Issue Brief

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Over its first seven years, CQI has established an effective consumer research voice regarding mental health care in Massachusetts, primarily through assessments of consumer satisfaction and perceptions of quality.

HOMELESSNESS AND PSYCHIATRIC HOSPITALIZATION: THE EXPERIENCE OF ADULT MASSHEALTH RECIPIENTS

Background

This Issue Brief reports on CQI's findings regarding the experiences of homeless MassHealth[1] recipients who are patients in Massachusetts psychiatric inpatient units. It also provides some suggestions for addressing the problems they face.

Studies have demonstrated that people with mental health disorders who are homeless, "can be engaged in services, can accept and benefit from… services, and can remain in stable housing with appropriate supports."[2] Nevertheless, according to the federal government many people who are homeless qualify for mental health services but do not access them.[3] Furthermore, even when such services are accessed, they often fail to meet the special needs of people who are homeless. As a result, many homeless people cycle between the streets, acute care settings, and jail.

Data

Since its beginning in 1999, CQI has had a contract with the Massachusetts Behavioral Health Partnership (MBHP), the state Medicaid behavioral health managed care company, to conduct interviews with MassHealth recipients about their satisfaction with a variety of behavioral health programs/services.

CQI has developed specific surveys for adult inpatient psychiatric, dual diagnosis[4] care, outpatient clinical care, and day treatment services, and has used those instruments to interview close to 2000 MassHealth recipients through the year 2005.[5]

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[1] MassHealth is the Massachusetts Medicaid program.

[2] Substance Abuse and Mental Health Services. Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-Occurring Substance Disorders. DHHS Pub. No. SMA 04-3870. Rockville, MD. 2003, p vii.

[3] SAMHSA. How States Can Use SAMHSA Block Grants to Support Services to People who are Homeless. DHHS Pub. No. SMA 04-2871. Rockville, MD. 2003.

[4] Specialized units for people dealing with both substance abuse and mental health issues. Some are even assisted with detoxification.

[5] After completing a series of interviews at a particular site/provider, CQI writes a data report that includes recommendations, and meets with

Besides satisfaction data, CQI surveys collect demographic information directly from the patient[6], including whether or not s/he has "stable housing."[7] This allows us to compare data for people with and people without stable housing. We are also able to track incidence of reported homelessness among users of various service types. .

CQI also conducts needs assessments to learn what is most important to consumers. For example, CQI's "Better World" survey was filled out by 425 people attending a statewide consumer conference in 2000. These consumers ranked and described the advocacy issues most important to them. CQI's "Quality of Life survey," which asks consumers to describe what helps and hinders their recovery, was used to interview 27 MassHealth clients in 2003.

Findings

The findings related to homelessness from CQI's surveys of MassHealth mental health consumers are summarized below.

Housing is a priority issue.

In Massachusetts, consumers and family members have identified stable and affordable housing as a priority issue. Consumers responding to the Better World survey identified "more affordable housing opportunities" as their number one priority issue.[8]

the provider to discuss it. CQI also presents the report to MBHP.

[6] This information is not otherwise verified, but respondents with "no stable housing" will often say that they live on the street, in shelters, with different friends and/or family members.

[7] For the purpose of CQI reports, "no stable housing" means "homeless."

According to results from the Quality of Life qualitative survey, many consumers attribute their stability and recovery to having a decent place to live, and consumers who are evicted or lose housing for other reasons often have mental breakdowns.

Many hospitalized consumers are homeless.

Respondents using inpatient services are much more likely to be homeless compared to those using outpatient services, such as clinics and day programs (Table 1). There are several hypotheses for the relationship between homelessness and the greater use of inpatient services.[9] First, the homeless are less likely to access outpatient services since they are busy dealing with daily survival needs e.g., food, money for transportation. Second, clinics and day programs may not sufficiently meet special needs of homeless people, or they may have trouble even getting to these programs. Third, people who receive outpatient mental health services are more likely to also be receiving housing assistance from that program or through a specialty housing program.

Rates of homelessness were particularly high for patients on dual diagnosis units. Hospital administrators explained to us that the barriers for helping dual diagnosis clients obtain housing, or even assistance with housing, are high. Many housing programs avoid working with this population, and many establish some housing complexes that do not accept people with an "active" addiction issue.

[9] This is not to state definitively that there is a cause and effect relationship.

Table 1: Percentage of Homeless Respondents by Type of Mental Health Care

	% Homeless (N)	Total N
Inpatient Acute Units 2004-2005	**19%** (123)	644
Inpatient Dual Diagnosis Units 2004-2005	**35%** (41)	118
Outpatient Clinics 2001- 2003/4	**3%** (22)	766
Day Treatment 2001-2004	**3%** (12)	426

Of further note, the rate of homelessness among inpatient consumers appears to have increased over the last several years (Table 2). Because our samples of inpatient units differed somewhat from 1999-2002 to 2004-2005[10], it is possible that this increase was due in part to differences in the samples. Nonetheless, other data support our finding that the rate of homelessness has risen, particularly in urban areas.[11] This increase was not surprising given cutbacks by the state after 2001 and the concomitant economic downturn.

Table 2: Change in Percentage of Homeless Patients in Inpatient Data Over Time		
	% Homeless	**N**
1999-2002 Inpatient Surveys	13%	446
2004-2005 Inpatient Surveys	22%	762

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[10] About one-third of the units in 2004-2005 study had been surveyed in the earlier study. A similar increase in homelessness rates to the one here could be detected within that smaller group.

[11] See *Strategies for Preventing Homelessness*, United States Department of Housing and Urban Development, May 2005, Appendix D, www.urban.org/UploadedPDF/1000874_preventing_homelessness.pdf, retrieved 4/10/06.

Consumers without stable housing are less satisfied with inpatient care. than are those with stable housing

People without stable housing were relatively less satisfied in almost all aspects of their inpatient care/treatment. Table 3 shows a difference in general satisfaction rates of 6%, and several other areas where the difference in satisfaction rates is greatest.

Table 3: Inpatient Satisfaction by Housing Status

	HOMELESS		NOT HOMELESS	
	% Satisfied (N)	Total N	% Satisfied (N)	Total N
Care and services overall	**74%** (120)	162	**80%** (455)	567
Staff available to talk when having hard time	**60%** (95)	158	**73%** (406)	553
Safety concerns taken seriously*	**46%** (13)	28	**65%** (53)	82
Information received about psychiatric condition	**50%** (77)	155	**64%** (349)	548

*Respondents were first asked if they had any safety concerns, resulting in a lower N for this question.

Our data do not allow us to specifically define the relationship between housing status and satisfaction, but one does exist and it needs to be examined from both patient and provider perspectives. For example, homeless patients were much more likely to feel that they were being ignored when having a difficult time or when expressing a concern around safety. This could indicate that they were more likely to have a difficult time on the unit, that they were less likely to feel that their distress was noticed/acknowledged by staff, and/or that they were less able to articulate their distress in a way that would promote a desired response. It is also worth considering whether individual staff even know if a patient is homeless; and if they do, whether they are more likely to discount the expressed needs of someone who is homeless. [12]

Homeless patients were significantly less likely to report improvements in their condition since they were admitted to the hospital. Table 4 shows the percentages of patients who felt either better or much better (versus the same or worse) in certain key areas since their hospital admission.

Homeless people in general were less likely to feel better. This difference was most acute with regard to their ability to cope when things went wrong. Lower levels of improvement are indicators of a greater likelihood of re-hospitalization and other problems.

Table 4: Inpatient Improvements in Condition by Housing Status

	HOMELESS		NOT HOMELESS	
	% Feeling Better Since Admission	Total N	% Feeling Better Since Admission	Total N
Mental health	**62%** (97)	157	**70%** (393)	559
Ability to cope when things go wrong	**50%** (78)	155	**63%** (341)	544
Confidence to deal with daily life	**51%** (76)	76	**58%** (318)	544

[12] Issues of communication difficulties between staff and homeless patients is further evidenced by the greater level of dissatisfaction among homeless patients regarding information received about their psychiatric conditions.

Homeless respondents were significantly less satisfied with staff's efforts to prepare them to access aftercare services. (Table 5). Staff may be spending relatively more time helping the homeless patients find housing, leaving less time to focus on other services/supports. Or staff may be confounded by the fact that they are not sure where the person will locate after discharge, perhaps not even until the day of discharge.

Table 5: Satisfaction with Staff's Efforts to Help with Aftercare Services by Housing Status

	HOMELESS		NOT HOMELESS	
	% Satisfied	Total N	% Satisfied	Total N
Outpatient Mental Health	73% (87)	119	81% (338)	415
Medical Aftercare	69% (70)	101	79% (235)	299

Just over one-half (56%) of the homeless respondents were satisfied with staff's efforts to help them find housing. Patients commented that they would like staff to talk to them about obtaining housing, more information about existing housing resources, and ultimately to have an appropriate place to go upon discharge from the hospital. We heard from hospital staff that this continues to be a major challenge for them given the short length of stays at the hospital and the difficulty in finding placements for certain patients.

The homeless and non-homeless groups were largely comparable demographically. There is just one difference that is quite possibly affecting satisfaction rates—the greater physical health needs of the homeless. Fifty-eight percent of homeless patients say their health is poor or fair versus 47% of other patients. Also of note, while 58% of the homeless were male, only 46% of the other patients were male. (Our analyses have not denoted a relationship between gender and satisfaction rates.)

Addressing the Problem

Homelessness rates are driven by a combination of economic, social, personal and environmental factors. It seems however that this is an opportune time for the Massachusetts Department of Mental Health (DMH), as the state mental health authority that now has direct oversight of MassHealth behavioral health programs, to both improve the care MassHealth patients receive and reduce homelessness rates. Listed below are several suggestions:

1) DMH offers a number of programs/services that are designed to help DMH clients find and stay in housing.[13] Immediately after a DMH client is admitted to a hospital, key DMH personnel or other relevant providers (eg., PACT team) should be contacted. If a homeless DMH client has repeated hospital admissions, DMH should conduct a review to determine whether the client is being provided with sufficient assistance to maintain community tenure, and whether that assistance meets their specific needs.
2) A hospitalized homeless person who is not a DMH client is at a significant disadvantage getting help with housing.[14] Many

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[13] For example, PACT (Program for Assertive Community Treatment) and case management.
[14] See *Strategies for Preventing Homelessness*, ibid.

hospitals do not feel prepared to help with housing. Thus, DMH should develop more flexible MassHealth funding supports to help people get and stay in housing. Examples include the peer support and aftercare program offered at selected hospitalsand the Real Choice self-directed care model.

3) The state Bureau of Substance Abuse[15] and DMH should work together on a plan for helping homeless people who are on dual diagnosis hospital units to find housing.
4) DMH should continue to develop creative programming to help consumers find and stay in housing. The Housing First model is a low-demand transitional shelter that meets the needs of chronically homeless adults who are dually diagnosed. An example is the Dudley Inn in Roxbury, where both primary care and psychiatric services are available on an ongoing basis.

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[15] A division of the Massachusetts Department of Public Health