Development and Implementation of Mental Health Respite Program Based on the Model of the Community Medical Respite Program in Raleigh, NC

Brooks Ann McKinney, MSW
Wake Crisis Cooperative
I. Groundwork of Mental Health Respite-Development

II. Specifics of program

III. Outcomes

IV. Outreach and Accommodation

V. Respite is Integration of Care
In April 2006, the first respite bed was used in the Raleigh Rescue Mission in downtown Raleigh, North Carolina.

By the end of 2007, there were 22 beds in the RRM, 8 at Wake County’s men’s emergency shelter, and 3 at a Catholic Worker’s home, and 1 respite apartment at the county’s transitional program.

In 2007, we put 30 clients into permanent or supportive housing.
We started to see more patients show up at the door that were being discharged from the soon to be closing state mental health institution with a script and an appointment card in hand. (Dorthea Dix closed December 2010)

Many of these individuals were dually diagnosed with complex mental diagnoses and in need of stabilization.

So...this led to setting the groundwork of MH Respite!!
1. Why bother? Is this the right time?

Medical Respite attracting referrals of medical + psychiatric patients

Acute shelter pattern of attracting clients with significant untreated mental illness and those discharged from inpatient psych without adequate planning

HCH having to assess and bridge recently inpatient homeless
1. What pieces are needed

External requisites (don’t be a javelin catcher)

- Define gaps in local system of care
  - Timely psychiatry follow-up
  - Adequate wrap-around services for high acuity clients
  - Service definition for state funded services
  - Documentation of cognitive impairment
  - Streamline disability/Medicaid/Medicare when obvious
  - Better catalog of discharge destinations

- Politics of action: Common ground, embarrassment, empathy
  - Buy in from underperformers
  - Identify the pressure points
    - SOS, Director of Human Services, and LME
2. Baseline data to make the case

- Is the need measurable in your community? Is the quantity of need adequate/convincing?

- What to measure? 18 of 122 homeless discharged from state IP psych unit made it back into care in 30 days
  - About 1000 discharges of homeless to the Triangle
  - Only 20 per month with specific referral to shelter of whom 5-6 were not stable enough for open shelter environment
3. Identifying potential allies

- Start with front line workers: “fire in the belly”
  - Shelters, HCH, community providers
- Who is responsible (Human Services/LME)
- Who’s got bad press (Inpatient psych social workers)

4. Convening stakeholders/collaborators

- Start with small committed group and build
- Corralling stragglers (LME and WCHS example)
1. What pieces are needed

Building on medical respite:

- Defining population precisely
  - Higher acuity level ADL’s, Continence, post detox, not suicidal ...
- Medication?
- Treatment plan/ progression plan
- Case management and rights & benefits advocacy
- A better destination
2. Funding mechanisms

- Who’s 501C3 to use
- Grant money
- Local fundraising
- Room and Board from the Shelter (Mission)
- In kind services
- Partnership with SOS for medication funding
3. Preparing to launch

- Conversion from exploratory group to work groups
- Hiring and training staff
- Referral Mechanism—worked with SWs from MH hospital to create forms and criteria. Referral form—Axis I, II were MH
- User education
- Staying flexible, adaptable
DETAILS OF FACILITY

- add on 2nd and 3rd shift MH Technicians (NCI, CPR)
- 2 FT Mental Health Technicians
- 3 PT Mental Health Technicians
- Staff existing from MRP: 3 MSW, 2 FT RNs, Admin.
- Regular shelter staff- 24 hour, another RN, psychiatrist
Choose a target date

Assure that existing staff at shelter understands the new program/ train if needed - Take time for this!

Start off slow, do not go public until everything is in place. Space out work group meetings to once or month, or as needed.
4 female beds in one room on Women’s floor

6 male beds in one room on Men’s floor

Overnight staff in place with added mental health techs

Layout of shelter may determine bed placement
**REFERRAL PROTOCOL**

1. Referral completed and faxed to RN.

2. RN decides if client can be in community setting, assures there is 14 days of medication.

3. Hospital SW communicates with MH Respite SW to assure there is continuing care plan and mental health provider is in place (CST, ACT, or IDDT team).

4. Set up transportation (MH team would be the best)
5. Set up MH team to meet on site and sign MOA. MSW works with client on a daily basis to see if daily goals are being met. MH techs are in communication with this point person on client’s needs and goals.

6. CST/ACT/IDDT team works on next placement after stabilization (assisted living, group home, or Shelter Plus Care voucher). Medical Respite Program is also a referring agent for the vouchers, but does not do the ongoing case management.

MSW on site is SOAR trained and will continue to work on disability or work with local disability advocates.
* Continue with shelter schedule, accommodate clients.

* Communication with MH case manager and mental health techs should be constant.

* Weekly/bi-weekly meetings should be set up with mental health team.

* Progression Plan should be updated when needed and case notes are important.
Our hope was to put 10 clients in permanent housing by the end of 2009. (either Housing First, group home, family, etc.)

Sustained Funding (SOS, hospitals, grants, etc)

With proper data collection: capture numbers of admission/discharge date, housing at time of discharge, and any numbers that may apply to grant specifics.

Compare recidivism rates to prove that this model works.
HELPFUL TIPS

- Identifying possible housing before intake with the referral
- Make sure the social work/discharging nurse has looked at every option before discharge
- See if SSI, SSDI, and/or Medicaid referrals have been started if needed. See who to follow up with after discharge.
- Sometimes their connections make be more valuable.
Make a client file checklist with all demographics.

Have local housing agency applications done by first week.

Get birth certificate, criminal record, and credit report for all clients upon entrance to program if possible.

With clients with bad records and credit history, look at which agencies have reasonable accommodation.
COLLABORATION IS KEY

- Relationships are key.
- During development, figure out the stakeholders.
- Find the key players in housing, who is in control.
- Make sure they understand the population you work with.
- Talk about cost avoidance, and tell the success stories.
- Invite them to your facility, allow them to meet your clients.
Invite family care home owners to your facility.

- Allow them to meet your clients.
- Get past clients to meet your present clients to talk to them about other options of housing.
Population has a higher chance of getting disability

Housing options available with elderly and ones that may have a disabling condition

Treatment team (Respite team, HCH clinic staff, hospital staff, etc.) may recommend client to assisted living, family care home, or family members.

Higher number of professionals on board that can help make decision on what is best for the client.
After 6 months, we were seeing 6 to 8 clients into permanent housing every month (MR and MH beds included).

We had collaboration with Housing First/Shelter Plus Care to be a referring agency with the MH team doing aftercare.

MH Respite was a critical agency in the Continuum of Care. All meetings concerning housing, homelessness, and MH with DSS were all involved.
The RRM closed the doors to MH respite in June 2011, due to lack of leadership and focus on spiritual values that did not settle well with the MH population.

Now, the county shelter is working with the LME and the new state hospital.

MH clients that are discharged can have a 7 day bed at the shelter if they have a MH team, 7 days of medication, and a follow appointment with the psychiatrist to refill meds.

If the client stays with goals of team, they can keep bed at shelter.
OUTREACH COMPONENT

Under the HCH clinic, full time SOAR worker under Wake County Medical Society and MH Outreach Nurse through an endowment from local church.

1. SOAR Specialist receives referral from CRH/Holly Hill (Central Regional Hospital - these hospitals have the most homeless).

2. MH team is identified and Hospital Transition Team may be involved. Primary care appointment is made.

3. Patient receives transportation from hospital to shelter. Contact with MH team, SOAR worker, MH nurse, or HTT is critical in the first 24 hours.
4. Patient is discharged with 7 to 14 days worth of psych meds and prescription that will allow enough time until they see psychiatrist.

5. Patient can keep the MH bed at county shelter a week at a time until housing.

6. The HCH MD will come to shelter to see patient and start relationship with individual so that they will feel comfortable going into clinic.

7. SOAR, MH Nurse, HCH Clinic, and MH team have to collaborate to get consumer into housing.