Homeless Mental Health Respite

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

Brooks Ann McKinney

Outline

- ***1. Medical Respite Model- Video***
- ***II. Groundwork of the Mental Health Respite- Development***
- ***III. Specifics of program***
- ***1V. Hopeful Outcomes***

Defining Characteristics of Medical Respite Care

- A short term specialized program focused on homeless persons who have a medical injury/illness and may also have mental illness or substance abuse issues
- Comprehensive residential care providing participants the opportunity to rest while being able to access hospitality, medical and supportive services that assist in their recuperation
- Length of stay is determined by medical need and progress on an individual treatment level
- Whole person care through collaboration with other local providers who offer a variety of services to participants during their stay in respite care and also provide continuity of care when the participant moves into the community
- Respect for human dignity of all residents and staff
- Active involvement by participants in the process of their recuperation and discharge planning

(Cont'd)

- A bridge that closes the gap between acute medical services currently provided in hospitals/emergency rooms, homeless shelters that do not have the capacity to provide the needed recuperative care and more permanent housing options
- Low cost, high quality and innovative care which result in emergency room diversion, additional hospital discharge options and cost avoidance for hospitals and communities
- Diverse service delivery models reflecting unique community needs, priorities, and resources
- An integral component of the continuum of care for homeless services in any community

History

- *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.*

History (cont'd)

- *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.*
- *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!!*

Setting the groundwork

- *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*

Setting the groundwork

- *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*

Setting the groundwork

- *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)*

Developing a Program/Product

- *1. What pieces are needed*
  - *Building on medical respite:*
    - *Defining population precisely*
      - *Higher acuity level ADL's, Continence, post detox, not suicidal …*
    - *Medication management*
    - *Treatment plan/ progression plan*
    - *Case management and rights & benefits advocacy*
    - *A better destination*

Developing a Program/Product

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 funded services*
            - *Documentation of cognitive impairment*
            - *Streamline disability/Medicaid/Medicare when obvious*
            - *Better catalog of discharge destination*
        - *Politics of action: Common ground, embarrassment, empathy*
        - *Buy in from underperformers*
        - *Identify the pressure points*
            - *SOS, Director of Human Services, and LME*

Developing a Program/Product

2. *Funding mechanisms*
   - *Who's 501C3 to use*
   - *Grant money*
   - *Local fundraising*
   - *Room and Board from the Shelter (Mission)*
   - *In kind services*
   - *Medicaid/Medicare decision*

Developing a Program/Product

3. *Preparing to launch*
   - *Conversion from exploratory group to work groups*
   - *Hiring and training staff*
   - *Referral Mechanism*
   - *Referral form*
   - *User education*
   - *Staying flexible, adaptable*

Staffing

- *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*

Implementation of Program

- *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.*

Details of Program in Shelter

- *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*

Start Date

- *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)*

Up and Running

- *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.*

Up and Running (Cont'd)

- *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.*

Projected Outcomes

- *Our hope is to put 10 clients in permanent housing by the end of this year. (either Housing First, group home, family,etc.)*
- *Sustained Funding.*
- *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.*


610