



MENTAL HEALTH STABILIZATION SERVICES

RALEIGH RESCUE MISSION
314 EAST HARGETT STREET
RALEIGH, NC 27601

Mental Health Stabilization Services (MHSS) are a comprehensive array of services designed to stabilize the conditions of acute psychiatric symptoms of homeless individuals upon release from an inpatient hospital. It is a voluntary program, provided in a shelter based community. This service is intended for persons whose condition can be stabilized with short-term intensive services.

The goal of the MHSS is to stabilize the crisis situation as quickly as possible and to prevent unnecessary inpatient re-hospitalization. We view inpatient hospitalizations as the treatment option of last resort. All clients are evaluated by their needs and will follow a Progression Plan once entered into the program.

Our program is staffed twenty-four (24) hours a day at RRM. This service provides help for mentally ill adults whose community placement would be threatened without 24 hour services; or who require more intense supervision / medical management than is available in the community. We connect client with local agencies to provide holistic services. The hours of participation will be based on individual needs.

Protocol:

- 1. Call MHSS RN at 919-400-3414 to see if bed space is available.**
2. Fax referral form and discharge orders/continuing care plan to 919-341-5680.
3. Insure that medications are provided.
4. Connect mental health agency with MHSS Case Manager at 919-400-3415.
5. Make sure contract of services is agreed upon.
6. Provide transportation to facility.

Admission Criteria:

- Homeless can receive IPRS funding.
- No longer a danger to oneself or others.
- Ability to access medications required for treatment-Must have medication in hand for a minimum of 14 days.
- Need of a safe environment that is less restrictive than inpatient psychiatric hospitalization. No longer meeting criteria for admission.
- Deterioration in psychiatric condition or environment, which may, if not addressed, result in severe exacerbation of symptoms leading to potential hospitalization or loss of community placement-
- Have a diagnosis of mental illness and/or substance abuse
- Be willing to be treated voluntarily
- Be medically stable, not in active alcohol withdrawal
- Agree to a personal belongings inventory and person search upon admission
- Agree to a urine drug screen if there is suspicion of substance abuse
- Be 18 years of age or older
- The referring professional / agency has a firm plan for client service disposition upon discharge from MHSS.

Exclusions:

- No active homicidal ideations and excessive violent acting-out behaviors.
- Suicidal ideations.
- Specialized medical services or intensive nursing care for clients on renal dialysis, tube feeding, or IV lines.
- Clients who are unable to care for themselves or perform routine activities of daily living.
- Clients with infectious/contagious diseases that require special isolation precautions.
- Clients who are incontinent of urine and/or feces.
- Clients who require PRN medications.
- Clients who have been in seclusion or restraints within 48 hours of discharge.

MENTAL HEALTH STABILIZATION SERVICES REFERRAL FORM
Raleigh Rescue Mission

Name:	Date of Birth:	SS#: MR#:
Referring Agent:	Cell/Pager:	Referring Agency:
Referring Provider:	Cell/Pager:	Office #:

Steps to a Mental Health Stabilization Services referral:

- *Mon-Fri:** 1. Contact RN at 919-400-3414 **BEFORE** completing referral form to see if bed is available.
 2. Fax Referral Form + D/C Med Form (inpt) + ADL record (inpt) to MHSS RN at 919-341-5680
 3. Insure that medications are supplied for at least 14 days.
 4. Connect MH agency to MHSS Case Manager.
 5. Make sure contract of services is agreed upon.
 6. Provide transportation to facility.

1. Current

Diagnosis: _____

Chronic
Illnesses: _____

Prognosis: _____

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Medical Provider to Complete all Following Sections

2. Admission Criteria – Check Boxes Below (must meet all criteria)

Homeless	Willing to see MHSS RN and can comply with medical recommendations	
Acute medical problem that would benefit from short-term care (14 days)	Behaviorally appropriate for group setting (including no Known suicidal or assaultive risks)	
Independent in ADL's including medication administration	No intravascular lines (IV lines)	
Independent in mobility (cane, walker, wheelchair)	Does not require > 6 week MHSS stay	
Continent of urine and feces	Does not need SNF placement	
Medically stable	Patient agrees to MHSS admission	
Is not in active alcohol/drug withdrawal	Diabetics have supplies	

3. Social Services Referrals:

Check all that apply:

- Referred to Triangle Disability Associates _____ (caseworker contact info)
- Current benefits client is receiving _____
- Current Agencies _____

5. Substance Abuse/Mental Health Services: Open case with Mental Health Agency? Yes No

SA/MH Counselor (Agency contact

info) _____

Mental Health

Diagnosis _____

Drug/s of choice _____

Prior treatment history _____

6. Number of Days requested: _____ (not to exceed 14) days.

7. Follow up appointments made prior to discharge:

8. Level of Functioning:

Physical: Independent ambulation Ambulates with assistance (Circle type: walker wheelchair crutches)

Speech/Vision/Hearing Impairment (Specify): _____

Skin Impairment (Specify): _____

Activities of Daily Living:

Independent with self-care

Assistance required with: _____

Primary Language: English Other (Specify): _____

9. Please list all discharge medications (name, dosage & frequency, to include insulin) or attach copy of discharge orders:

Patient must come with enough medication to cover length of stay – this is the referring provider's responsibility.

Client has all discharge medications

Client given enough medications at least 14 days.

Plan for client to obtain discharge medications: (where, when, how)

Specific Care Needs (check all applicable):

Requires Daily Dressing Changes

Wound care orders clear and precise

Dressing supplies given at discharge

Client instructed and will change dressings

Home Health ordered to assist with dressing changes

Agency: _____ Ph: _____

Requires Oxygen (4 liters or less):

o Liter flow: _____ Continuous With sleep/exercise Other

Specify: _____

Medical Company: _____ Ph: _____

Requires Nebulizer:

o Instructed on use of machine and medication dosage and times

o Has medication and machine for nebulizer at discharge

Medical Company: _____ Ph: _____

Has medication ONLY. Machine has been ordered (see company above)

o Requires Diabetic Management:

o Received diabetic education, understands how to respond to high or low blood sugars

o Has glucometer and understands use of meter

o Has glucometer and strips until next clinic appointment

o Patient performs monitoring independently

o Requires Home Health visits:

Agency: _____ Ph: _____

o Requires Physical Therapy:

o Physical therapy arranged

Agency: _____ Ph: _____

Requires Occupational Therapy:

o Occupational therapy arranged

Agency: _____ Ph: _____

Referring Provider's Checklist :

- Referring Provider has read and understands the "Attention Medical Provider" cover letter.
- Referring Provider has explained and had the guest sign the "Mental Health Stabilization Services Agreement" form.
- Referring Provider has explained and had the guest sign the "Release of Information" form.
- Referring Provider has (or will) completed doctor's orders and submitted to MHSS Case Manager.

Signature of Referring Provider: _____

To be completed by receiving Mental Health Stabilization Services Staff:	
Date Received: _____	Time Received: _____ Shift Supervisor Processing Referral
_____ Initials _____	
_____ Approved _____ Denied	
If denied, why? _____	
Dorm/Bed # Assigned _____	Day/Time Guest is expected to arrive? _____ Doctor's Orders Received _____
Information entered Shift Synopsis ? _____ Release of Information Received? _____ Orientation Complete _____ CHINS Complete _____	
Would pt have been sent to another facility in lieu of respite? _____, if yes, which facility _____	

RELEASE OF INFORMATION

_____ **and Raleigh Rescue Mission**

Guest Name: _____ Date of Birth: _____
First MI Last

I, _____ hereby authorize _____
(Guest Name) (Name/Address of Provider Agency)

to release specified information in my records to the Mental Health Stabilization Services at RALEIGH RESCUE MISSION. This data shall include:

- Diagnosis
- Treatment plan
- Medical history
- Diagnostic testing
- Lab results
- Identifying information
- Medications
- Doctor's orders

I understand that this information will be used for coordination of bed rest and medical services, temporary housing, and case management assistance.

Other information: This is a TWO WAY RELEASE FOR EXCHANGE OF INFORMATION BETWEEN THE ABOVE NAMED PARTIES

My right to confidentiality has been explained to me and I understand what information will be released, the need for the information and that State statutes and regulations protect the confidentiality of authorized information. In addition, information related to substance abuse in my records is protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. I freely consent to the release on information as stated in this document.

This consent will expire on: _____ (specific date, event or condition, not to exceed more that 365 days from signature). I understand that I may revoke this consent at any time but that it will remain valid to the extent releases based on this consent have already occurred.

Client Signature Date Signed

Witness Date Signed

Physician name and contact _____

Client Signature Revoking Consent Date
Mental Health Stabilization Services Agreement

Mental Health Stabilization Services are for homeless men and women needing short-term bed rest for mental health stabilization following mental health institutionalization. Before being admitted, the MHSS RN must have received and approved a referral packet, including this form, exchange information between the MHSS staff and the provider signed by the client.

Clients admitted to the Mental Health Stabilization Services are granted a specific length of stay. During your time in the program you will be required to:

- Attend an on-site orientation the first day of your stay;
- Remain Alcohol and Drug Free;
- Continuously remain in the area designated except for meals, documented medical and other necessary appointments;
- Have any medical assistance and / or transportation arranged by referring practice and documentation provided to the Nurse;
- Try to limit your personal belongings (Maximum 4 closed bags); &
- Comply with all MHSS rules and expectations, provided upon the day of admission.

During your stay, you will also have an opportunity to enter into our Recovery & Rehabilitation Services, if space is available.

My Signature on this document indicates that I understand and agree to follow these guidelines during my stay at Raleigh Rescue Mission while utilizing the Mental Health Stabilization Services. I understand I will be provided an orientation and Mental Health Stabilization Services rules and expectations on the first day of my stay.

Client Printed Name: _____

Client Signature: _____ Date: _____

Witness Signature : _____ Date _____