Mental Health America
of South Central Kansas

About the Navigators

Who Are the Navigators?

- A team through Mental Health America of South Central Kansas
- Answers to KDADS and the DRC
- Discharge Planning and Connection to Services
- Advocating for the rights of those who are in the NFMHs
- Heavily collaborates with other entities to assist with discharging residents
- *Stuck in Institution: The Crisis of Mental Health Supports and Services in Kansas*
- "Third Party Case Managers" --> "Olmstead Advocates" --> "Olmstead Navigators" --> "Navigators"

Stuck in Institutions Report

- "Olmstead Advocates" listed in the report to help "enable discharges"
  - Independent, unbiased party to help facilitate discharges
  - "in each NFMH to provide effective navigation, support, discharge planning, and advocacy for residents who want to discharge into the community"
  - Boots on the ground entity

What Is The Process?

Step 1: An individual has identified a desire to leave

- Review PASRR Goals
- Gather historical information from County of Origin
- Ask their desired location(s) they want to explore, desired services, etc.
- Reach out to the guardian (if necessary)

Step 2: Build the Care Team

- Reach out to the CMHC of the desired area for the NFMH Liaison
- Fill out and submit an MCO form
- Reach out to the appropriate boundary spanner
- Set up "transition calls" with CMHC(s), MCO, Liaisons, Navigator, guardian, boundary spanner, etc.

Step 3: Create a discharge plan

- Where are they moving?
- What doctor and pharmacy are they going to use?
- How are they going to get to that location?
- Who is going to meet them at this placement?
- When are the intake appointments?

The "In-Between" Steps

- Reviewing and assisting with goals
- Connection to local services (Clubhouses, therapy, peer support, etc.)
- Getting identifiers (IDs, Birth Certificates, Social Security Cards)
- SSI Verification Letter
- Housing Applications

After Discharge

Individual is followed for a year after discharge

- A member of the team creates a schedule to meet with the individual three days after discharge, then weekly, tapering out as the need fades
- Check that their needs are being met and services are in place
- Work out any details or complications after discharge

Other Components of the Role

- Assessments and Meetings
  - DLA 20, WRAP, PASRRs, Continued Stay Screens, RADAC Assessments
  - Care Plan Meetings, Transition Calls, Discharge Meetings
- Networking, Collaboration, and Relationship Building
  - Clubhouses (Breakthrough, Railway, Sunshine, etc.)
  - MCOs
  - CMHCs
  - NFMH Staff

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Stuck in Institution:
The Crisis of Mental Health Supports and Services in Kansas

Olmstead Act

Housing First