in the other visited program (A), it was more than a year.

Even though all the foster care programs have relatively long ALOSs, the differences in length of stay between programs may still be a significant consideration in developing a research design. A closely related factor with important implications for program comparability is the difference in the age of emancipation from foster care in their locations (18 for Program A and 21 for Program B). As discussed earlier, the range of available housing options also differs dramatically between the two programs visited. All these differences in program structure would need to be factored into the design of any potential evaluation study.

Equally important, the previously discussed differences in screening processes, number of clients served, early termination rates, and program goals for successful completers would need to be considered in an evaluation of these programs. These two programs are serving populations with different severities of problem behaviors and, thus, different likelihoods of

independent living success. We know less about other independent living programs, but any study would have to pay close attention to issues of program and population comparability. Also, higher rates of early termination complicate an evaluation since these clients may be at higher risk of becoming homeless and may be more difficult to engage in a study and follow up over time.

Analytic Questions: How are the programs in this setting funded and what are the implications for evaluability, if any?

Table 32 shows that three of the five programs receive all or the majority of their funding from state or local child welfare systems; one is funded through the local education department, and one receives over half of its budget from charitable donations. Several programs rely on grants and charitable donations to cover the gap between their child welfare or education agency reimbursements and their actual costs. The programs report that their funding is adequate for what they do, but Program A expressed the wish for additional funding to be able to extend services beyond the youth's 18th birthday. In no case is discharge planning billed, or its costs tracked, separately from other services and functions, another indication of the challenge of disentangling discharge planning from the range of other services these programs provide.

TABLE 32: PROGRAM FUNDING

FUNDING CHARACTERISTIC	VISITED PROGRAMS		NONVISITED PROGRAMS		
	A	B	C	D	E
Major funding sources	Per diem from referring child welfare agencies, county levy, county grant, charitable contributions	Per diem from referring child welfare agencies, charitable donations	One quarter is per diem from child welfare agency; remainder is charitable donations and private pay	County education department, some Federal education funds	State child welfare system
Funding adequacy	No funding past youth's 18th birthday, which truncates service period; no funding for postdischarge services or tracking	Generally adequate; would like funding for services beyond age 21; limited funding for postdischarge services and tracking	Adequate; youth can stay in foster care to age 21	Adequate to continue to provide services after discharge from foster care (usually at age 18)	Adequate; youth can stay in foster care to age 23 in some cases
Separate DCP billing?	No	No	No	No	No

Analytic Questions: What are key differences among the programs in institutional and program resources, constraints, and staff? What effects do these have on discharge planning characteristics and evaluability?

As previously mentioned, a key difference among foster care programs is the age of emancipation; programs that receive funding for youth up to age 21 (or older), as opposed to age 18, have the opportunity to work with youth longer and potentially affect a wider range of outcomes. Another key difference among these programs is the degree to which programs receive charitable donations to cover the gap between what they are paid by public agencies (child welfare, education, or juvenile justice) and the cost of providing services. Program C (a faith-based program), for example, receives relatively large charitable donations from individuals and businesses in the community, covering three-quarters of its budget with these donations, and is consequently able to provide relatively rich resources to clients (including swimming pools and horse stables on the large campus where the program is located). Program A has acquired several homes and apartment buildings for housing its youth, and these resources help support the wide continuum in housing options that this program provides. Program B, by contrast, owns none of the housing where its youth live and relies on good working relationships with landlords to provide housing for its clients. These types of resource differences underscore the wide diversity in independent living programs for youth in foster care, and a study would have to take into consideration these variations and their implications for aggregating or comparing the programs in an evaluation.

Analytic Questions: Do the programs have each of the elements of exemplary discharge planning? Which elements appear to be missing and with what effect on outcomes and evaluability? Can discharge planning be disentangled from other program activities in this setting? If not, what are the implications for evaluability?

Table 33 below shows details of the visited programs' discharge planning components. It is important to note that although both programs encompass all the exemplary discharge planning components, it is clear from the site visits that staff cannot clearly characterize discharge planning procedures separately from everything else they do. Discharge planning procedures have not been developed into separate evaluable programs with clear program theories and discharge planning logic models. In addition, programs must be clear about success criteria in order for discharge planning to be evaluable; for these programs, the desired end result of discharge planning procedures (pertaining to homelessness) was to have youth in their own apartments at

the point of discharge from foster care. However, this end result was achieved for only a minority of clients and depended partly on individual characteristics (e.g., a youth's developmental level) and available community housing resources. Thus the primary criterion for discharge planning success was an outcome that was probably heavily influenced by non-discharge-planning factors.

TABLE 33: PROGRAMS' DCP CHARACTERISTICS		
DCP COMPONENT	**PROGRAM A**	**PROGRAM B**
Early initiation of DCP	At entry into program	At entry into program
Comprehensive assessment	Formal assessment of self-sufficiency, daily living skills, mental health status, health status, family information, problem behaviors, clothing owned, mental health Diagnostic Assessment Form (DAF), Global Assessment of Functioning, Assessment of Young Adult's Independent Functioning, state mental health outcomes assessment	Formal assessment of self-sufficiency and daily living skills using the Daniel Memorial Assessment. Monthly service plan review form tracks progress (via narrative notes) in life skills training, educational program, vocational/employment plan, mental health/substance abuse issues, housing and community issues, medical exams.
Housing assessment	Informal discussions about youth's goals, interests, and capabilities	Informal discussions about youth's goals, interests, and capabilities
Identification of responsible individual	Each youth is assigned a social worker, who is in charge of DCP; roles are clear.	Each youth is assigned a case manager, who is in charge of DCP; roles are clear.
Team approach	Very team-oriented; teams include social worker, representative of the custodial system, clinical psychologist, representatives of other service agencies client will use postdischarge, guardian ad litem, court-appointed advocate, youth, other significant adults.	Limited team approach. Transition meeting held around 20th birthday includes all levels of staff, from case manager to executive director.
Community collaboration	Some collaboration with referring agency, landlords.	Some collaboration with referring agency, landlords.
Comprehensive DCP	Addresses educational, vocational, life skills, medical, dental, mental health, and housing needs	Addresses educational, vocational, life skills, medical, dental, mental health, and housing needs
Appropriate DCP to fit client's needs	Highly individualized for youth's needs	Highly individualized for youth's needs, but high early termination rates and limited range of housing options suggest limitations of program model
Client/Family involvement	Youth involved in DCP	Youth involved in DCP
Independent living services	12-unit life skills training program	Wide range of life skills classes
Postdischarge followup	Can continue some limited residential services while clients wait for housing to become available	Provides vocational and mentoring services and tracks clients for 18 mo after discharge, including beyond age 21
Supportive external factors	Strong relationships with local landlords; state provides tuition waivers and Chafee education and training vouchers for youth who age out of foster care	Youth can remain in foster care to age 21; strong relationships with local landlords; state provides tuition waivers and Chafee education and training vouchers for youth who age out of foster care

Table 33 shows other significant differences between the two programs. Program A conducts a more extensive and comprehensive assessment process at entry and discharge (and uses several standardized instruments), is much more team oriented in its approach to planning, and can offer only very few services to youth after discharge from foster care (which is at age 18 in this site). Program A's umbrella agency can provide limited and brief residential services through other non-foster-care programs it operates while youth wait for low-cost housing to become available. Program B's assessment process is much more limited, primarily assessing self-sufficiency and daily living skills using a single standardized instrument and without the extensive mental health assessments conducted by Program A. Program B's team approach also is more limited, involving primarily staff from the program rather than also including staff from community organizations. Program B tracks graduating clients for 18 months after discharge, providing some services and collecting outcome data. Program A has a quality improvement process that involves regular reviews of clinical indicators in client files to ensure appropriate assessment and treatment, but it does not distinguish discharge planning from other program services; Program B does not have a similar quality improvement process (quality improvement findings not shown in the table, but documented in the site visit reports).

The other discharge planning components are mostly similar between the two programs. Both begin discharge planning at youths' entry into the program; conduct informal housing assessments; assign a social worker or case manager to be responsible for discharge planning; incorporate some community collaboration, primarily with the referring agency; address a comprehensive range of needs; tailor the discharge planning to the youth's needs; provide life skills classes; and benefit from the supportive external factors of state tuition waivers and Chafee education and training vouchers for youth who age out of foster care. Program B's high early termination rates and limited range of housing options suggest some areas for improvement in that program's model. Although both programs have at least some aspect of each element of exemplary discharge planning, the inability to disentangle these elements from everything else the programs do (e.g., case management, financial support and planning, and job counseling) makes the evaluation of discharge planning more of a challenge.

The central goal for these foster care independent living programs is to educate youth and prepare them for the transition to an independent life in the community. After examining the discharge planning process in psychiatric settings, the American Association of Community Psychiatrists has recommended that the term *discharge planning* be abandoned in favor of the

term *transition planning*. One could argue that these foster care independent living programs are 12–24 month-long transition planning and preparation programs. If we look at these foster care programs from this perspective, it seems only natural that it would be especially challenging to separate discharge planning from a program whose only real goal is to prepare youth for this transition. The statement by program staff that everything they do is discharge planning is particularly relevant here.

The characteristics of these programs' discharge planning processes are similar within a program, regardless of which agency referred a youth. However, finer details of discharge planning practices differ somewhat depending on the referring agency (or funding stream) for particular youth. For example, Program B has clients referred by both the local county and city child welfare agencies. The city agency has fewer resources than the county agency and can provide fewer additional benefits to youth, such as startup kits and stipends at discharge and extra mental health counseling, which may help a youth transition successfully out of foster care. Youth referred through a juvenile justice agency have different requirements regarding independent living classes (generally, fewer classes are required, although youth are encouraged to participate in all the classes).

Analytic Question: What characteristics of the discharge planner need to be considered and how might they be measured? What characteristics could be evaluated, and how do these vary by setting?

Table 34 below shows the characteristics of the staff responsible for discharge planning at each of the two programs visited. These staff have similar training and credentials. In neither program do staff receive training on discharge planning specifically. In Program A, the average tenure is more than 10 years, which is unusually long for workers in this field. Although the absence of discharge-planning-specific training is a further indication of the nonseparable nature of discharge planning processes, were an evaluation of discharge planning to be conducted, the relatively long staff tenure would lessen the need for repeated training and ensure broad familiarity with community resources.

TABLE 34: CHARACTERISTICS OF DISCHARGE PLANNER		
CHARACTERISTIC	**PROGRAM A**	**PROGRAM B**
Who does DCP?	Youth's assigned social worker	Youth's assigned case manager
Training	B.S.W. or B.A. in related field, 1 yr of experience working with youth	B.S.W., background in child welfare, desire to work with youth
Credentials/Qualifications	L.S.W.	L.S.W.
How long in job?	Average > 10 yr	Average > 3 yr

B. Client Characteristics

Analytic Questions: What individual characteristics of the target population need to be considered, and how might they be measured? What target population(s) in relation to homelessness could be evaluated, and how do these vary by program?

Table 35 below summarizes client characteristics at the five foster care programs. The clients generally are teenagers, with one nonvisited program (C) admitting children as young as 10. That program also was the only one with private referrals (i.e., not exclusively referred through child welfare or juvenile justice systems), and the private referral portion of its caseload may have a lower risk of later homelessness. However, the child welfare portion of its caseload, similar to the clients in the other foster care programs, can be assumed to be at risk of homelessness because of histories of maltreatment, high incidence of developmental delays and disabilities, serious emotional disturbances, substance use disorders, and lack of academic preparation and employability skills. In addition, and in contrast to the other settings in this report, youth in foster care generally do not have previous housing to return to after discharge, whereas many clients in the other settings were domiciled before admission and would return to those housing arrangements after discharge. Youth in foster care likely are at higher risk of homelessness than clients with housing to return to after discharge.

TABLE 35: CLIENT CHARACTERISTICS					
	VISITED PROGRAMS		NONVISITED PROGRAMS		
CLIENT'S:	A	B	C	D	E
Age	16–18	17–21	10–16 at admission	At admission, within 1 yr of aging out of foster care (usually 17)	14–23
Gender	Female 55%	Female 52%	Male 56%	Male 60%	Not Ascertained
Diagnosis	One-third of the caseload has been diagnosed with a develop-mental disability.	5%–10% of caseload have developmental delays; 25% have history of drug abuse; 95% have family history of drug abuse.	Severe behavior problems.	Living in group homes; histories of mental health/substance use issues, multiple placements, academic non-achievement, and substance abuse or gang involvement.	Statewide foster care caseload, with typical characteristics.
Education level	At discharge, 53% had completed high school (HS), GED, or other educational program.	100% of graduates are discharged with a HS diploma (but only 19% of referrals complete the program).	Not Ascertained	At the end of program participation, 73% graduated from HS, received GED, or passed the state exam (an alternative to HS and GED in this state).	Not Ascertained
Previous system involvement	Primarily child welfare	Primarily child welfare	Primarily child welfare; some private referrals	Child welfare	Child welfare
Financial resources	At discharge, 58% of clients had a job or had completed job training.	Most clients graduate with at least a part-time job.	Not Ascertained	Not Ascertained	Not Ascertained
Prior homelessness	None	None	None	None	None
Risk of Homelessness (note that having been in foster care is a risk factor for homelessness)	Youth discharged at age 18, with developmental delays, mental health/ substance use issues, lack of employability skills, or no HS diploma or GED are at higher risk.	Youth with developmental disabilities are at higher risk.	Foster care clients have usual risk factors; private referrals may have lower risk of homelessness.	Youth discharged at age 18, with developmental delays, mental health/ substance use issues, lack of employability skills, substance abuse and gang involvement are at higher risk.	Youth with developmental delays, mental health/substance use issues, lack of employability skills, and no HS diploma or GED are at higher risk.

In Program A (in which the age of emancipation is 18), only slightly more than half of the clients had completed high school or a GED at discharge from foster care, compared with Program B (in which the age of emancipation is 21), where 100 percent of graduates had received a high school diploma or GED at discharge. (Note that youth who graduate from Program B may not be typical of youth in foster care; nearly half of the referrals to that program are not admitted, and fewer than half of the youth admitted end up graduating from the program–evidence of a highly selective, yet not very effective, screening process. Only 19 percent of youth referred to the program graduate.) In terms of assessing risk of homelessness in designing a study, youth discharged from foster care at younger ages (18 as opposed to 21), without a high school diploma or GED, and/or with developmental disabilities, serious emotional disturbances, or substance use disorders would be at higher risk for later homelessness, and these characteristics generally would be measurable. Note, however, that the potential study sample is then split into smaller and smaller *N*'s when youth are segmented by such risk factors, with the consequence that longer enrollment periods may be needed to achieve satisfactory statistical power in a rigorous quantitative study.

C. Community Descriptions

Analytic Question: How available are the key community resources and what are the implications for evaluability?

Table 36 below shows that Programs A and B operate in communities where low-cost housing is in short supply (especially hard to find for Program B), jobs are available for the program's clients but wages are low (especially low for Program A), mental health services and substance abuse treatment for low-income clients are inadequate, and affordable child care is scarce. On a more positive note, in both states where these programs are located, youth who age out of foster care are eligible for tuition waivers to state-supported 4-year colleges and community colleges, as well as Chafee education and training vouchers. Our observations suggest that community resources are at least as important as discharge planning in determining client housing outcomes, so the scarcity of essential community housing and employment resources means that discharge planning in these programs may be limited in terms of the housing outcomes it can achieve. Note that in addressing community resources, it is important to keep in mind geographic variability (where a youth goes to live after discharge may not be the immediate community where the independent living program is located) and program staff's knowledge

about community resources in the location the youth will be residing and how to link youth to these resources.

TABLE 36: AVAILABILITY OF COMMUNITY RESOURCES		
RESOURCE	**PROGRAM A**	**PROGRAM B**
Housing	Low-cost housing scarce	Severe scarcity of low-cost housing
Employment	Available jobs have extremely low wages	Low-wage jobs are available
Mental health services	Shortage	Shortage; generally available only for those on Medicaid
Substance abuse treatment	Shortage	Some shortage; limited effectiveness
Case management services	Shortage; child welfare agency provides some Chafee-funded support services	Limited
Child care	Shortage	Shortage
Education	State provides tuition waivers and Chafee education and training vouchers for youth who age out of foster care	State provides tuition waivers and Chafee education and training vouchers

Analytic Questions: What other community agencies are involved in the discharge planning? What are their roles? Does this differ by setting or by subpopulations within settings?

Both visited foster care programs cultivate collaborative relationships with several community agencies, as shown in Table 37 below. The closest relationships are with the referring child welfare agencies, since the referring agencies maintain legal responsibility for the youth, are required to participate in planning treatment and services, and have responsibility for establishing linkages and completing paperwork with adult systems into which some youth are eligible to transition. However, program staff report that the actual involvement of the referring agencies is inconsistent and depends largely on the caseworker's interest and abilities. Both programs also collaborate with area landlords, on whom they depend for a steady supply of apartments for their clients; even Program A, which owns apartment buildings, must find rental housing for some of its clients. They maintain their relationships with landlords by closely supervising and working with youth to help them be good tenants. Program A also collaborates with the county mental health board (which provides case management) for its clients with serious emotional disturbances, and participates in the county Continuum of Care for the homeless (which is developing a Homeless Management Information System). Program B cultivates a close relationship with the state licensing agency, which has developed into an advocate for the program. It also has relationships with local businesses that hire Program B's clients to work in package delivery and health care jobs.

For the most part, among the independent living programs examined, there is relatively little diversity in the other organizations playing a role in the discharge planning process. As mentioned previously, Programs A and B also serve a few youth from the juvenile justice system, although the differences between discharge planning "tracks" are relatively few between foster care and juvenile justice. Program A does have a pilot program, funded by the local mental health authority, that provides more intensive services for youth with serious emotional disturbances (SED). Most of the youth (about 60 percent) in this program are also in foster care. The purpose of the pilot program is to prepare the youth to transition into the adult mental health system—a time when many youth with SED "fall through the cracks." This is a distinct subprogram within Program A that has a different track for its discharge planning processes.

TABLE 37: COLLABORATIVE AGENCIES	
PROGRAM A	**PROGRAM B**
Referring child welfare agencies: formal contract-driven relationships; generally extensive collaboration, depending on needs of client	Referring child welfare agencies: formal contract-driven relationships; amount of collaboration varies depending on involvement of referring agency's case worker
Landlords: program cultivates cordial and effective collaborative relationships with landlords to ensure supply of housing for clients	Landlords: program cultivates cordial and effective collaborative relationships with landlords to ensure supply of housing for clients
County mental health board: program collaborates closely regarding clients who have serious emotional disturbances (SED)	State licensing agency: program collaborates closely regarding program expansion and state regulations; licensing agency advocates for program
Continuum of Care: program participates in development of Homeless Management Information System	Employers: program works with employer partners in the package delivery and health care fields, to locate appropriate employment for clients

D. Research Issues

Analytic Question: What is the appropriate followup period after discharge to determine clients' housing status and other outcomes, and what are the implications for evaluability?

For independent living programs for youth, an appropriate followup period for measuring homelessness would be at least 1 year. As the executive director of one of the programs said, "Kids can get by in the first 3 months [after discharge] on momentum alone." Youth generally are not discharged from foster care without housing, although a few might float among friends or go to shelters immediately after discharge. Because of the young ages of these youth, developmental issues are important factors in housing stability, and a followup period would have to take that into consideration. Recognizing these issues, Program B (which serves youth until

age 21) tracks its graduates for 18 months after discharge. Given that the rate of homelessness in a 1-year period is relatively low (one study found a 12 percent rate of homelessness in the year after exiting foster care[77]) even in high-risk populations, the followup period would have to extend long enough to capture some incidence of homelessness. Obviously a longer followup period makes tracking and data collection more difficult and expensive. And few programs have funding to follow up with clients or provide services after discharge; thus, the tracking and data collection capacity would have to be developed and funded by the researchers.

As shown in Table 38, Programs B (visited) and D (not visited) continue to provide at least some services after discharge from foster care. Program B (but not Program D) systematically collects outcome data on graduated youth for 18 months after discharge; in addition, Program B provides some supportive services and social opportunities. (But note that Program B provides systematic followup only to program graduates, who are only about 40 percent of the clients admitted.) Program D continues to provide mental health counseling, case management, and other services until the client is stable and comfortable with stopping the case management, often 6 months or more after discharge. However, Program D does not systematically collect data on the youth. None of the programs currently has a followup data collection system that would support an evaluation.

TABLE 38: CLIENT FOLLOWUP AFTER DISCHARGE

FOLLOWUP DESCRIPTION	VISITED PROGRAMS		NONVISITED PROGRAMS		
	A	B	C	D	E
Program follows client?	No. (Informal connections only)	Yes. Primarily graduates (40% of admissions) non-graduates can attend social gatherings, receive job-hunting advice	No. (Clients remain eligible to obtain community referrals)	Yes	No
Nature of follow-up	Not Ascertained	Job-hunting and apartment-hunting advice, mentoring, social gatherings, data collection	Not Ascertained	Case management, drop-in center services	Not Ascertained

[77]Courtney, M. E., Piliavin, I., Grogan-Kaylor, A., & Nesmith, A. (2001). Foster youth transitions to adulthood: A longitudinal view of youth leaving care. *Child Welfare, 80*(6), 685–717. Park, J. M., Metraux, S., Brodbar, G., & Culhane D. P. (2004). Public shelter admission among youth adults with child welfare histories by type of service and type of exit. *Social Service Review, 78*(2), 284–303.

TABLE 38: CLIENT FOLLOWUP AFTER DISCHARGE (Continued)					
FOLLOWUP DESCRIPTION	**VISITED PROGRAMS**		**NONVISITED PROGRAMS**		
	A	**B**	**C**	**D**	**E**
For how long?	Not Ascertained	18 mo for data collection; no limit on services	Not Ascertained	Often 6 mo or more after discharge, until client is stable	Not Ascertained
Services provided	Not Ascertained	Academic support, job-hunting, apartment-hunting, counseling	Not Ascertained	Weekly case management meetings; drop-in center services such as food vouchers, job referral information, crisis support	Not Ascertained
Data collected	Not Ascertained	Followup outcome interviews every 3 mo; cover housing, employment, education	Not Ascertained	Only informal updating of client files	Not Ascertained

Analytic questions: What types of data are available from what sources, what is the data quality, and what are the implications for evaluability? Is the type of outcome data recommended by the expert panel available, including homelessness indicators?

As shown in Table 39, Program A collects a variety of assessment data on mental health status, daily living skills, and independent functioning at entry and discharge, as well as data on services received and where youth went after discharge. Many of these data are available electronically. Program A does not track youth after discharge. Program B collects data on daily living skills at entry and 6 months after entry and tracks services and instruction provided. In addition, Program B, unlike any other independent living program contacted, systematically collects outcome data for 18 months after discharge, interviewing graduates every 3 months on housing, employment, and education outcomes. Program B has achieved a 100 percent followup rate with its graduates for the 6 months that the tracking system has been in place. However, the program does not currently collect postdischarge data on the 60 percent of youth who leave the program without graduating.

TABLE 39: DATA AVAILABILITY		
TYPE OF DATA	**PROGRAM A**	**PROGRAM B**
Predischarge: **Client assessments** **Services** **Outcomes** **Data format** **Data quality**	Formal assessments at entry and discharge include mental health Diagnostic Assessment Form (DAF), Global Assessment of Functioning, Assessment of Young Adult's Independent Functioning, and state mental health assessment form. Data on services, discharge assessments, and where youth went after discharge available in electronic system.	Daniel Memorial assessments at entry and 6 mo into program, as well as data on youth characteristics, services, hours of instruction, money management in electronic format.
Postdischarge: **Who collects?** **Services** **Outcomes** **Data format** **Data quality**	The referring child welfare agency collects postdischarge services and outcomes data (Daniel Memorial) on a small number of youth. County HMIS is being implemented.	Program conducts postdischarge outcome interviews every 3 mo with graduates; cover housing, employment, education. Available electronically. Local county child welfare agency and area university are conducting a study that will track foster care youth up to 4 yr after discharge.

Some postdischarge data may be available from other agencies, although coverage appears to be spotty both in terms of which youth and which data elements are included. For Program A, the referring child welfare agency provides some Chafee services and collects outcome data on independent living skills for a small number of discharged youth, and a county HMIS may have some data on any former foster care youth who become homeless and receive services from participating providers. For Program B, the county child welfare agency and an area university recently began tracking foster care youth from the county for 4 years after discharge.

The expert panel recommended that the following outcome data be tracked: clients who enter shelters, client's housing status at Days 1 (i.e., where discharged to) and 7, treatment linkages within 90 days of discharge, and recidivism within 72 hours. In addition, the panel stated that youth populations should be tracked for a longer period than adult populations, without specifying how long that period should be. Both programs collect housing status at Day 1, and Program B collects entry into shelters and housing at 90 days for the youth they follow up. There might be some information available on clients who enter shelters and treatment linkages within 90 days from agencies outside the programs—if the referring agency provides Chafee services to youth who were in Program A, there would be some information available. For Program B, the study being conducted by the child welfare agency and an area university might collect data on

clients who enter shelters and client housing at 90 days. Recidivism within 72 hours seems less relevant in foster care than in the other settings, as when youth age out of foster care, they generally cannot re-enter. Note the implications for evaluability: Inconsistencies in followup and type of data collected may make it difficult to compare the programs' outcome data or find consistent responses to the research questions.

Analytic Questions: What are the relevant independent, dependent, and mediating variables that should be studied in each setting, and how could they be defined and operationalized?

Table 40 shows variables that might be included in a study of outcomes associated with these independent living programs. Independent variables would measure various aspects of the transition process—for example, services received in relevant areas as well as dosage. Dependent variables would measure housing status, education, employment, mental health, and other outcomes of the programs that are relevant to homelessness. Mediating variables would capture youth and community resources that likely influence the ability of the program to achieve outcomes.

TABLE 40: POTENTIAL RESEARCH VARIABLES AND MEASURES

VARIABLE	MEASURES
Independent:	
DCP process	Initiation, comprehensive assessment, housing assessment, ID of responsible individual, team approach, community collaboration, comprehensiveness of plan, appropriateness to individual needs, client and family involvement, independent living services, postdischarge followup
Dependent:	
Housing status	Housing status at discharge (where discharged to) and followup
Service linkages	Linkages in place to services needed after discharge
Mediating:	
Treatment program	Case management, counseling, training, support received while in foster care that may affect youth's ability to function in community housing and service context
Youth characteristics	Mental health and substance abuse diagnoses, disabilities, functioning, age, parenting status, placement history, funding stream eligibility, education level, employability, social network, criminal involvement
Community resources	Availability of affordable and safe housing, health care, mental health services, substance abuse treatment services, employment, affordable child care, tuition waivers, Chafee education and training vouchers

E. Summary and Conclusion

In this section we highlight the key issues having implications for the evaluability of discharge planning in foster care settings and, where applicable, describe how these implications might affect potential research designs.

What does "discharge planning" mean in the context of a foster care independent living program?

- Independent living programs are fundamentally about assisting youth to make a transition to living independently in the community. While these programs have processes that correspond to each element of exemplary discharge planning, those processes are tightly interwoven with everything else these programs do (e.g., case management, financial support and planning, and job counseling). This makes an evaluation of discharge planning alone a very questionable undertaking.
- None of the five programs examined either bill or track discharge planning costs separately from other services provided. This also contributes to the impression that discharge planning would be difficult to disentangle and evaluate separately from the rest of the program.

Are the programs to be evaluated and the clients they serve sufficiently similar to be aggregated in one study?

- Wide variations in program resources—and, to a lesser extent, differences in client funding streams—lead to large dissimilarities in what the programs can offer youth, making it more difficult to compare programs in an evaluation.
- Some programs' admission processes involve highly selective screening, which may preselect youth most likely to achieve positive housing outcomes and exclude youth at highest risk of homelessness. Programs that preselect admissions in this way should not be compared with programs that accept all referrals, because outcomes will partly reflect the clients' pre-existing conditions.
- Youth served in the programs vary substantially in the degree to which they are at risk of homelessness. Although simply having been in foster care is a risk factor for homelessness, additional risk factors include being discharged from foster care at a younger age (i.e., 18 as opposed to 21), not having completed high school or obtained

a GED, and having developmental disabilities, serious emotional disturbances, or substance use disorders.

- Whether or not programs receive funding for youth beyond age 18 creates big differences in the services that can be provided and the outcomes that can be achieved. Note that in many cases, not completing high school or earning a GED may be a result of the age of emancipation being 18 or the youth having developmental disabilities, rather than being an independent risk factor.

Community resources vary significantly from program to program and across the multiple communities served by a single program. Achieving the intended outcomes of the discharge planning process is at least equally dependent on the availability of housing and other community resources. The impact of the discharge planning process cannot be evaluated without fully addressing these resource inequity issues.

- The scarcity of community resources in the areas of low-cost housing, employment, mental health services, substance abuse treatment, and affordable child care means that discharge planning in these programs may be limited in terms of the housing outcomes it can achieve with clients.
- Other community agencies involved in discharge planning generally include the referring child welfare agencies, which maintain legal responsibility for the youth and are required to participate in planning treatment and services; however, the actual involvement of the referring agencies is inconsistent across programs. Thus, the extent of the referring agency's involvement in discharge planning should be addressed in any discharge planning evaluation.

Developing the client tracking and research infrastructure to support a future evaluation study of discharge planning as a strategy to prevent homelessness in this setting would probably be a costly undertaking.

- An evaluation of housing outcomes for independent living programs would have to follow youth for at least a year after discharge, both to account for developmental issues in the youth and to capture some incidence of homelessness.
- Independent living programs rarely have funding to follow clients or provide services after discharge; thus, a research infrastructure would have to be developed to track clients and collect necessary data.

- Depending on what conclusions are reached about the extent to which programs and client subgroups can be aggregated, it may be necessary to include many programs and/or to have extended (possibly multiyear) client enrollment periods to attain sufficient sample sizes to have adequate statistical power to address key research questions.

In summary, there are numerous reasons to question the utility of evaluating the discharge planning processes (however they are defined in this programmatic context) separately from the independent living programs as a whole. Also, based on the five programs in this study and the differences in whom they accept, how long they work with clients, what data they collect, whether housing is provided (and type provided), and client followup, there are many reasons to question whether foster care programs could be aggregated and evaluated together. Any rigorous quantitative study of discharge planning in this setting would almost certainly be extended and costly. However, it is possible that the efficacy of individual programs could be evaluated and the findings could help us understand how to prevent homelessness in carefully defined vulnerable populations in a well-defined community resource context.

Cross-Setting Observations and Conclusions

This chapter outlines some of the observations the research team has made after reviewing key issues as they apply across all four settings studied. Here we state conclusions that cut across the four discrete settings and present conclusions about the evaluability of discharge planning as practiced in the programs we examined as well as key measurement and data collection issues.

Key Findings

- **A Summative Evaluation of Discharge Planning Is Not Justified at This Time**

The study team concluded that a rigorous summative evaluation (i.e., an outcome or impact evaluation) of discharge planning as a strategy to prevent homelessness in institutional and/or custodial settings is not justified at this time. The recommendation against conducting a summative evaluation of discharge planning as a strategy to prevent subsequent homelessness is based on the findings that discharge planning is not readily separable from the broader program, that it is not well defined or consistently implemented, and that a summative study would be costly and is premature given the state of knowledge in this area. However, we found that alternative study designs to evaluate specific issues or activities related to discharge planning and homelessness prevention are feasible and justifiable, and these designs are described in the next section of this report.

- **Discharge Planning Is Not Readily Separable From the Broader Program**

A key evaluability question for each of the four settings is whether the discharge planning process is separable from the broader program in which it operates. Many discharge planning activities, such as client assessment, are also critical to treatment planning and are often performed by the same staff. While there are distinct, identifiable activities associated with discharge planning, they take place within the context of the broader treatment or service delivery process and cannot be clearly separated from that context. For example, the primary goal of a residential substance abuse treatment program is to reduce or eliminate a client's dependence on alcohol or other drugs.[78] However, the intervention of interest for the evaluability assessment is

[78] Center for Substance Abuse Treatment (CSAT) (1995). *Detoxification from alcohol and other drugs, Treatment Improvement Protocol (TIP) #19*. Department of Health and Human Services (DHHS) Pub. No. BKD172. Substance Abuse and Mental Health Services Administration (SAMHSA).

not the entire treatment (which includes discharge planning) provided in the residential substance abuse treatment program. Rather, the evaluability assessment focuses on the discharge planning process alone; other activities that occur in the residential substance abuse treatment program would be mediating variables in an evaluation of the discharge planning process.

- **The Discharge Planning Process Is Not Well Defined Or Consistently Implemented**

Few programs appear to have a well-designed and integrated model of the discharge planning process, nor have they implemented the process in a systematic manner likely to produce consistent results over time or across clients. Probably only one of the eight programs visited—the rural state psychiatric hospital—could clearly be said to have a well-articulated model of discharge planning whose goals emphasized avoidance of homelessness. Recalling the test presented in the introduction to this report,[79] to be evaluable, a program must have a design or model (implicit or explicit) that makes clear its goals and objectives and their relationship to program activities. Some of the tests we applied to reach this conclusion are listed below.

- Is it clear what set of activities and objectives constitute the discharge planning process?
- Are discharge planning procedures adequately developed as a process?
- Is there a clear relationship among goals, activities, and outcomes?
- Is there unambiguous agreement on success criteria—do people and documents make clear what the desired end result of discharge planning should be?
- How well are discharge planning procedures documented?
- How clearly can staff characterize their discharge planning procedures?
- Is there standardization of assessment and measurement—using instruments with established validity and reliability?
- Is there standardization of staff training?
- Is there standardization of quality assurance procedures?
- Is there followup data collection and a process to use those data for ongoing process improvement?

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[79] Kaufman-Levy, D. & Poulin, M. (2003) *Evaluability assessment: Examining the readiness of a program for evaluation*. Washington, D.C.: Juvenile Justice Evaluation Center, Justice Research and Statistics Association, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

The rural state psychiatric hospital discharge planning process meets all of these tests, with the exceptions that the validity and reliability of the assessment instruments being used have not been established. Every other program would have negative answers to multiple questions from this list. There must then be questions as to whether the other programs have a sufficiently developed model of discharge planning to be evaluable.

While most programs do have at least rudimentary discharge planning procedures and forms, few of the programs examined have a written protocol to ensure that staff members apply the interventions uniformly or document discharge planning processes well. None of the 19 programs studied used screening instruments to identify clients at risk of homelessness and in need of intensive discharge planning efforts.

In addition, most programs examined lack rigorous staff training and quality assurance activities in support of discharge planning. As a result, the discharge planning process is inconsistently applied within each program. Likewise, programs collect very little systematic postdischarge data that could create a feedback loop to improve the discharge planning process over time.

Another way to think about this issue is whether the model of discharge planning is sufficiently well developed that it could be replicated elsewhere. This is a test that is commonly applied in this era of concern with the evidence base of a program. In a hypothetical case in which two staff members were blindly working with the same client, we do not believe the kinds of broad principles articulated in most program policy statements on discharge planning are sufficient to ensure that staff members would take the same actions or achieve the same results. Clearly, the only one of the eight programs visited that might approach the replicability test would be the rural state psychiatric hospital.

The discharge planning process consists of an imprecisely defined set of activities. While some governmental and professional organizations have developed consensus standards on what constitutes a model discharge planning process,[80] we found little evidence that these models have

[80] Substance Abuse and Mental Health Services Administration (SAMHSA, 1997). *Exemplary practices in discharge planning*. Rockville, MD: Author.; American Association of Community Psychiatrists (AACP, 2001a). *Continuity of care guidelines: Best practices for managing transitions between levels of care.* Dallas: Author.; American Association of Community Psychiatrists (2001b). *Continuity of care guidelines for addictions and co-occurring disorders.* Dallas: Author.; Osher, F., Steadman, H.J., & Barr, H. (2002). *A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model.* Delmar, NY: The National GAINS Center.

been effectively disseminated or widely implemented. No studies have yet tested the effectiveness of these models in actual practice. Critics have suggested the models were not attuned to "real world" scarcity of housing and other resources, or the tendency of organizations to pursue self-interest rather than collaborate effectively.

- **Housing and Community Services Are Also Essential for Preventing Homelessness**

The study team found that avoiding homelessness, the outcome of interest, is determined as much or more by the availability of suitable housing and support services in the community as by the discharge planning process. An example of this was found in the most well-structured and best implemented discharge planning process observed in this study. This model discharge planning process was implemented in a rural community so lacking in housing options that many clients were placed in large congregate semi-institutional conditions upon discharge. The best discharge planning process cannot overcome a lack of community housing and services.

- **Practical Research Design Considerations Would Make a Summative Evaluation Challenging and Costly**

The tremendous variability in the discharge planning process across clients, programs, settings, and communities dictates that a summative evaluation enroll thousands of clients across many programs. The discharge planning process is highly complex and tightly bound to programmatic, client, interorganizational, and community resource factors. Numerous mediating variables affect the discharge planning process and its outcomes; some of these variables lack well-formulated measures. A summative evaluation of the discharge planning process as a strategy to prevent homelessness would be complex, lengthy, costly, and could not be assured of producing clear and definitive findings. Further preliminary and exploratory research is called for before undertaking a study of such complexity and resource requirements.

- **Eligibility and Funding Sources Dictate Intervention and Discharge Planning Tracks**

Within a single residential or custodial program, there are several intervention and discharge planning "tracks" depending on who pays for or oversees a client's care and the community programs for which they are eligible. These tracks often result in differences in clinical interventions, lengths of stay, agencies involved in the discharge planning process,

community housing alternatives, and available community services. For example, the treatment and discharge planning process a patient receives in a psychiatric hospital will be determined in part by whether the person meets eligibility criteria for Supplemental Security Income (SSI), Medicaid, a private insurer, the state mental health department, or is self-pay and of limited means. For youth in residential treatment centers, the discharge process is partially determined by who has custody of the youth—the family, child welfare, or juvenile justice.

Geography can be considered as a special case of eligibility. A person's home region, often the region to which he or she will be discharged, has a tremendous impact on what housing and other services are available. Each funding source or community program may have its own complex eligibility standards and application process that is time-consuming to negotiate. In general, rural areas tend to be less well resourced than others. Distant and widely scattered regions may also be less familiar to program staff, so they may lack the knowledge base to develop an optimal discharge plan to take advantage of that region's resources. Agencies that serve large geographic areas may be less able to form an effective network of interagency linkages over the entire service area. An evaluator of the discharge planning process must address the complexity of multiple discharge planning tracks that results from the involvement of these diverse payers and community contexts.

- **No Separate Payment Exists for Discharge Planning Activities**

In most cases the discharge planning process is funded as incidental to the treatment and custodial care, often as part of a bundled per diem rate. Any study will face challenges in determining financial expenditures for discharge planning activities since they are not billed separately and are usually carried out by the same program staff who provide clinical care.

- **Revised Logic Model Needed**

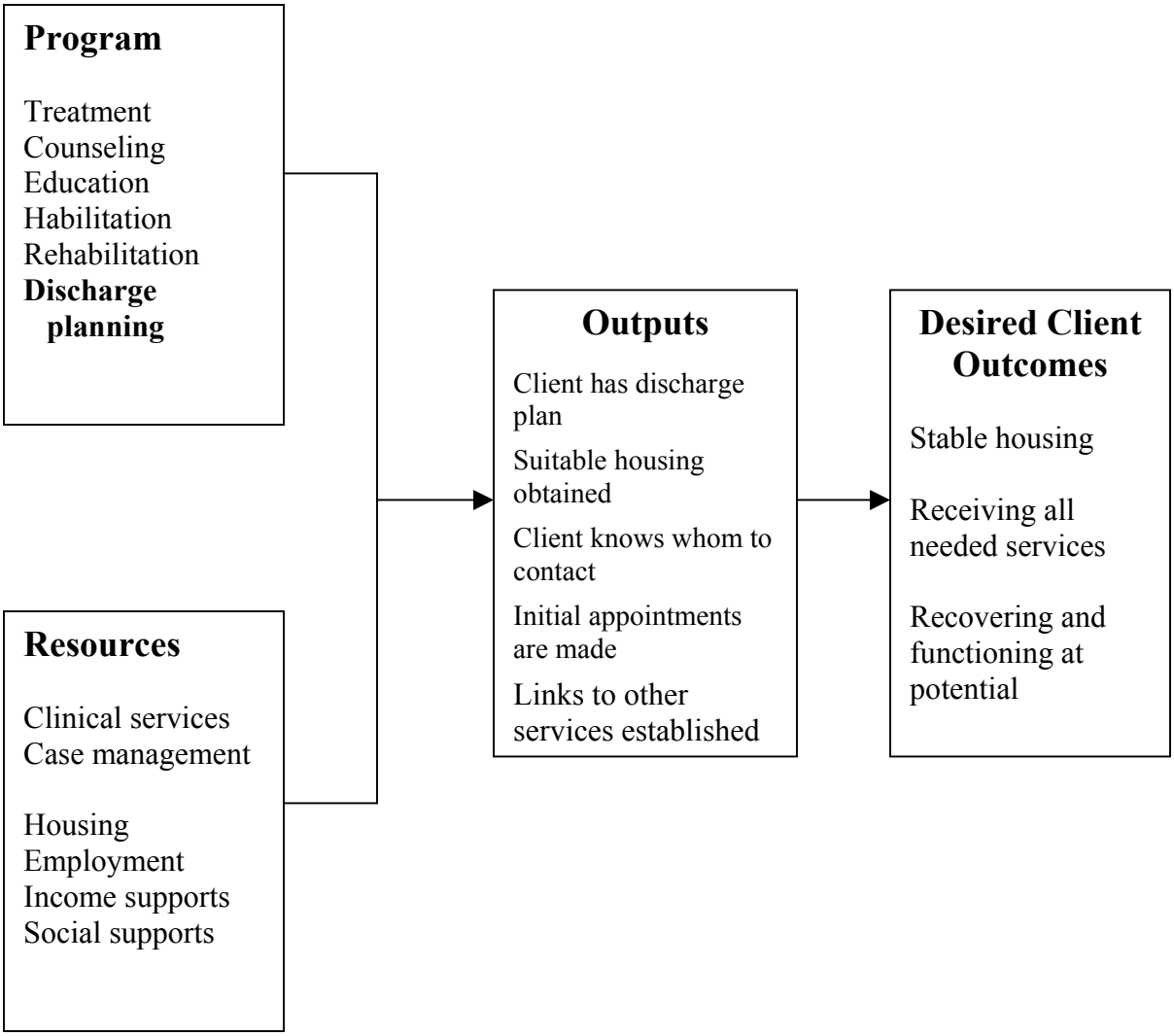
The analytic findings raise the issue of what is the appropriate depiction of the logic model for discharge planning. Logic models provide a tool to assess the adequacy of a program design or model. The research team developed two preliminary generic logic models of the discharge planning process, one for the three institutional settings (Exhibit 1) and the other for foster care (Exhibit 2). We also developed logic models for each of the 19 programs included in the documentary review process.

However, after careful deliberation and consideration, we believe that the program-specific models have some flaws due to their difficulty in realistically characterizing the discharge planning process. Our bases for reaching this conclusion are outlined in the findings presented above. First, we question whether most of the programs have well-developed models of the discharge planning process, or whether discharge planning is instead a less well organized set of activities that is enmeshed within the treatment process. Second, we believe the structure of our original models underestimated the importance of community resources and how completely dependent client outcomes are on the availability of housing and other community resources.

Figure III-1 presents an alternate core for a generic logic model applicable to all four settings that better illustrates our conclusion about the relationship among discharge planning, the treatment process, community housing and other resources, discharge planning outputs, and client outcomes. This model is intended to illustrate that discharge planning is embedded in the program and that the desired outcomes are contingent on both the program (including discharge planning) and community resources. Note that this model presents only the core and would need to be contextualized to represent any specific program.

Figure III-1

Simplified Generic Logic Model



Key Study Design and Measurement Issues

This section presents a number of definitional and measurement issues that will need to be addressed and resolved as part of any subsequent research program. The initial bullet points below address factors critical to designing a study, while later bullets discuss mediating variables that would need to be controlled for in a summative evaluation and other design considerations. In most cases, there are existing measures that could be used, although they will require some adaptation depending on the study context and setting. There are some key concepts, such as the availability of appropriate community housing, that will have to be carefully negotiated and for which no definitive measures are readily available. This section outlines some of these measurement, data collection, and other design issues. Refer to Tables 10, 20, 30 and 40 for additional details on potential research variables and measures for each of the four settings.

- **Sample Size Depends on Purpose of the Study**

The sample size needed will depend on the purpose of the study. A sample of several thousand will likely be necessary to achieve sufficient statistical power if a summative evaluation is the goal. A more modest sample size of one hundred or fewer might suffice if the purpose of the evaluation is formative or exploratory. Although obvious, it is important to state that precise calculations of sample size and statistical power will require a clear articulation of study goals and design.

- **Recruit Clients Who Are at Risk of Homelessness**

The study should recruit clients who are at significant risk of homelessness. Some programs serve only those who are homeless or at high risk of homelessness; however, most of the programs examined serve a significant proportion of clients who typically return to stable housing after the conclusion of their residential stays. Clients should be screened and included in an evaluation study only if they meet some risk threshold for homelessness.

While we have found no screening instruments in regular use to assess the risk of homelessness, there is a good deal of research evidence on client and situational characteristics that place someone at risk of becoming homeless, and we have found two relevant protocols that

were developed experimentally.[81] Presumably, these data could be used to develop reliable tools for identifying individuals most at risk for homelessness. Note that we used the plural *tools* to reflect our judgment that different assessment procedures would be required for different populations. Certainly, different tools would be required across settings and age groups.

- **Develop Strategies To Track Early Terminators**

Early terminators—those who leave programs after a brief stay, sometimes against professional advice—present particular challenges to any evaluation study of discharge planning. Some programs have high early termination rates (50 percent or higher) and followup data on these clients are often limited. These clients may be at the greatest risk of homelessness, yet are least likely to receive adequate treatment or discharge planning because of their early termination. They may also be more difficult to enroll and follow in a tracking study, but are critically important to include if the goal is to prevent homelessness.

The issue of early termination from programs is one of particular importance in the adult treatment settings, and is also relevant in the youth settings. The early termination rates in these settings vary widely and often data about these clients are sparse. For example, in a review of the literature, Stark (1992) found early termination rates as high as 40 percent to 80 percent from adult substance abuse treatment programs.[82] Early termination rates from adult inpatient psychiatric settings vary widely, but estimates of 15 percent or more are not uncommon. Yet many studies that follow clients after discharge exclude clients who have very brief treatment stays or leave against medical advice.[83] Also, some of the factors that may predict early termination, including co-occurring serious mental illnesses and substance abuse disorders and poor functioning, also predict homelessness. These circumstances present particular challenges to any proposed evaluation study. The clients at greatest risk of homelessness are least likely to receive adequate treatment or discharge planning, may have less available data in existing information systems, and may be most difficult to enroll and follow in a tracking study.

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[81] See, for example: Olfson, M., Mechanic, D., Hansell, S., Boyer, C.A., and Walkup, J. Prediction of homelessness within three months of discharge among inpatients with schizophrenia. *Psychiatric Services* May 1999 Vol. 50 No. 5, pp. 667-673. Christ, W.R., Clarkin, J.F., & Hull, J.W. (1994). A high-risk screen for psychiatric discharge planning. *Health and Social Work, 19,* 261-270.

[82] Stark, M. J. (1992). Dropping out of substance abuse treatment: a clinically oriented review. *Clinical Psychology Review, 12,* 93-116.

[83] Boyer, C.A., McAlpine, D.D., Pottick, K.J., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *American Journal of Psychiatry, 157* (10), 1592-1598.; Olfson, M., Mechanic, D., Hansell, S., Carol, A. B., Walkup, J., & Weiden, P. J. (2000). Predicting medication noncompliance after hospital discharge among patients with schizophrenia. *Psychiatric Services, 51*(2), 216-222.

- **Followup Period of 1 Year or More for a Summative Evaluation**

If a summative evaluation study of discharge planning in any of the four settings is undertaken, the study team recommends a followup period of 1 year or longer. This recommendation differs from the recommendation of The Technical Expert Panel (TEP), which emphasized making a clear distinction between what good discharge planning could be expected to accomplish, and what was the responsibility of the community agencies to which client care and treatment were being transitioned. Consequently panel members suggested that, for adults, housing arrangements should be evaluated on the day of discharge and for 1 week after. Linkage to services can take somewhat longer to establish, so they suggested that service linkages be evaluated up to 90 days following discharge. They felt that any subsequent outcomes could be attributed to a variety of client and community factors after discharge, rather than to the discharge planning process. Their conclusions were less specific in the case of foster care, where they felt followup periods of 1 year (or more) were probably called for since the transition is complicated by the attempt to achieve independence through gradual maturation. This latter argument would seem to apply equally well for the other youth programs (residential treatment centers for youth).

Based on our findings from the documentary analysis and the site visits, the research team recommends a followup period of a year or more if an outcome evaluation study is conducted. Our rationale for this position is based on two observations:

1. **In many cases there is a relatively modest short-term base rate of homelessness.** A shorter followup period dramatically lowers the likely base rate of homelessness that could be observed even with unsatisfactory "as usual" discharge planning. To explain that point, consider that available research shows that only 7.6 percent of patients with schizophrenia discharged from general hospitals in New York City became homeless for some period of time within 90 days of discharge,[84] while a study in San Diego, California, found a 15 percent homeless rate among people served by the public mental health system within 1 year.[85] An important limitation of the New York City study was that it excluded patients who left against medical advice—a group likely to be at higher risk of homelessness. However, the San Diego

[84] Olfson, M., Mechanic, D., Hansell, S., Boyer, C. A., & Walkup, J. (1999). Prediction of homelessness within three months of discharge among inpatients with schizophrenia. *Psychiatric Services. 50*(5), 667–673.

[85] Folsom, D. P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., Garcia, P. Unutzer, J., Hough, R., & Jeste, D.V. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry, 162,* 370–376.

study was not subject to this limitation as it included everyone receiving treatment for serious mental illnesses in a large public mental health system in a 1-year period. If typical of other areas, even the 15 percent prevalence rate is relatively modest, and it is over a time period considerably longer than 7 days. Large sample sizes would be required to detect differences between these low base rates and even lower rates that might be achieved by highly effective discharge planning.

A similar argument applies across the four settings. For example, a study of youth leaving foster care found that 12 percent of youth became homeless within 18 months.[86] Newly released findings from this continuing Chapin Hall study of Midwest youth from the foster care system found that 14 percent of those 19-year-olds who were no longer in care had been homeless at least once in the preceding 12 months.[87] Analysis from another study found a public shelter use rate of approximately 7 percent within 12 months of aging out of foster care[88]. If we assume the 1-year base rate of homelessness is then somewhere between 7 percent and 14 percent, a relatively large sample size may be required to detect a reduction in the rate of homelessness related to improvements in discharge planning.

It is critical to recognize that the longer term rates of homelessness in these populations may be much higher and may constitute a serious social problem. It is only in the context of a developing a research design to study the relationship between discharge planning and homelessness that these more modest short-term rates of homelessness present a methodological challenge.

2. **Serious mental illnesses and substance use disorders often require multiple episodes of care.** As McLellan and others have argued in the case of substance use disorders, these disorders are prone to relapse and it is commonly the case that multiple episodes of care are required before recovery is achieved.[89] Research also

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[86] Courtney, M.E., Piliavin, I., Grogan-Kaylor, A., & Nesmith, A. (2001). Foster youth transitions to adulthood; a longitudinal view of youth leaving care. *Child Welfare, 80*(6), 685–717.

[87] Courtney, M.E., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., & Bost, N. Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19. *Chapin Hall Working Paper*. May 2005.

[88] Park, J.M., Metraux, S., Brodbar, G., and & Culhane D.P. (2004). Public shelter admission among youth adults with child welfare histories by type of service and type of exit. *Social Service Review, 78*(2), 284–303. (Also had personal communication with Dr. Park regarding 1-year shelter use rates.)

[89] McLellan, T.; Lewis, D.; O'Brien, C., and Kleber, H. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*,1689–1695.

shows that continuing care greatly enhances the likelihood of maintaining sobriety,[90] so ideally a discharge is only a transition to another level of care. As McLellan argues cogently, short-term research that is based on an acute care model is inappropriate for understanding a chronic disease, such as a substance use disorder. Similar arguments can be made in the case of serious mental illnesses with adults. In the case of youth exiting foster care or RTCs, there is the longer term maturation process to be considered, as well as the fact that many of those at high risk of homelessness also have serious emotional disturbances or substance use disorders.

Thus, a short-term study of discharge planning runs the risk of confounding "natural relapses" with the outcomes of a faulty discharge planning process. A longitudinal design provides the opportunity to examine multiple transitions across settings and levels of care and is better able to distinguish between factors associated with the natural course of the disorder and those attributable to the handling of the transition (i.e., discharge) process.

- **Meaningful Formative Evaluation Is Possible Without a Followup**

Conversely, if the evaluation is formative or exploratory in nature an argument can be made for conducting a study that examines only what happens at the immediate point of discharge. In that case, the housing measure is not residential stability, but only what setting the client is placed in on the day of discharge. The measure of service linkage is not attendance at scheduled appointments, but only that appointments are made and the client informed. These types of measures are clearly insufficient to assure residential stability in the community but could, in conjunction with a variety of other measures, provide rough indicators of the quality of a program's discharge planning process.

- **A Study Will Require Infrastructure for Data Collection and Followup**

Any evaluation study examining homelessness outcomes will require a resource commitment to develop the infrastructure for data collection and client followup. Existing program data (hardcopy and electronic medical records) contain some but not all the information needed to conduct a discharge planning evaluation, and these data are of varying quality.

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[90] McKay, J. R., Foltz, c., & Leahy, P. (2004). Step down continuing care in the treatment of substance abuse: Correlates of participation and outcome effects. *Evaluation and Program Planning, 27*(3), 321─331.

Furthermore, most programs do not have the resources to follow up with clients after discharge or collect data on followup outcomes. The response rates for programs that do collect data on followup outcomes are inadequate for a rigorous evaluation. If a study is conducted it will be critical to tighten procedures and provide additional resources for program data collection and followup; alternatively, the data collection activities could be contracted to external organizations with expertise in this area.

- **Identify Client Demographic and Clinical Characteristics To Be Measured**

Differences in client characteristics affect the discharge planning process, options available to discharge planners, and postdischarge outcomes. Key client characteristics that should be measured in a discharge planning evaluation include presence of mental illnesses, substance use disorders, physical disabilities, developmental disabilities, co-occurring disorders, current and historical involvement with criminal or juvenile justice, and past success in mental health or substance abuse treatment. Critical factors for youth in foster care include the age of emancipation and educational attainment, as well as the presence of serious emotional disturbances, substance use disorders, and developmental disabilities. These individual history, demographic, and clinical characteristics also affect a client's eligibility for entitlements and services upon discharge, and influence discharge planning outcomes.

- **Measure the Availability of Housing and Other Supports**

Another critical variable is the availability of appropriate housing and supports in the communities the programs serve. The arrangement of stable housing and other needed services depends not only on the quality of the discharge planning, but also on the availability of appropriate resources in the community. Even in exemplary discharge planning programs, the outcomes achieved can be disappointing if the housing resources and services are not available.

The shortage of available, affordable housing is a key contributor to the problem of homelessness. For many persons with severe mental illnesses or substance use disorders, housing with supports may be necessary to assure residential stability. There are regular periodic publications that provide data on rental housing affordability by market.[91] There are also decennial census data on housing characteristics and vacancy rates. While we have not yet

[91] O'Hara, A., and Cooper, E. *Priced Out in 2002*. Technical Assistance Collaborative, Inc. Boston, MA. May 2003.; National Low Income Housing Coalition. *Out of Reach 2004*. http://www.nlihc.org/oor2004/ Cited March 18, 2005.

examined this possibility in detail, the HUD Continuum of Care plan submitted by grantees may include some data on housing and service availability relevant to people at high risk of homelessness. HUD-sponsored Homeless Management Information Systems (HMIS) systems under development in communities throughout the nation also may include some data on housing availability in the homelessness services system. There may be other readily available data that characterize housing at the community level. However, it appears that no single source provides data on housing and supportive services. Any outcome study must include a valid and reliable measure of the availability of affordable housing appropriate for the target population of the study. This problem is being addressed in the National Performance Outcomes Assessment (NOPA) study by simply asking each of the partner agencies in the Collaborative Initiative to Help End Chronic Homelessness (CICH) sites for their assessment of housing and service availability by type on a 4-point rating scale, an approach that might work well in the current context.

- **Measure the Policy Context**

Each program is defined in part by the larger policy context in which the program operates (e.g., contractual obligations; accreditation standards and requirements; and state laws, rules, and regulations). The regulatory and accrediting bodies, like the payers, influence the conditions in the program and the discharge planning process. Their policies help determine which services are provided, how discharge planning activities are implemented, and who provides oversight.

- **Measure Treatment Provided in Residential or Custodial Setting.**

Considerable care and attention should be given to what and how to measure treatment services as they contribute to explaining postdischarge client outcomes. As stated earlier, it is difficult to separate discharge planning from the treatment services provided in the residential or custodial setting. Standard measures have been developed in various studies to characterize, for example, residential substance abuse treatment.[92] In the field of psychiatric treatment, a recent review found the status of measures of care for people with schizophrenia lacking, with few

[92] See, for example, McLellan's Treatment Services Review, available at http://www.niaaa.nih.gov/publications/tsr.htm Cited March 22, 2005.

measures fully operationalized and tested for reliability and validity.[93] The same authors point out, however, that there is a good deal of ongoing research into treatment quality assessment that promises to refine these measures. This is a complex and challenging area to assess.

- **Measure Characteristics of the Residential or Custodial Organizations.**

There are many other characteristics of the residential or custodial organizations that could contribute to explaining the postdischarge outcomes and should be measured. Each measure will require some attention, although most are straightforward. In brief, they include:

- Mission of the organization, particularly in relation to discharge planning;
- Type(s) of clients served, including referral paths and screening criteria;
- Cultural, clinical, and geographic diversity of clients served;
- Types of services provided (in addition to treatment services);
- How discharge planning protocols are applied for clients who terminate early, as well as for those who receive expected length of service;
- Length of services;
- Proportion of clients terminating before expected length of services;
- Client assessment information and data availability and collection procedures for entry, discharge, and followup data;
- Quality assurance procedures (for discharge planning and generally); and
- Funding sources, including implications of multiple, differing payers.

- **Measure the Program's Relationship to Other Organizations**

A critical factor that helps determine the effectiveness of discharge planning in obtaining housing and community services is the quality of the linkages and partnerships between residential/custodial and community organizations, such as housing and service providers. SAMHSA's ACCESS (Access to Community Care and Effective Services and Supports) Study devoted a great deal of attention to measuring the characteristics of interagency linkages and their

[93] Hermann, R.C., Finnerty M., Provost, S., Palmer, R. H., Chan J., Lagodmos, G., Teller, T., Myrhol, B.J. Process measures for the assessment and improvement of quality of care for schizophrenia. *Schizophrenia Bulletin*. 2002; 28(1):95–104.

effects on client outcomes.[94] Secondary analysis of the ACCESS study data by Orwin, Myers, and Sonnefeld[95] concluded that more effective linkages were achieved when they were established with other units of the same parent organization than when they were between two independent organizations. Martin and Myers[96] have also described a partnership model that characterizes the conditions necessary for two organizations to collaborate effectively to provide necessary services to clients. The NOPA study has built on the ACCESS model to develop a multidimensional measure of interagency linkage that appears likely to be more sensitive than the measures employed in the ACCESS model and appears promising for use in a study of discharge planning.

- **Use Separate Studies for Different Program Settings**

Considerable care must be taken in determining which programs to compare with which other programs in any study. It might be appropriate to develop a typology of programs that identifies the key dimensions on which they differ in relationship to the discharge planning process and the other determinants of homelessness-related outcomes. That should help to ensure appropriate comparisons. Furthermore, because discharge planning is bound by the context in which it occurs, including a wide range of client, program and community factors, caution is called for in generalizing findings from a study in one program setting (or subtype within a setting) to other programs that may differ on these key dimensions.

It would be impractical to aggregate across settings that treat adults (psychiatric inpatient treatment, residential substance abuse treatment) and youth (foster care, psychiatric inpatient treatment, residential treatment centers for youth, and residential substance abuse treatment in a single evaluation study. A partial listing of significant differences between adult and youth settings would include legal status, maturation, funding sources, typical program lengths of stay, and governmental agency involvement. Our expert panel also suggested that appropriate followup periods should be longer for youth (a year or more vs. up to 90 days for adults). We have found that adult and youth settings are so different that statistical methods could not be used to control for differences.

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[94]Morrissey, J.P., Calloway, M.O., Thakur, N., Cocozza, J., Steadman, H.J., Dennis, D., et al. Integration of service systems for homeless persons with serious menal illness through the ACCESS program. *Psychiatric Services*, August 2002; 53(8): 949–957.

[95]Orwin, R.G., Myers, M.A., and Sonnefeld, J. (2003, November). *Secondary Analysis of the CMHS ACCESS Multisite Program for Homeless Mentally Ill Persons.* Presented at the Annual Meeting of the American Evaluation Association, Reno, NV.

[96]Martin, W. W. , Hobson, W., Myers, M. A. and Wolfe, P. (2003, July). *Ending Chronic Homelessness: Strategic Partnering for State and Local Administrators.* Presented at the Annual Meeting of the National Alliance to End Homelessness in Washington, DC.

Within the youth settings, foster care differs from residential treatment centers (RTCs) on some less clear cut but important dimensions. The RTCs are more likely to have youth with varying custody statuses, including parental, juvenile justice, and foster care. The RTCs are also more likely to have an explicitly clinical programmatic intervention designed to address serious emotional disturbances, substance use disorders, or both. While the kinds of foster care independent living programs we have examined may also include youth with those disturbances or disorders, their central focus is primarily educational, with the aim of preparing the youth for independent living after they "age out."

The issues encountered in aggregating programs across the two adult settings are no less formidable. Psychiatric and substance abuse treatment programs historically have cultural differences in their manner of operations, professional roles, and expectations of clients. The clinical models are different and the expectations for discharge planning diverge in significant ways.

Furthermore, each of the four program settings addressed in the study—foster care independent living programs and residential treatment centers for youth, and psychiatric inpatient treatment and residential substance abuse treatment programs that serve adults—actually represent many discrete types of programs. For example, in the psychiatric inpatient treatment setting category we examined both state psychiatric hospitals and psychiatric units of general hospitals. While the programs examined did not include free-standing private psychiatric hospitals, that was a matter of chance, not design. Yet these three types of psychiatric inpatient units differ in many important respects, including characteristics of clients served, length of stay, staffing patterns, risk of subsequent homelessness, and form and extent of linkage to community agencies, all of which bear upon the operation of the discharge planning processes.

We also observed clear differences in characteristics of clients served, length of stay, early termination rates, staffing patterns, risk of subsequent homelessness, and other variables between residential treatment centers for youth that primarily serve youth with serious emotional disturbances (SED) versus those primarily serving youth with substance use disorders.

Similar distinctions are apparent between subsets of programs within the other two types of settings included in the study: foster care independent living programs and residential substance abuse treatment programs serving adults.

IV. Alternative Research Designs

Introduction

The purpose of this section is to describe feasible alternative evaluation approaches to increase our knowledge of how to prevent homelessness among those served in the four program settings. The study team questions whether a rigorous, objective summative evaluation of discharge planning as a strategy to prevent homelessness in institutional and/or custodial settings is justified at this time. However, we found that alternative study designs to evaluate specific issues or activities related to discharge planning and homelessness prevention are feasible. These designs are described in the following section of the report.

Given the breadth of program settings examined in this evaluability study, as well as the related settings not included (e.g., jails serving people with serious mental illnesses or substance use disorders), it is also important to consider what settings should be examined in any follow-on research. A good argument could be made for studying the setting in which the discharge planning process is best developed. Our observations from this evaluability study indicate that one particular state psychiatric hospital setting that we visited (discussed in detail in the Inpatient Adult Psychiatric Setting section, pp. 92–116 had the most structured and developed discharge planning procedures. Conversely, there is equal or greater need to find ways to improve discharge-planning-related performance in other settings, which argues for additional research in those environments. Perhaps the choice of setting for subsequent study is more a policy question than an evaluation question.

This section presents four preliminary outlines for evaluation studies that could enhance our knowledge of the discharge planning process as it relates to subsequent homelessness or, more generally, to the prevention of homelessness in the four settings in this study. None of the proposed designs is intended to provide a comprehensive answer to the central question of the relationship between discharge planning and subsequent homelessness. Instead, they should be considered as elements of a more comprehensive research program that could, over time, fill in more pieces of the puzzle. We offer for each evaluation design:

- Research questions,
- A rationale,
- Description of methods that might be used,
- Measure and data breakouts,
- Description of the final product(s) of the study,
- Products and utility,
- Recommended scope and setting,
- Human subject and information collection issues,
- Limitations, and
- Estimated duration and cost.

1. A Study of Client Screening Protocols To Predict Risk of Homelessness

Research questions: Can screening protocols that predict which people are at high risk of homelessness following discharge contribute to improving the effectiveness of the discharge planning process? Can such protocols predict the necessary type of discharge planning activities required and the level of discharge planning effort needed to help assure suitable housing at discharge? How are existing protocols structured and what are their psychometric properties, including their effectiveness as predictors of the risk of subsequent homelessness? Are programs currently making use of protocols to predict risk of homelessness or type and level of discharge planning effort? How are those programs using the information gained to improve their service quality and discharge planning processes? What barriers prevent others from adopting the use of such screening protocols?

Rationale: Knowing which clients are at higher risk of becoming homeless could facilitate linking them to appropriate housing or community programs that are targeted to preventing homelessness. Similarly, knowing which clients are likely to require a higher level of effort to prepare an effective discharge plan could improve the allocation of staff resources during the stay in the institutional or custodial setting. There is an extensive literature on risk factors for homelessness across populations.[97] In foster care, a variety of client assessment tools are used to

[97] See for example: Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve. Highlight report. Findings of the National Survey of Homeless Assistance Providers and Clients U.S.*; Washington, DC: The Urban Institute Press.; Park, J. .M., Metraux, S., Brodbar, G., & Culhane D. P. (2004). Public shelter admission among youth adults with child welfare histories by type of service and type of exit. *Social Service Review, 78*(2), 284–303.

measure risk of various adverse outcomes that might be related to later homelessness.[98] In the case of discharges from psychiatric hospital settings, a few studies have reported on client assessment instruments and protocols that appear to be reliable predictors of high risk of subsequent homelessness or need for a high level of discharge planning effort.[99] The proposed study would review the literature on client-related (as opposed to environmental) predictors of a high risk of homelessness in one or more of the settings and populations included in this study. The study could examine whether such client screening protocols are used in relevant settings, and why or why not. (Note that none of the programs examined in the current study used such protocols.) If settings are making systematic use of such screening protocols, the study could include a process assessment of the way they are used and the contribution they make.

Methods: This would be a qualitative case study design that examined how screening protocols that predict risk of homelessness and level and type of necessary discharge planning activities fit into the discharge planning process in specified settings. Depending on design decisions that would be made well into the project, it could be either a one-group pretest-posttest design or a non-equivalent static group comparison design.[100] Except for the few published studies, we have no current evidence that settings are using such screening protocols. Therefore, a more extensive environmental scan will be critical to determine what settings and individual sites are available and appropriate to include in the study. The environmental scan would include a targeted review of the literature, a review of the Web, and consultation with experts in the area. If feasible, state and local plans to end chronic homelessness might also be examined for references to discharge planning and screening instruments to identify risk of homelessness. Only after the environmental scan is complete could we determine whether sites are available that are currently using protocols. If current protocol users are not found, the next best alternative would be sites that are currently collecting data that would support protocol application and that are willing to implement a screening protocol. Failing that, we would seek sites that are open to implementing a protocol based on published research. Clearly, the exact nature of the final study could be decided only after we have a better understanding of the current extent of screening protocol use. [An optional activity not included in our recommendations would be to develop and test a screening protocol.]

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[98]Nollan, K. A., Wolf, M., Ansell, D., Burns, J. 2000. "Ready or not: Assessing youths' preparedness for independent living." *Child Welfare* 79(2), pp. 159-176.

[99]See, for example: Olfson, M., Mechanic, D., Hansell, S., Boyer, C. A., & Walkup, J. Prediction of homelessness within three months of discharge among inpatients with schizophrenia. *Psychiatric Services* May 1999 Vol. 50 No. 5, pp. 667–673. Christ, W. R., Clarkin, J. F., & Hull, J. W. (1994). A high-risk screen for psychiatric discharge planning. *Health and Social Work, 19,* 261–270.

[100] Campbell, D. T., & Stanley, J. C. Experimental and quasi-experimental designs for research. Boston: Houghton Mifflin Company.

Literature review and environmental scan: The first activity would be a targeted review of the literature and environmental scan focused on client screening protocols that are intended to predict the risk of homelessness or need for more intensive discharge planning efforts.

Expert panel: An advisory panel would be selected with expertise on risk of homelessness, effective discharge planning strategies, and psychometric properties of screening instruments. Their role would be to advise on risk screening protocols and their integration into the discharge planning process in ways thought likely to improve residential stability in the community.

Site selection and case study visits: Through the environmental scan and the advisory panel process, the study team would attempt to identify settings that are: (1) currently making use of such screening protocols, (2) currently collecting client data (such as the Brief Psychiatric Rating Scale, global functioning measures, and structured social histories) that could be used to derive risk estimates following existing models and express willingness to implement a screening protocol, or (3) open to implementing a screening protocol based on published models and to allowing a study of how such a screening protocol contributes to improving the setting's discharge planning process. Somewhat arbitrarily, we propose that a total of eight sites be visited.

Details on subsequent procedures would vary considerably, depending on whether the cooperating program settings were of the first, second, or third types. If the program is already using a protocol (Type 1), the site visit might review the characteristics and workings of the discharge planning process and collect data on a small sample of clients discharged recently. The number of client discharge processes to be evaluated in each setting would be negotiated with due consideration to respondent burden; for example, 12 client discharges, divided into 5 at high risk of homelessness, 5 medium risk, and 2 low risk might be appropriate. In Type 2 or 3 programs, it would first be necessary to orient the discharge planners to the use of a new screening protocol, using one of the two identified protocols[101] or others found during preliminary stages of the study. In Type 2 sites, the risk screener scoring process would be based on data already collected by the site; in Type 3 sites it would be necessary to introduce both the data collection and the risk

[101] Olfson, M., Mechanic, D., Hansell, S., Boyer, C. A., & Walkup, J. (1999). Prediction of homelessness within three months of discharge among inpatients with schizophrenia. *Psychiatric Services. 50*(5), 667–673. Christ, W. R., Clarkin, J. F., & Hull, J. W. (1994). A high-risk screen for psychiatric discharge planning. *Health and Social Work, 19,* 261–270.

screener value calculation. After the protocol is in use at the Type 2 and 3 sites, the study could collect the kind of data discussed for Type 1 programs.

If Type 1 sites are available and selected for inclusion in the study, it would be appropriate to enroll a number of matched comparison sites that are not using a screening protocol (four of each), thus making this a non-equivalent static group comparison design. If Type 2 or 3 programs are enrolled instead, it may be viable to collect the discharge planning and immediate client outcome measures pre- and postimplementation of the screening protocol, making the study a one-group pretest-posttest design. In either case, the very fact of using the screening protocol is likely to change both the process and the outcomes, so some form of comparison is important to assure internal validity.

For Type 2 or 3 programs, a minimum of two site visits per program would likely be required, while a single site visit might suffice for Type 1 programs. In all cases, information on barriers to use of screening protocol data would also be examined. [If the optional instrument development activities are included in the study, the screening calls and original site visits could also attempt to identify sites that are well suited to testing and refining a screening protocol.]

Measures: Examples of key measures for this study would be:

- When and how the program staff implemented the risk screening protocol; (Independent variable)
- Whether and how program staff reported they had changed their approach to discharge planning based on the information obtained from the screening protocol;
- Whether the length of stay in the residential or custodial setting was longer than expected because of difficulty in devising an appropriate discharge plan.
- Whether the client had been given a choice of appropriate and available housing options;
- Whether program staff had spoken or met with the relevant community housing or program staff prior to the client's discharge;
- Whether the client had the opportunity to visit housing options prior to discharge;
- Whether the client had and was aware of scheduled appointments for community-based services appropriate to their needs on the day of discharge;
- Whether the client had met with community-based staff and/or visited community programs prior to discharge;

- Whether the client was placed in a housing setting appropriate to their needs on the day of discharge (this might be either a staff assessment or an independent rating by research staff);
- Whether, if appropriate housing is not immediately available, the client is placed into an alternate residential placement that is part of a coordinated longer-term plan to move them into an appropriate housing settings (e.g., placed in a specialized treatment-oriented shelter while awaiting permanent housing).

Data breakouts needed: These too will vary depending on the final structure of the study, but could include:

- Clients at high, medium, or low risk of homelessness as predicted by the screening instrument;
- Client diagnostic groups (since one of the published protocols was originally validated for use on patients with schizophrenia or schizoaffective disorder);
- Clients whose length of stay was longer or shorter than program expectations;
- Individual program site, or site pair if matched site design.

Optional development and testing of a screening protocol (not included in core study time or cost estimates): Building on the two identified protocols (Olfson et al., 1999; Christ et al., 1994) and others found during a targeted literature review and environmental scan, the study could develop and evaluate protocols that could be used in specified settings. This optional activity would involve actual development and testing of screening protocols with current clients in selected settings. Unlike the core study proposal, this would require followup with clients in the community after discharge to ascertain their housing and service participation status at 90 days (or longer if foster care independent living or residential treatment centers for youth were selected for the study setting). Depending on the findings from earlier study activities, a detailed design would be developed for client enrollment, assessment, and postdischarge community followup. Informed consent procedures would be essential, and review and approval by both the Office of Management and Budget (OMB) and relevant Institutional Review Boards would be required. Depending on the setting and client population selected (e.g., youth vs. adults; psychiatric hospitals vs. substance abuse treatment programs), clients would be assessed following discharge to ascertain community housing status at specified time intervals. Appropriate psychometric measures would be used to evaluate the predictive validity of the

screening instrument—that is, whether the score on the screening instrument was associated with the probability of becoming homeless following discharge. The instrument might be refined (e.g., items eliminated or timing of administration adjusted) on the basis of these findings. If successful, a screening instrument and administration protocols suitable for use in the setting type might be finalized, or additional research recommended. For this substudy, it would be necessary to include non-equivalent matched comparison sites that did not implement the screening protocol in order to reduce the threats to internal validity.

Products and utility: A final report would be prepared that summarized the findings, including answers to each of the research questions, and made recommendations for next steps. The report would show what was learned about the utility of existing screening procedures, how they are or are not integrated into discharge planning, and how their use can improve the discharge planning process and immediate client outcomes. If they are in the public domain, copies of existing screening protocols would be included. The report would also include discussion of barriers to more widespread use of risk screening protocols and possible means to overcome any barriers. If multiple examples of current risk screening protocols are found, there might be discussion of their relative utility and contribution. [If an optional instrument is successfully developed, the recommended next steps might include a dissemination process intended to broaden the use of this and similar screening instruments.]

This study could provide concrete information that would be of use to other programs similar to those studied on how to make use of risk assessment protocols to improve their discharge planning processes. This knowledge could lead to better targeting of resources to those in greatest need, making more cost-effective use of discharge planning time and community housing and services. [If the optional new or modified protocols are developed, the report could also provide information about their development, utility, and psychometric characteristics.]

Scope and setting: We would recommend that about eight case studies be conducted. If Type 1 settings that already use a screening protocol are identified, then half this number would be non-equivalent matched comparison sites. If Type 2 or 3 settings are enrolled so that pre- and postmeasures are possible, then all eight programs may be implementing some form of screening protocol. This study could contribute substantially if conducted in either adult or youth settings. Our review of the existing literature indicated that either adult psychiatric hospital settings or foster care independent living settings could be appropriate and useful environments in which to conduct the study. The most relevant published studies were conducted in psychiatric hospital

settings. Note that our expert panel recommended that there be longer followup periods for youth, but this is relevant only if the optional task is included because no client followup is proposed for the core study.

Human subjects and information collection clearance issues: As proposed, the study conceivably could be conducted without client contact, thus minimizing the human subjects issues. However, interviews with clients during site visits would certainly enrich the study. If client interviews were included, it is likely that Institutional Review Board (IRB) reviews would be required at each site, which will slow the overall project schedule to some extent. It is very likely that OMB clearance would also be required, which will need to be considered in completing the project timeline.

Limitations: The proposed study is qualitative in nature and would provide only a limited amount of data on the immediate outcomes associated with the use of risk assessment screening protocols. As proposed (without the optional protocol development activity), it would be based on the assumption that the limited number of published studies and existing practice are adequate to provide a useful direction on how to assess the risk of homelessness following discharge. In the absence of a well-developed setting typology and a sampling frame, case study site selection would be based on limited data, therefore restricting the ability to generalize findings to other settings with a known degree of precision (external validity).

Estimated duration and cost: Based on prior work on similar projects, we would estimate that the project could be completed in approximately 18–36 months, depending on a number of detailed design choices. The estimated cost would likely be relatively low. Addition of the optional protocol development activity would extend the estimated duration to approximately 48 months and boost the cost to the moderate range.

2. A Study of Early Terminators/Foster Care Runaways and Methods To Engage Them

Research Questions: What client and program factors are associated with terminating early from substance abuse and psychiatric treatment program settings or running away from foster care? Do these differ, depending on whether it is a first early termination/running away or a subsequent one? Do programs assess the likelihood of terminating early/running away, and do they have alternative approaches to providing discharge planning services to clients that are likely to terminate early/run away? What amount and type of discharge planning is necessary for these

clients? When clients terminate early or run away, where do they go? How long are they there? How often does the termination/running away result in homelessness, and what predicts the homelessness? What factors are associated with coming back into treatment/foster care? What practices are effective in preventing early termination/running away, or shortening the period before clients come back into treatment/foster care, to ensure that they receive adequate discharge planning? What are clients' perceptions of their situations, including the factors considered in their decisions to terminate early/run away and their experiences (especially regarding homelessness) after they terminate/run away?

Rationale: Several of the programs examined in this study had substantial numbers of clients who left the program before discharge planning could be completed—some in excess of 50 percent. And one recent study found that a youth's likelihood of running away from foster care increased significantly starting in the late 1990s.[102] Early termination from treatment and running away from foster care likely lead to a higher risk of homelessness when clients do not receive the full dose of treatment and/or discharge planning. Diverse strategies attempt to engage and retain clients in treatment or foster care, and to provide services after clients terminate, but little is known about the role of discharge planning in these strategies. Thus, the proposed study would focus specifically on effective methods of discharge planning with this difficult group of clients. Much is unknown about these clients, partly because of the challenges in studying them. Many studies that follow clients after discharge exclude clients who have brief stays or leave against medical advice,[103] and there has not been a systematic study of early termination/running away in relationship to discharge planning and homelessness. Documenting how programs address the problem of providing sufficient discharge planning to early terminators, and understanding more about how these high-risk clients differ from clients who complete treatment or stay in foster care until discharge, will help in developing strategies to address the problem of homelessness among these populations.

Methods: The proposed study would consist of case studies of programs including discussions with selected staff and examination of program and government administrative data on dropouts (where available), methods to identify and provide discharge planning to clients

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[102] Courtney, M. E., Skyles, A., Miranda, G., Zinn, A., Howard, E., & Goerge, R. (2005). Youth who run away from out-of-home care. *Issue Brief #103*, Chapin Hall Center for Children, University of Chicago.

[103] Boyer, C. A., McAlpine, D. D., Kottick, K. J., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *American Journal of Psychiatry, 157*(10), 1592–1598; Olfson, M., Mechanic, D., Hansell, S., Carol, A.B., Walkup, J., & Weiden, P. J. (2000). Predicting medication noncompliance after hospital discharge among patients with schizophrenia. *Psychiatric Services*, *51*(2), 216–222.

likely to terminate early/run away, and homelessness outcomes experienced by clients who terminate early or run away. These homelessness outcomes might include, for example, whether the client had been homeless (i.e., not had a regular place to stay) at any point since dropping out/running away; if so, for how many nights; whether client currently owned or rented housing, and how long in that housing; who client currently lives with, and for how long; and the client's perception of the safety of the current place or residence (home and neighborhood). An environmental scan, including a targeted literature review on early termination/running away, a Web review, and consultation with experts in the area, will provide a basis for selecting the case study sites. Important considerations will be data availability and program focus on identifying and providing services to clients at risk of early termination/running away. An optional longitudinal study would follow clients who dropped out or ran away, to learn about their outcomes some time after their experience in the program. Locating and interviewing samples of clients who recently dropped out or ran away will be an important and resource-intensive part of the study. The longitudinal study would involve telephone interviews with clients every 3 months for up to 18 months. Local representatives would help maintain contact and help with the tracking.

Literature review and environmental scan: The first activity would be a review of the literature on early dropouts from treatment and running away from foster care, and an environmental scan to learn about programs that focus on early dropouts and runaways, to obtain a better understanding of this high-risk group and services targeted to improving their outcomes.

Expert panel: An advisory panel would be selected with expertise in studying early termination/running away and in providing services to clients at risk of early termination/running away. Panel members would advise on obtaining and using data on early terminators/youth who run away and recommend promising or proven models for providing services to clients at high risk of early termination/running away.

Site selection and case study visits: Through the environmental scan and expert panel advice, the study team would identify (1) programs where administrative data would allow comparisons of early terminators/runaways and completers and (2) programs with an effective or promising focus on clients at high risk of early termination/running away. The number of programs would depend on available resources and the number of settings and populations of interest; here we propose nine, as described later. Site visits would involve learning about the program's goals and discharge planning services regarding early terminators/runaways and

conducting interviews with small samples of clients thought to be at high risk for dropping out, as well as clients who had recently dropped out. The interviews with early terminators/runaways could collect information on the demographics; their housing status at entry into the program (not applicable for foster care); their plans for housing when they leave the program; whether they had ever dropped out/run away before, and if so, where they went and whether they experienced homelessness; their current foster care setting (only applicable for foster care); the discharge planning activities they had received; and their satisfaction with the program and services. One site visit per program may suffice, although second sites visits may be necessary to locate and interview former clients. If the longitudinal study is pursued, a further round of site visits might be necessary. In addition, as part of the case studies, the study team would obtain program and/or government administrative data on characteristics of clients who dropped out and those who completed the program. The administrative data will help in identifying differences between dropouts and completers, and their experiences in the settings. Depending on the completeness of the data, correlation and cluster analysis might help to target who is likely to terminate early/run away.

Measures: Examples of key process and outcome measures for this study include:

- Whether programs assess clients' likelihood of early termination/running away, and how;
- Whether programs provide alternative discharge planning services to clients at high risk, or with a history, of terminating early/running away;
- What the alternative discharge planning services are;
- What proportion of clients terminate early/run away, and how the length of stay (LOS) of dropouts differs from the LOS of program completers;
- How characteristics of clients who terminate early/run away compare with characteristics of clients who complete programs;
- What types of programs or program characteristics are associated with a high proportion of dropouts;
- What strategies program staff believe are effective in preventing early termination/running away and ensuring that clients receive the appropriate “dose” of discharge planning;
- What the core discharge planning activities are that staff believe make a difference in outcomes (especially homelessness) for clients who terminate early/run away;

- Among clients who terminate early/run away, how many are homeless after leaving the program;
- Among clients who terminate early/run away, how many later come back into treatment/foster care; and
- The perceptions of clients who terminate early/run away regarding why they dropped out, what might have kept them in the program longer, and their experiences after dropping out (especially with homelessness).

Data breakouts needed: Program and government administrative data could be used to help better understand early termination/running away. Examples of data breakouts could include:

- Comparisons of the demographics, program experience (e.g., foster care placement history), and LOS, as well as any available information about homelessness and related outcomes, of clients who terminate early/run away with clients who do not;
- Identification of programs with high and low dropout rates and investigation of their different program strategies for ensuring that clients receive discharge planning services.

Optional longitudinal data collection on clients: This optional activity would involve tracking and interviewing clients for up to 18 months after they terminate early or run away, at each site selected for the study. The value in this effort would be that the study could learn what happens to these high-risk clients—whether they become homeless, other outcomes they experience, and their perspectives on the treatment or foster care program they were in. A telephone interview protocol would be developed and subsequently administered every 3 months, and tracking procedures would be implemented for staying in touch with the clients. A stipend would be paid to clients for each interview completed (e.g., $25). We propose hiring local representatives for tracking and contacting clients, such as older youth who had stayed in the foster care program. Where necessary, an additional round of site visits could be conducted to hire and train the local representative and implement the tracking procedures. The telephone interviews would be administered by the study team.

Products and utility: A final report would summarize the findings, answer the research questions, and identify promising or proven practices for discharge planning with this high-risk group. This proposed research would promote understanding of the role of early

termination/running away in subsequent homelessness, and shed light on how programs could address the problem—both to keep clients in the program longer and to identify and ensure that those clients who are likely to drop out receive the discharge planning services that will help prevent homelessness.

Scope and setting: In the evaluability assessment study, the residential treatment centers for children and youth were the only programs in which early termination/running away was not a significant problem. Therefore, we recommend that the proposed study be conducted in the other three settings—adult substance abuse treatment centers, inpatient psychiatric programs, and foster care. The number of sites selected for the proposed study would depend upon resources available, but ideally at least three programs per setting would be selected, to represent both high dropout and low dropout programs in each type of setting.

Human subjects and information collection clearance issues: Since the proposed study includes contact with clients, IRB approval would be required. Time and effort to prepare for IRB review, at the contractor level and possibly at each site, must be factored into the timeline. The design proposed here (i.e., discussions at nine sites) would not require OMB clearance, but if more sites are selected, OMB also may need to be factored into the timeline. However, the optional longitudinal client followup design proposed here would require OMB clearance, so resources should be allocated for developing an OMB package and complying with OMB requirements.

Limitations: (1) Availability of program and government administrative data might be limited. For foster care settings, state child welfare data systems generally have information on runaways, but comparable state-level data systems do not exist for substance abuse treatment centers or psychiatric hospitals. However, many such programs may keep data on early terminators that could be used for the proposed study. Also, there might be a time lag between a termination/runaway event and the availability of administrative data about the event and client. (2) Clients who drop out of treatment or run away from foster care, especially those who experience homelessness, can be extremely challenging to locate and interview. Programs must acquire from clients, while they are still in the program, contact information for people who will know where the clients are after they leave the program. In addition, sufficient resources must be expended and persistent efforts made to locate the clients after they leave. The followup sample of these clients will likely be quite small and possibly biased because of missing homeless clients, and will provide anecdotal rather than quantitative information for the study. However, the

richness of the data that could be gathered and the lack of alternative data on outcomes make this part of the proposed study very important. In the case of foster care, interviewing minors is additionally complicated by the need to obtain agency or parental approval, or both; one solution might be to interview only clients who are at least age 18. (3) This descriptive study will not establish program or model effectiveness, but would provide an important first step toward designing an evaluation that would assess effectiveness. In addition, the study will not support generalization from the results in the studied programs to the situations of clients in other programs or locations. However, it will begin to address a knowledge gap regarding early terminators/runaways in these populations.

Estimated duration and cost: Assuming a selection of about nine sites, we estimate that the study could be completed in approximately 18 months and the cost would be relatively low. If the longitudinal study of early terminators/youth who run away is conducted, that could entail an additional 18 months and increase the cost into the moderate range. Tracking and interviewing these clients would be labor intensive, but would produce valuable data about outcomes that could be obtained in no other way.

3. A Study of State Policies To Improve Discharge Planning and Prevent Homelessness

Research Questions: What policies have states adopted to improve the discharge planning process as a means of preventing subsequent homelessness? How do policies differ across program settings (e.g., state psychiatric hospitals, private hospitals, foster care, substance abuse treatment programs, and others). What oversight and training are required to successfully implement these policies? What incentives, penalties, and performance measures are in place to ensure implementation of the policies? What do performance measure data reveal about the effectiveness of these policies? What problems have been encountered that act as barriers to effective implementation of these policies? What elements and strategies seem to be critical to the successful design and implementation of discharge planning policies in the various sectors in which they are being employed?

Rationale: State adoption of discharge planning policies may be a promising strategy for improving discharge planning practices and preventing homelessness. The Federal Interagency Council on Homelessness Web site tells us that 49 of 50 states have developed a state-level

interagency council on homelessness.[104] States throughout the nation have developed 10-year plans to end chronic homelessness, and many of those plans call for developing or strengthening policies to improve discharge planning as a strategy to prevent homelessness.[105] While states are adopting various discharge planning policies and practices, little is known about the policies themselves or their impact on the discharge planning process and outcomes. For example, one approach is to incorporate provisions into state contracts that prohibit providers from discharging a person into homelessness. As part of this evaluability assessment, we visited a state with this type of policy and learned that some providers view it as having limited effectiveness because of the serious lack of affordable housing in the area, the absence of performance measures, and lax enforcement. Other policies adopted by states include regulations specifying which organization is responsible for planning and conducting the discharge planning process, including the timing of all discharge planning components, specification of the parties involved, and information presented in the discharge planning form. Some states reward effective discharge planning through the use of performance-based contracting.

There is a clear need to catalogue the relevant discharge planning policies adopted by states to better understand the critical elements and impact of these policies. Since the policies are developed for and applied to a broad range of institutional and custodial settings, it will also be interesting to examine the similarities and differences across settings. It may be easier to impact policy in psychiatric hospitals wholly funded by the state than in private general hospitals or residential substance abuse treatment programs, for example. Depending on the setting, different incentive and measurement approaches may be needed to bring about change in performance at the organizational and interorganizational level. Examination of this range of issues and an attempt to identify policy elements that appear critical to success could provide valuable information for state and local policy makers throughout the nation.

Methods: We would first attempt to develop a comprehensive catalog of the various discharge-planning-related policy changes states are making, then select states with innovative or promising approaches for further study, particularly if they have performance data that documents changes in practice or outcomes (e.g., homelessness) as the consequence of policy implementation. Since this study would be, to the best of our knowledge, the first to examine this issue, we recommend a blended method approach that combines a qualitative case study design of

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[104] www.ich.gov, cited July 12, 2005.

[105] www.endhomelessness.org/localplans, cited July 12, 2005.

implementation and contextual issues with a quantitative analysis of performance measurement data as available. To the extent that time series performance data are available that predate the implementation of the policy change, each case study could have the characteristics of a time series quasi-experiment. However, if the only available data series starts concurrent with or after the policy change, the site study would be a one-shot pre-experimental case study.

Survey and cataloguing of state policies: As the first step, we would conduct a survey of state policies related to discharge planning and homelessness prevention. Starting by contacting state interagency council on homelessness staff, we would attempt to identify what discharge planning policies are in place to prevent homelessness across the four settings included in this study. To the extent possible, we would obtain copies of existing policy and procedure documents and catalogue the discharge planning practices, performance measures, and incentive provisions by setting. We would make phone calls to informed contact persons in the state systems to clarify any ambiguous issues regarding the structure and implementation status of the policies. For example, it would be critical to understand the extent to which policy in particular areas is centrally administered by state government or more independently administered by counties or localities. The type and availability of performance measurement data would be an especially important issue that could help determine which states and policies were good candidates for more in-depth study. We know, for example, that some states have relatively comprehensive outcome data on those served in the public mental health system that might be useful in this context. We would create a database with descriptive information on the various policies and their features by state and setting, including copies of policies as they are available.

Analysis of performance data and site visits: A limited number of states and policies would be selected for closer examination. The number would be determined by the extent of variation in policy across states and settings and by the availability or resources for the study. As practical, we would obtain and analyze state time series performance data that showed how practices or outcomes had changed over the time period associated with policy implementation. We would also look at the differences in measures and approaches across the selected policy implementation processes. Two or three-day site visits would be undertaken to obtain contextual information on the policies and implementation processes. Interviews with state and local officials, program representatives, advocates, and other relevant stakeholders will provide a richer and more nuanced understanding of how the policies work in context and what other environmental factors might contribute to explaining the observed changes in performance measures.

Measures: Examples of key measures for this study would be:

- What standards the policy requires the implementing parties to meet,
- What performance measures are used to assess compliance,
- What consequences are available to assure compliance,
- What procedures are in place to facilitate continuous quality improvement,
- How complete the policy implementation process is —which elements are in place and which are not,
- What other relevant changes in the environment were occurring simultaneously with implementation of the policy (e.g., developing housing or starting new community service programs),
- What changes in discharge planning practices have been observed,
- What changes in the rate of homelessness at discharge have been observed, and
- How performance has varied across settings and administrative entities.

Data breakouts needed: These could include:

- The type of setting(s) to which the policy applies,
- The type of clients served by the programs, including their risk of homelessness,
- The policy goals,
- The types of performance measures and consequences provided in the policy.

Products and utility: The proposed study would produce two major products. The first would be a descriptive database with policy text and categorization of the policies and implementation features on a range of dimensions. The second would be a narrative report that provides brief summaries of the case studies and attempts to identify cross-cutting observations on the key characteristics of effective policies and implementation methods by setting. Both products could be very useful in improving future state efforts to change discharge planning practices, particularly if the rollout is combined with the development of appropriate training materials.

Scope and setting: The initial survey would be conducted across all 50 states, and there should be a significant effort to obtain full participation. This would involve contacts with state interagency councils for homelessness and would attempt only to identify which settings were

implementing relevant policy initiatives. The second stage of the survey is at the level of individual policies. At this second stage, we would attempt to contact policy makers in particular settings (e.g., child welfare or mental health) to obtain copies of and information about relevant policies. It seems likely that respondent burden will limit cooperation in obtaining detailed information on the individual policies by setting, but an effort to obtain a high response rate at this second stage will enhance the value of the final product. As mentioned previously, the most useful scope of the detailed analysis and site visit component of the study would depend on the extent of variation in practice found across states. Resource availability is always a determining factor, but we will assume detailed analysis of performance data and site visits would be conducted for nine policies for planning purposes.

This study could be conducted across all the setting types included in the evaluability assessment study. There are sharp differences in circumstances and practices across settings and these differences could contribute to understanding. It will be critical to recognize that the intersetting differences are determined by the programs' relationship to the state, the role of county or local governments, their funding streams, and their ownership and governance structure, not just the type of clients served or services provided. If policy interests or resources dictated, the study could also be limited to one or a few setting types.

Human subjects and information collection clearance issues: There are human subjects issues both with the collection of the performance data and with any potential client interviews during the site visits. We would propose that the states remove any unique client identifiers from all data sets they send for analysis. This approach has been successful in similar research contexts in the past. Client interviews, while potentially revealing, seem less important in a policy study like this than in a study more specifically focused on discharge planning practices per se. Determinations on these design issues will have to be finalized and discussed with each state that is sharing data or being visited. The states will have to determine if an IRB review is required at each site, in addition to the review at the study director's organization. OMB clearance would be required for the survey of the states, which will need to be considered in finalizing the project timeline.

Limitations: The proposed study is primarily qualitative in nature and would include only pre-existing performance data on the process and outcomes from a purposively selected sample of policy implementation processes. Obtaining performance data from an adequate number of states may be a challenge. The extent to which the design allows for any control of

threats to internal validity depends on whether the time series of performance data starts before the policy change or starts concurrently with the policy change. Assuming the initial survey of states and policy implementation processes achieve high response rates, case study site selection would be based on reasonably comprehensive data, but the purposive selection of policy implementation processes will be limited to those with available data and a willingness to cooperate. Therefore, the ability to generalize findings to other settings with a known degree of precision (external validity) will be very limited.

Estimated duration and cost: Based on prior work on similar projects, we estimate that the project could be completed in approximately 24 to 36 months. The timing and cost will be significantly influenced by the number of datasets acquired from the states and the amount of analysis conducted. The estimated cost would likely be relatively low.

4. A Study of the Discharge Planning Process and Outcomes

Research Questions: Can we identify specific discharge planning practices that are associated with improved outcomes for those at risk of homelessness? Does implementation of model discharge planning practices improve client outcomes? Are specific discharge planning practices differentially effective depending on the client's level of risk of homelessness? Are the discharge planning practices shown to be effective in maintaining continuity of care also effective in preventing homelessness? What barriers are there to more widespread implementation of any identified promising practices?

Rationale: Although we have not found any studies that directly measure the impact of discharge planning practices on subsequent homelessness, there are a number of studies that indirectly provide support for practices that seem likely to be helpful; for example,two quantitative studies of continuity of care following psychiatric hospital discharge for people with diagnoses of schizophrenia provide useful insights.[106] The findings from those studies were that (controlling for other factors) patients were much more likely to attend postdischarge outpatient appointments when any one of the following took place before discharge: (a) the client had contact with the outpatient clinician, (b) inpatient staff had contact with the outpatient clinician, (c) the client participated in an outpatient program before discharge, or (d) the family was involved during the inpatient stay. Secondary analysis of the ACCESS data by Orwin, Myers,

[106] Olfson, M., Mechanic, D., Boyer, C. A., & Hansell, S. (2000). Linking inpatients with schizophrenia to outpatient care. *Psychiatric Services*. 1998, 49:911–917. Boyer, C. A., McAlpine, D. D., Pottick, K. J., & Olfson, M. Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *American Journal of Psychaitry*. (157)1592–1598.

and Sonnefeld concluded that agencies that provide a service (such as housing or outpatient treatment) internally are more effective in securing it for their clients than are those agencies that rely on external linkages to obtain that service.[107] In addition to these studies, which provide indirect support for practices that might improve client outcomes, there are at least three consensus models of discharge planning practices (SAMHSA, AACP, and APIC) that have been developed but not systematically studied to date to determine their impact on client outcomes.

From this range of sources, it should be possible using indirect evidence or informed judgment to identify a menu of discharge planning practices associated with improved client outcomes. This hypothesis could then be tested in a design similar to that being employed by the National Outcomes Performance Assessment (NOPA) study for the Collaborative Initiative to Help End Chronic Homelessness (CICH). Grants would be offered to local institutional or custodial programs willing to implement a menu of exemplary discharge planning practices based on those referenced above and participate in a client followup study that would assess agency practices and client outcomes. Each local program would also have to identify a well-matched cooperative comparison site that would agree to implement discharge planning "as usual" and not to change their practices for the duration of the study's client enrollment period.

Methods: This proposed study would be a multisite study that could be implemented as a non-equivalent control group quasi-experimental design. Because it is similar in many relevant respects, we are proposing that it be structured much like the CICH NOPA study, although it would build in the requirement for control sites from the beginning and add a client enrollment phase before implementation of the model discharge planning practices at the intervention sites. Ideally, the control sites would be located in the same or similar communities so that housing and service availability would be comparable. The NOPA instrumentation is also well suited to meet many of the data collection goals for this study with only modest adaptation and the addition of instrumentation focused specifically on the discharge planning processes.

Recruitment of intervention and non-equivalent control programs: A notice of funding availability would be prepared and issued to recruit sites willing to implement model discharge planning practices, identify and gain the cooperation of suitable control sites, and participate in a national evaluation of their discharge planning processes and outcomes. Ideally,

[107]Orwin, R. G., Myers, M. A., & Sonnefeld, J. (2003). *Secondary analysis of the CMHS ACCESS Multisite Program for Homeless Mentally Ill Persons.* Presented at the Annual Meeting of the American Evaluation Association, Reno, NV.

neither the implementation nor the control sites would currently be using any/many of the model discharge planning practices, although we recognize that this is unlikely to be the case.

Study initiation, baseline process assessment, and Phase I (pre-intervention) client enrollment: Once 11 sites have been selected, along with their 11 control sites, a baseline site visit would be conducted to assess the discharge planning process at each site (intervention and control) and training would be provided on client enrollment procedures. The purpose of Phase I client enrollment would be to obtain a sample of clients going through each program before the model discharge planning processes are implemented at the intervention sites. These clients would be followed for 2 years after discharge, as would the clients enrolled in Phase II.

Training and implementation of model discharge planning processes: Intervention sites would then be trained in the model discharge planning processes and their performance monitored for a period of time (perhaps 3 months) to ensure that the model discharge planning processes have been fully adopted across the intervention sites. Annual site visits to both the intervention and control sites to assess the implementation process and the status of interagency linkages should take place throughout the period of Phase I and II client enrollment.

Phase II (postintervention) client enrollment: A second stage of client enrollment would be started after the model discharge planning processes were fully implemented at the intervention sites. Equal size samples would be obtained at both the intervention and control sites. Approximately 80 percent of all clients would be enrolled in Phase II, since the major interest is in the effects of the model discharge planning processes.

Client baseline and followup assessment: All clients would be assessed at enrollment (while they remain in the institutional or custodial setting) and again at 3-month intervals over a 2-year period following discharge. The baseline assessment instrument will incorporate data elements that assess the risk of subsequent homelessness. Housing status and program participation will be assessed at each interview. Every effort would be made to maintain client participation in the study over the 2-year postdischarge period, recognizing that subsequent admissions to the same or other residential treatment settings may well take place.

Measures: Examples of key measures for this study would be:

- Which of the model discharge planning practices were actually implemented with each client discharged; (Independent variable)

- The client's assessed risk of homelessness and other key clinical and demographic indicators;
- Client housing status at day 1, day 7, and 3-month intervals over 2 years;
- Client presence at scheduled (or rescheduled) outpatient appointments following discharge within the first 90 days;
- Client participation in community treatment programs at subsequent 3-month interviews over 2 years;
- The client length of stay in the institutional or custodial setting;
- The level and types of services provided in the inpatient setting;
- The quality of interagency linkages between the institutional or custodial program and community partner agencies; and
- The availability of appropriate community housing and services, as reported by all the partner agencies.

Data breakouts needed: These could include:

- Whether the client data were from an intervention or control site,
- Whether client data were from Phase I (pre-intervention) or Phase II (post-intervention),
- Expected LOS and early termination status, and
- The level of client risk of homelessness.

Products and utility: The major products would be journal articles, presentations, and a final report that described the findings of the study and answered the major research questions. The study should provide the best evidence obtained to date of the effectiveness of discharge planning practices as a strategy to prevent homelessness. The data from the site visits and measures of interorganizational linkages should provide very helpful guidance on how to implement effective discharge planning practices in settings similar to those studied. The study would also provide a wealth of information about the longer-term course of people at risk of homelessness following discharge from an institutional or custodial setting. The knowledge gained should be helpful in improving program discharge planning practices, especially if rolled out in combination with suitable discharge planning training materials.

Scope and setting: As discussed above, we propose that there be 11 pairs of sites, each pair including an intervention site and a control site. We suggest that approximately 2,200 clients be enrolled, or about 100 clients per site. Phase I (pre-discharge-planning implementation) clients should be about 20 percent of the total number, with the remaining 80 percent enrolled in Phase II. We recommend that the study be limited to a single setting type in order to reduce the variability attributable to factors other than the changes in discharge planning processes. Much of the research on which its design is based took place in psychiatric units of general hospitals, so those settings could be ideal candidates. Any of the four types of settings (i.e., foster care, RTCs, psychiatric, or substance abuse) could be a viable candidate, with the possible exception of state psychiatric hospitals. State psychiatric hospitals arguably have the unique disadvantage of being, on average, the most advanced in their current discharge planning practices and therefore having the least room to make measurable improvement. Discharge planning has long been a substantial focus of the National Association of Mental Health Program Directors.

Human subjects and information collection clearance issues: There are very clear human subjects issues given the extensive collection of client assessment and interview data from a vulnerable population. We would expect each site to require an IRB review, in addition to the review at the study director's organization. OMB clearance would also be required for the client and site-level data collection instruments and procedures.

Limitations: The proposed study is a relatively robust quasi-experimental design that controls effectively for many threats to internal validity. There is a risk that the control site will also change its approach to the discharge planning process as a result of measuring the client-level discharge planning activities, although this would be clearly visible in the data collected. Using the terminology of Campbell and Stanley, the chief remaining internal validity threat possible in this design is associated with the interaction of selection and testing and possibly with regression, although neither seems highly likely in this case. The study design assumes that we are capable of implementing a valid and reliable assessment of the risk of homelessness (which is the goal of the first alternative research design outlined in this section). For questions where the site is the unit of analysis, the *N* is very small and the statistical power will be extremely limited. For questions that can be answered by aggregating data across clients, the *N* is substantial and statistical power should be adequate. As with the other designs discussed, the ability to generalize findings to other settings with a known degree of precision (external validity) will be very limited since the site pairs will be selected through a nonrandom grant application and award process.

Estimated duration and cost: We estimate that the project could be completed in approximately 5 to 6 years. The estimated cost of the study would likely be relatively high.

A number of additional alternative research designs were proposed, but deemed to be of lower priority for development by the study team. These included:

- Developing a typology of transitional programs that aim to prevent homelessness by supporting people during their transition from residential or custodial settings;
- A strengths-based study of people at risk of homelessness who have made successful transitions from institutional or custodial settings to community living settings that would include interviews with consumers and providers;
- Contrasting residential programs that provide community housing or services within the same umbrella agency with those who rely only on external agencies to provide postdischarge housing and services;
- Secondary analysis of data from the National Outcomes Performance Assessment (NOPA) Study for the Chronic Homelessness Initiative examining the housing status of anyone discharged from a treatment setting during the course of the 2-year study; and
- Secondary analysis of data from ongoing outcome studies of aggressive measures to enroll clients in SSI and other benefit programs that are key determinants of access to housing and treatment services in the community.

V. Conclusion

This evaluability assessment was intended to assess the feasibility of conducting a rigorous summative evaluation of discharge planning as a strategy to prevent homelessness and to alternative evaluation designs. Four distinct settings were examined: adult psychiatric inpatient treatment units, residential treatment centers serving children and youth with serious emotional disturbances and/or substance use disorders, residential treatment programs for adults with substance use disorders, and foster care independent living programs. The 2-year study involved seven components: a review of the literature and issues, an expert panel process, analysis of discharge-planning-related policy and procedure documents from selected programs, site visits to a subset of those programs, an analytic findings report, the development of alternative research design options, and this final report.

The study substantially added to our knowledge about the discharge planning process and the context in which it takes place. The study team questions whether a rigorous, objective summative evaluation of discharge planning as a strategy to prevent homelessness in institutional and/or custodial settings is justifiable at this time. However, we found that alternative study designs to evaluate specific issues or activities related to discharge planning and homelessness prevention are feasible, and these designs were described in this report.

The recommendation against conducting a summative evaluation of discharge planning as a strategy to prevent subsequent homelessness is based on three key findings:

1. Discharge planning is integral to the treatment and custodial activities in the settings and is not considered a separate activity with a well-developed model intended to prevent homelessness;
2. Discharge planning is not systematically implemented and most programs lack structured protocols, focused staff training, and quality assurance activities to assess and improve the process over time; and
3. The tremendous variability in the discharge planning process across clients, programs, settings, and communities dictates that a summative evaluation enroll thousands of clients across many programs.

Furthermore, the discharge planning process is highly complex and tightly bound to programmatic, client, interorganizational, and community resource factors. Numerous mediating variables influence the discharge planning process and its outcomes, some of which lack well-formulated measures. Also, we conclude that the desired outcome of avoiding homelessness is determined as much or more by the availability of suitable housing and support services in the community as by the discharge planning process. For all of these reasons, a summative evaluation of the discharge planning process as a strategy to prevent homelessness would be complex, lengthy, costly, and cannot be assured of producing clear and definitive findings. Thus, further preliminary and exploratory research is called for before undertaking a study of such complexity.

This report presents a range of findings about the character and working of the discharge planning process in four institutional or custodial settings, including the existence of multiple discharge planning "tracks" in any program depending on who pays for or oversees a client's care and critical differences in discharge planning processes and outcomes associated with organizational and community factors. Specific findings that address the key research questions are presented regarding each of the four setting types, as well as cross-cutting observations that apply to all of the settings.

In this report, we have identified at least four alternative study designs that would further the field's understanding of discharge planning as an intervention to prevent subsequent homelessness. These studies include the following:

- **Client Screening Protocols To Predict Risk of Homelessness**. This study would examine the role of screening protocols in identifying people at risk of homelessness at discharge so that special effort could be directed to securing appropriate placement. Such screening protocols have been developed, but their use does not appear to be widespread as yet.
- **Early Terminators/Foster Care Runaways and Methods To Engage Them.** Foster care runaways and those who terminate prematurely from substance abuse or psychiatric treatment programs are at high risk of homelessness. This study would aim to increase our knowledge of effective ways to engage this at-risk population and provide more effective discharge planning services.
- **State Policies To Improve Discharge Planning and Prevent Homelessness**. As part of the focus on preventing homelessness, states have developed a range of

policies intended to improve the discharge planning process. This study would catalogue those policies and their features for the types of settings included in the evaluability assessment, examine promising policies in greater detail, and identify common elements and themes associated with their effectiveness in preventing homelessness; for example, the use of performance measures, incentive provisions, penalties, and changes in homelessness rates over time.

- **Discharge Planning Process and Outcomes**. This proposal is for a quasi-experimental study targeting one of the four settings included in the evaluability assessment. It would examine the relationship between discharge planning practices and client outcomes over a 2-year period following discharge. The design would be structured similarly to the National Outcome Performance Assessment for the CICH and could use some of the same instrumentation. The study could identify model discharge planning practices effective in preventing homelessness.

The problem of homelessness remains a challenging one. Despite the unprecedented energy currently being devoted to ending chronic homelessness and addressing other aspects of the problem, there remain areas in which our knowledge is deficient. We hope this report will make a contribution to answering some of the outstanding questions, and that further research, as suggested here, will provide solutions for preventing homelessness in communities throughout the nation.

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