civil rights protection & advocacy system for montana

disability rights montana

December 8, 2022

Disability Rights Montana (DRM) is the state's protection and advocacy center for Montanans with disabilities. It is our responsibility to monitor state facilities that provide care and treatment to people with disabilities. We monitor to ensure residents in facilities are not abused or neglected and receive appropriate care and treatment.

The Yellow Bags: Discharges into Homelessness from Montana State Hospital highlights a broken underfunded mental health delivery system. It details the inappropriate and inhumane practice of discharging people from the state hospital to homelessness with a yellow bag and sometimes a sleeping bag.

I want to thank Casey Pallister, an investigator/advocate with DRM, who spent many hours travelling around the state and interviewing people for this story.

Every person mentioned and quoted in this report is real and has expressly given DRM consent to share their story. We are grateful for their willingness to trust us with their experiences. We honor them by sharing this report and advocating for change.

I want to thank the staff of the homeless shelters and providers throughout our state: the Poverello Center in Missoula, the Butte Rescue Mission, Great Falls Rescue Mission, God's Love and Our Place in Helena, Human Resource Development Council (HRDC) in Bozeman, Flathead Warming Center in Kalispell, St. Vincent De Paul in Billings, Community Crisis Center in Billings, and Montana Rescue Mission in Billings. Your commitment to helping people being discharged from the Montana State Hospital is noticed and appreciated.

It is my hope after reading *The Yellow Bags*, you will be motivated to join the conversation in finding solutions for this issue.

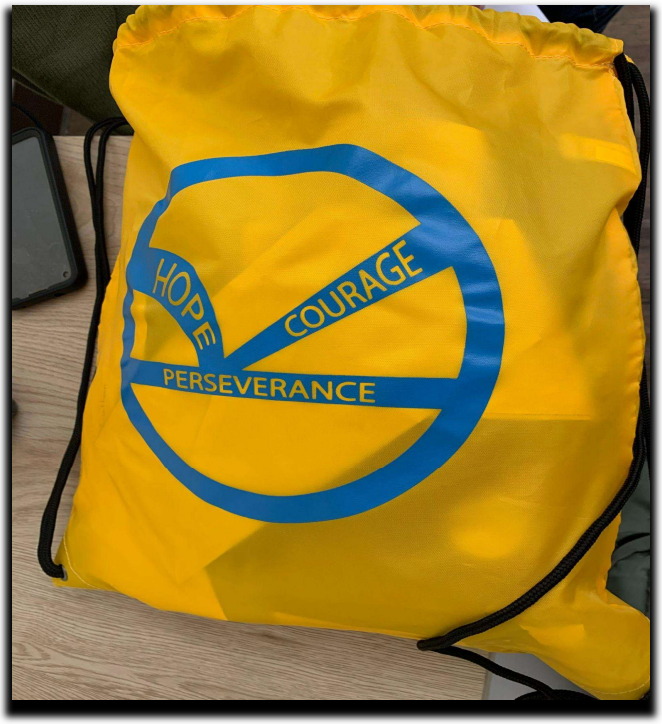
Bernadette Franks-Ongoy
Executive Director

Content Warning

This report contains topics such as suicide, sexual abuse/assault, and substance use.

The Yellow Bags:

Discharges into Homelessness from Montana State Hospital



Casey Pallister, Ph.D.
Investigator/Advocate

Disability Rights Montana
December 1, 2022

Disability Rights Montana's mission is to protect and advocate for the human, legal, and civil rights of Montanans with disabilities while advancing dignity, equality, and self-determination.

Mya Attwood sat alone, crouched over a small desk in the corner of Our Place, a day center for homeless persons in Helena. A yellow draw-string bag was before her, partially opened. Mya, who turned nineteen last week, shook her head and smiled, pointing at the words that stood out in bright blue on the bag's front: "Hope," "Courage," "Perseverance."

"I don't feel those right now," she said.

A few hours earlier, staff from Montana State Hospital (MSH) in Warm Springs dropped Mya, a patient who was discharging, at God's Love, a homeless shelter in Helena.[1] Mya explained she was told by hospital staff that they secured a bed for her at God's Love for thirty days. When she arrived in Helena, she found that no beds were available. In fact, no one knew she was coming.

"Luckily this place is open," she said. "I don't know where I would go if it wasn't."

God's Love staff told Mya to return at 5:30 that evening to see if they could find a bed for her, at least for the night. But demand for the shelter's limited beds is high, so there were no guarantees. Mya's anxiety was clear when she spoke.

"I don't know if I'll make it more than a few hours," she said, bouncing her leg.

The next day Mya was at God's Love, eating lunch at a crowded table of women. She was lucky that a bed was available for three days, she explained, and she was grateful that her roommates offered help. Mya said that her small frame makes her an easy target for predatory men.

"I'm going to try to buy some pepper spray and make an emergency contact list to keep on me at all times. And I'm going everywhere in groups of women for safety."

Despite her plan, Mya expressed dismay.

"I don't feel well and I don't know how to do this. I've never been homeless."

Her forehead wrinkled and her smile faded. "Maybe I'll make it," she said.

She smiled again.

Hours later, alone in her room, Mya swallowed dozens of pills from five bottles of medications prescribed to her by Montana State Hospital. Fast-acting paramedics and emergency room staff managed to save her life.

[1] In this report, "Montana State Hospital," "the state hospital," "MSH," and "Warm Springs" interchangeably as names for Montana State Hospital.

"I called 9-1-1 after I took the pills," she recalled later. "If help came, that was fine. If it didn't, it was God's will."

Mya briefly stayed at the local hospital's ICU before being returned to Warm Springs by a court order.

A few days later on Bravo unit, one of the state hospital's five main pods, Mya described her discharge experience over the phone.[2]

"I was very anxious because I wasn't sure if I could keep a roof over my head. It was traumatic. It was too much for me to handle."

In the few days since her return to Warm Springs, Mya said she was in a physical altercation with a fellow patient and, the day before, restrained by staff for an extended period. In the latter case, she said she lost control of her bladder and sat in soiled clothes for over an hour.

Mya was set to discharge again in a few days.

Although she said she will be sent to relatives in another state this time, Mya expressed the same concerns as before.

"I don't know if I'm ready," she admitted. "I'll probably be back. My social worker here told me that. She said 'it's the cycle.'"

[2] The five pods or units at Montana State Hospital are called Alpha, Bravo, Echo, Delta, and Spratt.

Mya Atwood sits at Our Place shortly after her drop in Helena.

The Cycle

Beyond the state capital–in Kalispell, Missoula, Billings, Bozeman, Butte, and Great Falls–staff at homeless shelters and mental health crisis centers have seen the yellow bags, identical to the one Mya carried.[3] Given to recently discharged persons by the state hospital, they are the emblems of a decades-old cycle of discharge and recommitment from the streets, emanating from the gates of Warm Springs. Their bright blue expressions of positivity belie a system that, as one Billings provider said, "sets up countless people to fail, over and over again."

[3] In this report, the term "providers" is used specifically as shorthand for staff at homeless shelters and mental health crisis centers in Montana. The facilities interviewed were Poverello Center (Missoula); Butte Rescue Mission; Great Falls Rescue Mission; God's Love (Helena); Our Place (Helena); Human Resource Development Council (HRDC) (Bozeman); Flathead Warming Center (Kalispell); St. Vincent De Paul (Billings); Community Crisis Center (Billings); and Montana Rescue Mission (Billings).

According to providers and former patients in every major city of Montana, the state hospital at Warm Springs regularly discharges patients to homelessness, dropping them at or near facilities that cannot provide adequate care, medication management, mental health services or, sometimes, even a bed for the night. A similar story plays out across the state: a discharged patient with a yellow bag arrives, almost always without warning, and with little or no "wrap around" supports put in place by the state hospital.[4] Providers report that the discharged patients they see are almost always "cold dropped" by MSH, a phrase used to describe the practice of driving persons to sidewalks, street corners, or parking lots near shelters or crisis centers and leaving them with their yellow bags and other belongings.[5] They also reported cold drops by MSH at low-budget motels, and many shared stories of individuals arriving at city bus stations after discharging from Warm Springs, alone and far from anyone or anything they knew.

The "cycle" Mya referred to is well-known to providers, and there are few success stories among those caught within it. Almost all persons discharged into homelessness decompensate, winding up in local police cars, detention centers, and hospitals.[6] Many return to Warm Springs for short periods before being discharged again to the streets. For some, the cycle is a death sentence.

Yellow Bags

Providers repeatedly say that, due to the consistent lack of communication by MSH about discharges from the state hospital, the contents of a yellow bag are often the only way to know anything about a former MSH patient.

"A person shows up with their yellow bag with bright blue emblems," said Jenna Huey, shelter manager of Bozeman's HRDC, which provides housing for 80-90 homeless persons on any given day. "That's usually the only way we know where they came from."

The yellow bags can offer bits of information, through brief discharge paperwork and medications or prescriptions, which shelter staff can use to try to assist individuals who are often in crisis upon arrival.

But there are problems.

"We can't take their bag and look into it. They have to let us," said Dave Miller, director of God's Love.

---

[4] Wrap-around services are community-based services and support systems which can include housing, psychiatric care, medication management, or substance abuse counseling.

[5] Providers contrast this with "warm drops" or "soft drops"--when discharged individuals are taken into a facility by a trained staff from the discharging hospital, ensuring an individual arrives safely with their belongings and the intake facility staff are given pertinent written or verbal information about the individual. "Warm drops" are rarely reported by providers in Montana.

[6] "Decompensate" is a psychiatric term used to describe the deterioration of a person's mental health.

If granted access, providers can look inside. But they reported that the contents of yellow bags are diverse. Some have an assortment of pills issued by the hospital, some have both medications and prescriptions, and some have no medications or prescriptions. If present, discharge paperwork can also vary depending on who completed it at the state hospital. A sampling from yellow bags revealed that some did not include key information such as diagnoses and lists of community resources, while others only included addresses of drop sites under "Discharge Arrangements." One patient said she had to ask for her paperwork when leaving MSH, as staff forgot to include it in her yellow bag. She was supposed to review and sign it, she said, but was told "there is no time" by her transporting staff. The line "Patient Signature" on her Discharge Instructions was indeed blank. She only saw the paperwork after the van drove away.

Just minutes after being dropped near God's Love by state hospital staff, Shawn Du sat at a picnic table in a large park near the shelter. He was happy to reveal the contents of his yellow bag.

"I've had a lot of these," he said.

Shawn explained that he has been discharged six times from the state hospital and that he has been dropped in Helena "more than a few times." As he opened his bag, he hummed a Maroon Five song and wondered aloud if he could make some money singing on the street.

Shawn's yellow bag contained a brown paper sack with several medications from the state hospital along with various prescriptions. Accompanying paperwork said the meds were for "mood stabilization," "psychosis," "excitement," and "tension." Some pills were to be taken regularly, while others were listed "as needed." Along with the drugs was a sheet of paper with generic instructions, such as avoiding alcohol use while taking the pills and keeping them away from children. The first instruction recommended that a discharged patient "Learn the name of the medication and the reasons why you are taking the medication," although it was uncertain how that education would occur. Among the multiple prescriptions was one for sixty pills of Ativan, an addictive benzodiazepine that can produce fast highs and can be easily sold on the street.

The prescription said Shawn should take the drug "as needed," although he has a history of drug abuse, a condition noted on his discharge paperwork under "Diagnosis." Along with addiction are a number of other afflictions, including "homelessness unspecified." Shawn laughed at that.

"Yeah, that's a sickness they decided to give me."

The homelessness "diagnosis" appeared on Mya's paperwork as well, even though she had never been on the streets.

Another sheet of paper, "Discharge Instructions," said Shawn had a five day supply of medications with prescriptions that would see him through another thirty days. He had to fill the prescriptions himself. He also had an appointment to see a physician that day, although he said

he was unsure if he would go. There was a list of "community contacts," which had facilities or crisis hotlines as well as phone numbers, but no names of real people and almost no indication of services provided. It was clear the list was one given to many discharged patients, as there were contacts that were not applicable to Shawn: one was Florence Crittenton, a facility in Helena for young mothers, while two others were food banks in the far-off towns of Lincoln and Augusta. The paperwork claimed Shawn would live at God's Love but, like Mya, Shawn said he was promised a long-term stay by MSH staff only to find that a bed was not available when he arrived.

"I guess I have my sleeping bag," he said.

Along with Shawn, three other recently discharged patients shared that they were given sleeping bags by the state hospital and told by MSH staff that they would be living on the streets.

Shawn smiled and looked around as if someone might be listening.

"Don't tell anyone, but a staff at MSH said she would find me and bring me a tent to sleep in."

Shawn Du, minutes after his drop near God's Love in Helena.

Just down the street at God's Love was Dave Miller, the man listed as Shawn's "contact person."

"I had no idea Shawn was coming," said Miller, minutes after Shawn's drop.

Miller shared that Shawn's past behaviors at the shelter, which threatened the safety and wellbeing of other residents, led to a staff decision to ban him from the premises. But Miller said he was not able to protest. By the time Shawn walked into God's Love, his transporters from MSH were already headed back to Warm Springs. Ultimately, Miller allowed Shawn to stay.

“We don’t have the resources . . .”

Beyond the limited information found in the yellow bags, providers expressed deep frustration and confusion about a host of other issues related to homeless discharges from the state hospital.

A few facilities reported that they were sometimes called by the state hospital prior to a drop but were only told that a person was coming.

“If we get any information it is on the day of discharge,” said Jenna Huey.

Morgan Stewart, director of the women’s shelter at Great Falls Rescue Mission, said she occasionally gets a call “the day before” a person is dropped.

At Missoula’s Poverello Center, director Jill Bonny recalled being contacted once by MSH about an upcoming drop. A woman showed up with a yellow bag one month later.

Despite some efforts at communication from the state hospital, all facilities reported receiving drops from MSH without any prior communication, and all said that the state hospital did not follow up to ensure a person had made it in their door. One staff member recalled a man dropped by MSH in Helena outside of God’s Love. No one at the shelter received any communication from the state hospital that he was coming or that he had arrived. Eventually the man managed to make it in the doors, but it was more than six weeks after being left on the curb.

Providers also expressed frustration regarding the treatment needs of discharged patients, who they said are often left to fend for themselves when it comes to acquiring and taking medications and making appointments to see mental health providers.
.

“We have had patients come to us from the state hospital and say they were told we will manage their medications, but we can’t do that,” said Bonny. “We don’t have the resources to provide that service.”

Brayton Erickson, director of Butte Rescue Mission, shared a similar story.

“They walk in with a little yellow bag, full of pills, and we have no idea who they are,” he explained. “We find that the pills they are sent with or the prescriptions they are left to get are often sold or stolen. They are expected to use drugs appropriately and fill prescriptions when they are struggling to take care of their most basic needs.”

Providers reported medications being misused, lost, stolen, or non-existent among those discharged into homelessness by the state hospital.

Across the state, shelters offer various kinds of housing support and have different rules, but providers say those are often ignored by the state hospital.

“Patients are told ‘this is your home now’,” said Dave Miller. “But we can’t offer that. We can’t guarantee that someone can stay.”

God’s Love is a “working shelter,” requiring that residents actively work, seek employment, or receive disability. Others, like Butte Rescue Mission, have an application and vetting process for their housing programs. Some, like the Community Crisis Center in Billings, offer 24-hour emergency shelter and stabilization but do not provide long-term housing. Despite the varied services, cold drops occur in every location.

In all communities, beds are in short supply.

“Due to high demand at the Poverello Center, we have a daily lottery for beds in the morning,” explained Jill Bonny. “But people are often dropped by MSH in the late afternoon or evening. On top of that, local pharmacies are closed then. So right away, they have no housing and no way to fill prescriptions.”

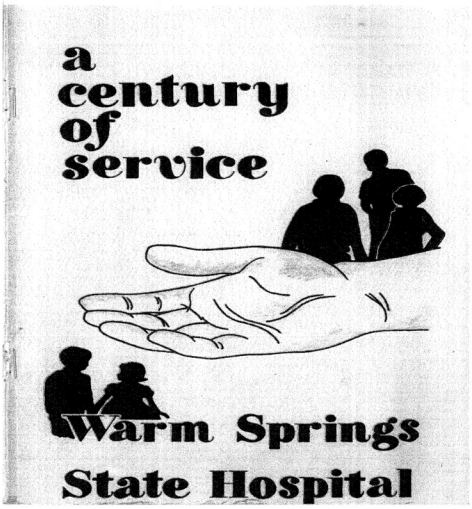
Other facilities reported frequent cases of discharged patients decompensating because they were dropped by MSH at times when their facility was not open or properly staffed. Yet even when drops occurred during hours of operation, providers repeatedly stressed they had limited services and could not provide adequate assistance to individuals discharged from the state hospital.

“They need aftercare and medication management,” said Erickson. “We don’t have the staff to do that and we aren’t trained to manage that.”

All providers insisted they have repeatedly made the state hospital aware of their specific services, hours of operation, staffing, and rules. Still, discharged patients with yellow bags arrive, almost always without warning, to facilities across the state that cannot accommodate them or provide for their needs.

Sometimes, the care required goes beyond mental illness. Providers described helping dropped individuals who were partially blind, who had wounds requiring medical care, who were “in flip flops and a tee shirt” in winter, and who were developmentally disabled.

“This has been a problem for years”



A 1977 brochure produced by Montana State Hospital, celebrating the institution’s 100-year anniversary.

Founded in 1877, the facility at Warm Springs was initially a privately-owned “sanitarium” for “insane” people before being purchased by the state in November 1912. 110 years later, MSH remains the only publicly funded state institution for people with mental illnesses in Montana. The state hospital has had innumerable problems over its long history, from overcrowding and inadequate staffing to bad food and infrastructure issues. In the past year, a series of events made the hospital a regular feature in the news: reports of inadequate care during the COVID pandemic; deaths from patient falls; patient-on-patient assaults; termination of funding and oversight by the Center for Medicare and Medicaid Studies (CMS) after the hospital failed to remedy a number of issues; a change in administration; visits to the hospital by legislators and government officials; and the hiring of private consultants by the Department of Health and Human Services (DPHHS) to undertake a study of the state’s various healthcare facilities, including MSH.

But those running homeless shelters and crisis centers in Montana, as well as former patients, say the discharge problem is one that dates back well beyond this past year’s turmoil. For more than two decades, through different hospital administrators, policies, budgets, staff numbers, and fluctuating party control in the state legislature and governor’s office, the state hospital has been discharging patients to homelessness.

These days, Jennifer Facque of Helena has had little time for anything but putting the final touches on her Masters Degree. Her new career path–Clinical Mental Health Counseling–is directly related to her personal challenges with mental illness and her desire to help others with similar issues. In 2000, at age eighteen, Jennifer was committed to Warm Springs for the first time. From 2000-2013, she recalled thirteen separate commitments and discharges to and from

the state hospital, with stays ranging from a few weeks to three months. Diagnosed with four mental illnesses, Jennifer said she was first discharged as homeless by the state hospital to Bozeman in 2000. She stayed at a shelter for homeless parolees (although she was not one of them) before winding up on the streets and, ultimately, back at Warm Springs. Jennifer recalled being given from thirty days to as little as three days of medications when discharged from the state hospital over the years.

"I would run out of meds and didn't have appointments to see providers, or they were made so far in the future I would run out of meds before I could see them."

Jennifer had repeated mental health crises in three different Montana communities, finding herself recommitted to Warm Springs time after time. On her last discharge she was placed in adult foster care, where she has thrived for the past several years and prepares to begin her new career.

Jennifer's recollection of her discharge experiences from years past, including homelessness and problems with medication and appointments, aligned with stories shared by providers across the state.

"This has been a problem for years," recalled Marcee Neary, Program Director of the Community Crisis Center (CCC) in Billings.

Beginning in 2012, Neary contacted and visited the state hospital multiple times to address the discharge problem. She ultimately drafted a document to serve as a protocol for the state hospital: "Ensuring Warm Handoffs for All Persons Discharging from MSH to Yellowstone County in Hopes of Reducing the Readmissions from Yellowstone County." The document offered a "proposed process" for MSH social workers to follow with patients at the state hospital prior to discharge. It insisted that a MSH social worker call the CCC to discuss discharge plans and that MSH staff make appointments for care in the community to ensure support services. In hopes of preventing more drops outside of the CCC, Neary wrote, "To be clear, the CCC is not housing or a shelter, so the client can never be discharged directly to the CCC." Although Neary submitted her document for review and comment from the hospital, she never received feedback. For years after, she continually informed the state hospital about the services they did and did not have. Things improved for a while in the year before the COVID pandemic, but the drops never ceased.

"In the last few years, communication has fallen by the wayside," Neary said.

Like Neary, Jill Bonny traveled to Warm Springs years ago with a group of mental health providers from Missoula.

"We met with all the social workers at MSH and told them what our programs were and what we needed from the hospital," said Bonny.

The visit had limited impact. "Things improved for about six months. Then it was back to little or no communication and cold drop-offs."

Efforts by providers to halt the discharge cycle continue as in years past. Frustrated that "people would show up and we didn't know who they were or what their situation was," Oksana Zakharchenko, Program Director of Montana Rescue Mission (MRM) in Billings, traveled to the state hospital in 2021 to educate staff there about the referral process for MRM, as well as her expectations for the hospital.

Jeanine Holt-Seavy, Executive Director of St. Vincent De Paul, a shelter in Billings, said she was "floored" when she came to St. Vincent and "saw that they were dropping them with no aftercare plan." She contacted CMS and began the process of filing a formal complaint about the patient drops, but the agency terminated their funding and oversight of the state hospital before she could submit the paperwork.

At other facilities, staff describe less formal yet consistent calls for the state hospital to change its practices.

"I called them and said we can't do this anymore," said Morgan Stewart at Great Falls Rescue Mission. "We are getting people whose physical and mental health needs are beyond our ability to accommodate." Stewart's call seemed to reduce the drop numbers, but she believed people were simply diverted to Butte.

Butte Rescue Mission, the only shelter in Butte and the one closest to Warm Springs, reported more drops than any other facility.

"Every time we call and talk to a case worker and tell them we won't take them this way," said Erickson. But the drops continue.

Staff at Butte Rescue Mission reported trying to flag down drivers who had dropped patients, hoping they would take them back to the state hospital.

The calls and confrontations have never led to lasting changes, but providers continue to try.

"Over and over, for many years, we have begged them to stop," said Dave Miller.

MSH has had discharge planning policies in place since at least 1978.[7] Even as discharges to homelessness occurred throughout the past two decades, the hospital regularly updated and revised its discharge policies–in 2000, 2001, 2003, 2006, 2009, 2012, and 2016.[8] The most recent policies from 2016 (AD-02 & AD-04) provide detailed steps and procedures involving various staff members (including a designated "Discharge Technician," which MSH currently employs) as well as state hospital-initiated interaction with community providers during the discharge planning process. According to MSH discharge policies, every patient should have a Community Reentry Plan and an Aftercare Plan, each involving "a cooperative

[7] *Discharge Policy*, November 1978. (HOPP 13-01d.031379).

[8] MSH policies were available for the public to view and download until February 2022, when they were removed from the state hospital website for unknown reasons. The policies remain unavailable on their website as of the time of this writing (December 1, 2022).

effort" with community contacts in "the discharge plan review process." One policy insists that a patient's social worker contact aftercare providers "to assess the quality of the discharge process and linkage to aftercare services."[9]

But policies can differ from practice.

Despite multitudes of discharged patients dropped at their doors, no staff at any facility said they were involved in a discharge planning process for a patient from the state hospital. Likewise, no staff at any facility said they were called by the state hospital to ensure a patient dropped by MSH had even arrived.

Some had no idea MSH had discharge policies.

Policing Discharges from MSH

Over the years, problems with discharges from the state hospital have not gone unnoticed by federal and state oversight agencies, such as CMS and the state's Office of the Inspector General (OIG).[10] In 2013, CMS investigators found that the state hospital failed to follow a legal requirement of completing medical records within 30 days of discharge for 40 of 115 patients. Some records were nearly five months past due.

In December, 2016, only two months after MSH's latest discharge policy update, CMS investigators cited the hospital for treatment planning that was "non-measurable" and "failed to develop and document individualized treatment interventions with specific focus." CMS found this to be true in 100% of sample patients they reviewed, and they listed six patients who the hospital recently discharged that were "affected by the deficient practice." The "corrective action plan" included the hiring of two mental health program consultants from Western Interstate Commission for Higher Education (WICHE) to provide training to staff on treatment plan development, including discharges.

Despite the "corrective action plan," similar issues with treatment plans remain today. One patient, dropped in Billings in 2022, had her treatment plan in her belongings. It contained nearly word-for-word reprints of two "discharge goals" CMS found to be "generic" and "unmeasurable" in 2016. In its report that year, CMS ultimately concluded, "These failures lead to the development of treatment plans that do not adequately reflect what the facility plans to do to enable the patient to improve and be discharged to a less restrictive setting."

In October 2017, CMS again found that the state hospital had inadequate discharge planning in a 23-page finding related to a single male patient. Despite exhibiting a range of behaviors documented by the hospital up until his discharge—including sexual misbehavior, violence, and an inability to care for basic needs— the man was discharged to a "wet house" – a

[9] "Discharge or Conditional Release from Civil Commitment" (AD-02), October 18, 2016.

[10] As of Dec. 1, 2022, these investigation reports can be found on the DPHHS website, "Certification Bureau Survey Results and Plans of Correction": https://dphhs.mt.gov/qad/poc

homeless shelter that allows chronic alcoholics to drink alcohol—in another state. Investigators found that the hospital's discharge planning "failed to evaluate the patient for his capacity for self-care" and "failed to evaluate the patient's need for post-hospital needs, including evaluating the patient's risk of residing in a homeless shelter, in another state, based on his continued inappropriate behaviors."

Similarly, in 2021 and 2022, the state OIG found in its investigations of the hospital that, for some discharged patients, there was no written evidence indicating support by MSH in planning for housing or other services, of recommendations related to aftercare, or of summaries of a patient's condition on discharge. The most recent inspection occurred in early September 2022.

With years of oversight that seems to have had little impact on discharges, some providers believe the only meaningful change will come through legislation. Montana has a "Discharge Plan" law (MCA 53-21-180) for individuals "admitted as an inpatient to a mental health facility." The law has six basic requirements related to discharge plans, including "identification of a community-based agency or individual who is assisting in arranging post discharge services."[11] It does not mention housing or homelessness.

However, some legislators have made efforts in the past to combat homeless discharges from the state hospital.

In 2011, Democrat Senator Ellie Boldman Hill of Missoula (then a Representative) introduced House Bill 395 to require that discharge plans for people with mental illnesses specifically address housing issues.[12] The bill sought to amend the duties of DPHHS to include the development of housing options for persons discharged from a mental health facility and to specifically prevent discharges from the state hospital to homeless shelters. It also called for changes to the state's existing "Discharge Plan" law with an additional section: "A discharge plan may not allow for the discharge of a patient directly into a homeless shelter."

The bill died in the House.

Boldman Hill reintroduced the bill again in the 2015 and 2017 sessions. Each time it failed to pass into law.

Despite outcries from providers, investigations and "plans of correction" from oversight agencies, consultant advice, policy creation and revision, and attempts to address the problem through the state legislature, the cycle of discharges into homelessness from the state hospital continues in Montana.

[11] https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0010/section_0800/0530-0210-0010-0800.html
[12] https://legiscan.com/MT/text/HB395/2011

Looking Outward

In both length of time and numbers of individuals involved, the state hospital's practice of homeless discharges may prove a unique system in the nation. While it is uncertain what a continuation of "the cycle" will bring for the hospital and for the state, two cases related to homeless discharges from smaller psychiatric facilities–in California and Massachusetts–may reflect future outcomes for Montana.

In April 2021, the Civil Rights Division of the U.S. Department of Justice (DOJ) concluded an investigation of John George Psychiatric Hospital, a public institution in northern California's Alameda County. Disability Rights California (DRC), the state's protection and advocacy organization, filed suit against Alameda County in 2020 following their 2018-2019 investigation, citing "boilerplate" discharge plans from John George that included frequent discharges into homelessness, disconnection from community services, and high rates of recidivism. DOJ investigators found the allegations to be true, concluding that the hospital "does not provide adequate discharge planning and transition services to connect [people] with community-based services." Investigators argued that the practice of discharging individuals into homelessness led to repeated "contacts with the criminal justice system" and "frequent readmissions" to John George. They concluded Alameda County "violated the Constitution and federal law" in various ways. In addition to recommending "minimum remedial measures," the report reminded Alameda County that the U.S. Attorney General could initiate a lawsuit to correct the various deficiencies.[13]

A few months later, Disability Law Center, a protection and advocacy organization in Massachusetts, issued a report on the discharge and death of a woman, CaSonya King, from High Point Hospital, a private psychiatric facility. High Point staff dropped CaSonya outside of a shelter on the streets of Boston, a city in which she was unfamiliar and had no "friends or service providers." Using hospital documents and interviews, investigators concluded that staff at High Point were aware CaSonya was decompensated prior to discharge and that she was unable to care for herself. She was also "given prescriptions she was directed to fill herself." Even though the shelter told hospital staff they did not have beds available and that they could never guarantee beds for anyone, CaSonya was dropped outside of the facility. No one is clear exactly where that was, but it is certain that she never made it inside. Just hours after discharge, CaSonya took an overdose of over-the-counter medications purchased at a pharmacy six miles from the shelter. She later died at a local hospital. CaSonya King's mother has since filed a lawsuit against the hospital, including individual staff members, as well as CVS Pharmacy.[14]

The Alameda County and CaSonya King cases share striking similarities to the stories about discharged patients from Montana State Hospital. Providers and former patients across Montana reported drops in unfamiliar cities with no contacts or resources, uncertainty if patients made it into facilities they were dropped at or near, expectations by the state hospital that

[13] https://www.justice.gov/crt/case-document/file/1388891/download

[14] https://www.dlc-ma.org/wp-content/uploads/2021/06/CK-Final-Report.pdf https://commonwealthmagazine.org/health-care/mental-health-patient-died-in-2018-after-discharge-to-boston-streets/

individuals will fill prescriptions and use medications appropriately, and drops at facilities despite being told no beds are available. If King's tragic death was able to shine a light on a substantial crack in the foundation of the nation's mental health system, Montana's multitudes of similar cases, over many years and in every major population center in the state, expose a deep and broad chasm.

"They are dying"

Rachelle Farnsworth's forearm is a roadmap of red and pink stripes–battle scars of her past and present struggles with mental illness. The nineteen-year-old's most recent suicide attempt came after a discharge to a homeless shelter from Montana State Hospital in a community far from any place she had been before.

"My social worker at MSH said a new place would be a fresh start," said Rachelle, who is from Missoula. "They didn't give me a choice."

Shelter staff were unaware Rachelle was coming, although they managed to secure her a bed for a few days. Rachelle had a yellow bag with medications, prescriptions, and brief paperwork. It was her second discharge to homelessness from the state hospital. The first drop was outside of Missoula's Poverello Center when she was eighteen.

Rachelle explained she had been raped twice before and that, shortly after the drop, another assault seemed imminent.

"This man said he was going to have sex with me," she said. "I said 'no way' but he laughed and said 'I'll make you.' I see him everywhere. I don't know why but after he said that I started to have my period really heavy."

Rachelle spiraled down quickly.

On the third day after her drop, the last of her guaranteed housing, she took an overdose of drugs issued and prescribed to her from the state hospital, then used glass to cut her arm and neck. Shelter staff called the police and, after being treated at an emergency room, Rachelle was returned by a court order to Warm Springs.

Less than one month later, Rachelle was discharged. Once again, she was dropped somewhere near the Poverello Center.

Across the state, providers share stories like Rachelle's–of individuals who cycle back and forth from the streets to the state hospital, sometimes for years. Many recall the names of those who have vanished or, like CaSonya King, passed away.

In Helena, one staff member at God's Love recalled a woman who had repeatedly gone from the state hospital to the streets for several years before police found her body along the railroad tracks in 2016.

In Missoula, Poverello staff lamented the passing of two women, both of whom went from the state hospital to the homeless shelter for years. One died at a young age of heart failure last year on the streets of Missoula.

Staff from St. Vincent De Paul expressed concern about one young woman, a previous victim of human trafficking and forced prostitution, who was dropped by MSH in 2021 outside of their facility in Billings. She never made it in their doors. The only evidence police found of her was a yellow bag, abandoned in a gutter.

The disappearances and deaths resulting from discharges to homelessness by the state hospital are not distant memories.

On October 13, 2022, state hospital staff dropped Earl Sholey-Larson at Butte Rescue Mission. According to Misty Johnston, Operations Manager at BRM, the shelter had no calls ahead from the state hospital and could not provide a bed. At the time, the shelter was on an intake freeze, a fact Johnston said she would have certainly relayed to the state hospital if she knew they had planned a drop. Earl arrived with his yellow bag nearly three hours before the facility opened, although he hung around and managed to give the receptionist some paperwork—a letter from MSH to the Social Security Administration saying that Earl now resided at the Butte Rescue Mission, and a one-page discharge information document saying Earl was to be transferred by "MSH Van" to a "Homeless shelter," with the Butte Rescue Mission's address listed for the driver. As with other persons dropped unknowingly at Butte Rescue Mission by MSH, Johnston and shelter staff tried to assist Earl, hoping they could at least find short-term housing and psychiatric services.

But by the following morning, Earl had vanished.

Nineteen days after his discharge into homelessness from Montana State Hospital, Earl jumped to his death from a building in Portland, Oregon. He was 28 years old.

Earl's older sister, Cassy Sholey-Larson, was teaching at Big Sky High School in Missoula when she received a call from a Multnomah County medical examiner confirming her brother's death.

"I melted down," she said. "I had to have my coworkers cover so I could go out to the parking lot and cry."

Days before, Earl had called his sister and announced he was in Portland, having arrived by bus after being given a ticket by an unknown source. Earl had no friends or family in Portland, so Cassy was immediately worried. She tried to maintain contact, calling his phone until a stranger answered, saying he found it in a Safeway parking lot. Cassy called shelters and enlisted social worker friends in the area to help locate Earl. She ultimately filed a missing person's report. One day later, Cassy learned of Earl's death.

Prior to his discharge, Cassy had worked hard on her own to transition Earl.

"I'd begun filling out paperwork for supervised housing. I ended up having to use $125 of my own money to fax that paperwork, and accessing a social worker in my own community to receive the verification of disability that would help him access housing."

Cassy said she tried to contact Earl's case manager at Warm Springs repeatedly in the days prior to his release to discuss housing. She did not hear back.

Cassy also left messages at the state hospital in the days following Earl's death, hoping to speak to someone about what happened. She filed a complaint through DPHHS using their online form. In her writing, she not only expressed her frustrations with the system, but also her feelings of personal guilt.[15]

"I keep wishing that I had taken out a loan to get the first month's rent and a deposit for him somewhere. But ultimately, it's unbelievable that he went through one of the most acute mental health care resources in our entire state and I, someone who works full time and attends graduate school, still would have had to use my own time, money, energy, and resources to get him housing . . . more needs to be done to ensure that our most vulnerable people don't fall through the cracks in the system."

Cassy has not received any response.

In his obituary, Earl's family remembered him as a person who battled mental illness throughout his life. But more importantly, they recalled his love of animals, his artistic abilities, and the way his wit and sense of humor could put people at ease. A proud member of the LGBTQ+ community, Earl had a strong sense of justice and compassion for those who struggled in the world.

"He was well loved, funny and bright, and really smart," recalled Cassy. "And he was very loving and kind and creative. He was just really awesome."

Cassy's feelings of frustration and sadness reverberate across the state, as they have for years, among the providers working on the ground who know the stories of the individuals discharged to homelessness by Montana State Hospital. But after many years and many efforts, most have come to understand that the discharge problem from the state hospital is beyond their power to remedy.

[15] https://dphhs.mt.gov/qad/qadcomplaint

The photo accompanying Earl Sholey-Larson's obituary.[16]

Misty Johnston received the call about Earl Sholey-Larson's death a few days after he passed.

"I couldn't believe it when I heard," she said. "I cried a lot of tears. So many."

But Johnston, like other providers around the state, has an eye on change despite years of disheartening experiences.

"My hope is that this ends–that the hospital is made to fix this. A homeless shelter isn't the solution. I just wish they understood . . ."

Her voice cracked and she paused, gathering herself.

"I want them to know that these are people. And they are dying."

[16] https://www.legacy.com/us/obituaries/name/earl-russell-sholey-larson-obituary?id=37029836