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Unlocking the door to supportive housing: addressing the challenge of post-discharge transitions in safety-net psychiatric care

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Independent living and housing stability are core principles of the psychiatric recovery process. Only when basic needs such as safe, affordable and permanent housing are met can individuals with serious mental illnesses (SMI) reintegrate into their community, consistently engage with mental health services and begin (or restart) recovery.[1] Yet, post-discharged individuals with SMI and their psychiatric care providers often grapple with where to go after discharge from psychiatric hospitalisation. This question is particularly central in safety-net hospitals serving people affected by severe health disparities with myriad deficits in social determinants of health (SDoH). In this commentary, we aim to shed light on post-discharge challenges related to housing often encountered by safety-net psychiatric hospitals and propose ways to address them.

At the conclusion of psychiatric hospitalisation, patients report worries about their community reintegration.[2] For people with SMI who are severely affected by SDoH, particularly poverty, homelessness and loneliness, a safe place to return to is a major concern.[3 4] Many are admitted to the safety-net hospital while using supportive housing, which they may lose during hospitalisation, while others are admitted from the streets.[5] Safety-net psychiatric hospitals serve large numbers of marginalised individuals, and in the USA, they are often located in low-income communities, where the majority of the patients cannot pay for their care as they have no health insurance or rely on federal insurance (Medicaid).[6] Due to the high rates of poverty and homelessness among these patients, psychiatric care providers in safety-net settings often report concerns and challenges not only in ensuring psychiatric safety and the continuity of psychiatric care for their patients after discharge but also in discharging patients with nowhere safe to live.[5 7]

THE PARADOX OF HOUSING PROVISION

A shortage of affordable supportive housing[8] for marginalised patient populations traps patients and psychiatric care providers in a complex situation, often forcing them to choose between ongoing hospital confinement or the threat of homelessness. Many US safety-net hospitals that serve the poorest and most disadvantaged populations face a paradox: while patients are hospitalised, they often cannot go on-site visits to explore housing options outside the hospital, even with a family member. However, after discharge, many patients do not use housing services but instead return to the streets, which often leads to further hospitalisations. Psychiatric care providers do not want to prolong psychiatric inpatient stays, but discharging the most vulnerable patients to the streets is not a viable solution. Fearing the severe ethical and health consequences of sending patients to the streets and lacking familiarity with other psychiatric services in the community, psychiatric care providers in safety-net hospitals are reluctantly pushed to extend inpatient hospitalisation as a safety net for their patients, while patients are placed on long waitlists for scarce semi-permanent housing resources. The reliance on inpatient hospitalisation as a temporary solution to housing insecurity highlights systemic failures, particularly for marginalised patient populations who already suffer from many SDoH. It is a double-edged sword; while inpatient hospitalisation protects patients from being on the streets, providing safety, food and access to ambulatory care, it also perpetuates a cycle of

dependency, institutionalisation and disenfranchisement. In addition, patients who are hospitalised cannot fully engage in their own housing search or other community resources, which further inhibits their reintegration into the community and recovery process.

THE FINANCIAL AND ETHICAL BURDENS OF INVOLUNTARY HOSPITALISATION

Choosing to extend psychiatric hospitalisation to protect vulnerable patients from ending up on the streets creates both financial and moral dilemmas. Financially, the costs of keeping patients hospitalised exceed the reimbursement that safety-net hospitals receive from the state, resulting in financial losses and additional strain on hospital resources, which can impact their quality of care. Ethically, patients who are hospitalised for moral reasons occupy beds that could otherwise be used for others in need. Given the scarcity of healthcare for marginalised populations, the lack of available psychiatric beds further exacerbates the situation, as people in need cannot receive sufficient inpatient psychiatric care and may receive less-optimal care while awaiting a psychiatric bed in an emergency or medical inpatient setting.

CHARTING A PATH FORWARD

While addressing the challenge of post-discharge transitions requires a multi-faceted approach, there is a need for immediate interventions that address care transition and integrate community navigation skills. Particularly, there is a need to raise awareness among patients and healthcare providers about community-based psychiatric services available on discharge. Beyond housing, these services include occupational support, case management and peer support, education, recreational services and environmental supports.[9 10] Psychiatric care providers and patients are often only aware of housing as an option, which may not always be available. Having a more comprehensive and collaborative discharge process beyond housing can reduce the risk of homelessness and the subsequent need for inpatient hospitalisation. Interventions based on shared decision making (SDM)[11] can help patients and psychiatric care providers gain the necessary knowledge about psychiatric options available in the community and help them make informed, person-centred decisions regarding psychiatric and mental health services after discharge.[12] SDM interventions can also facilitate navigation for neighbourhood resources and support that can serve as alternatives to involuntary hospitalisation. For example, our team developed an SDM discharge intervention that helps psychiatric care providers and patients make informed decisions regarding treatment and recovery plans in the community before discharge.[13] Integrated into the current discharge process, this SDM discharge planning intervention includes a computerised decision aid that offers information on available community psychiatric services and additional steps including, for example, goal setting and preference-based decision-making. During discharge appointments, the SDM intervention allows patients and psychiatric care providers to set goals, review and discuss options in the community, weigh their pros and cons and set a discharge plan. The computerised decision aid element of the intervention can also be used independently by patients during and after the discharge consultation. By facilitating connections with community resources through social prescribing, this intervention helps both patients and psychiatric care providers understand and access the right combination of community recovery and rehabilitation services for the patient on discharge based on the patient's preferences and values.[13]

While other discharge interventions, such as the Transitional Discharge Model (TDM),[14] aim to improve care coordination with community mental health services on psychiatric discharge, TDM relies on external peer support and maintenance of continuous interaction with the inpatient treatment team.[12] These types of interventions require additional time, resources, external support and infrastructure[15] that are not available in most US safety-net hospitals, which operate within segregated healthcare systems and lack effective communication processes between community mental health services and hospitals. Consequently, inpatient psychiatric care providers are not able to maintain relationships with discharged patients. While peers can assist during hospitalisation or in the community, they are not available to monitor the transition stage from the psychiatric hospital to the community—a core principle of the TDM. In contrast, the SDM model offers a potential 'in-house solution'.[16] Psychiatric care providers, patients and other caregivers (if available) collaboratively decide on a plan and how to access community services while the patients are still hospitalised.[17 18] Through the SDM process, patients become more knowledgeable, motivated and committed to using the chosen community services ('if I choose it, I use it'), leading to better navigation and utilisation of housing services on discharge. However, it is important to mention that while SDM is promising and can benefit many, it is not a universal solution. Some patients may not be accepted into community psychiatric programmes for various reasons that may not be addressed by SDM, TDM or other approaches. Psychiatric care providers and patients often reach a stalemate when it comes to discharge, and SDM along with other models should be further investigated to improve the quality of person-centred care and outcomes.

CONCLUSIONS

Limited housing options for psychiatric inpatients, together with limited knowledge about available psychiatric rehabilitation services in the community on discharge, affect safety-net hospitals in particular. Psychiatric care providers face an ethical and social dilemma, sometimes pushing them to decide on prolonged

hospitalisations. Employing a timely SDM approach for care transition and neighbourhood navigation holds the potential to reduce the prescription of long-term hospitalisation in the immediate term. These types of SDM interventions should be prioritised, further disseminated and explored. This includes investigating how this approach may be generalised or transferred to similar regions in other high-income countries with comparable under-resourcing, as well as to low- and middle-income countries.

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