HSD Provider Conference
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Notes from Session: **Behavioral Health Support & Care Navigation: Practical Tools for Frontline Providers**

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-Main Points from Session Overview/Presentation (high level):

- Increasing need to support clients who have behavioral health needs. Focus on understanding the current behavioral health system.
- How to address client challenges within the current system.
- Cascadia Healthcare: one of the largest behavioral health service providers in the State. Partnership with the County—Project Respond, Urgent Walk in Clinic, Respite program, street outreach program.
    - Core Values: Meeting individuals where they are at.
    - Limitation: Crisis services formed with having little or no limitations such as age, insurance, race, gender. Only limitation are County limits (Cascadia will navigate that, onus not placed on providers)
    - Crisis services don't discriminate, including both unhoused and housed folks. Doesn't account for insurance.
    - Some limitation on ages but that does not stop the team from going out to the crisis
- The Peer Company: Evolve Program Manager
    - All peer run organization that values lived experience
    - Provide peer support for re-entry programs, hospitals, etc.
    - The Peer Company runs the Behavioral Health Resource Center downtown
    - Also has street outreach team, Prime +
    - Core Value: meet people where they are at, recognize that each individual is the leader of their journey.
    - Access services at thepeercompany.org
    - Peer support services play a unique role. Focus on lived experience, hope, early intervention, self advocacy, minimize stigma. Recovery

focused alternative when appropriate. Help navigate other services and promote other recovery based goals.
    - Help minimize recidivism, re-hospitalization, etc
        - Work closely with service providers, law enforcement, hospital workers, social workers, etc.
    - Limitation: Peer support does not provide therapy, diagnose individuals, or provide medical support. Can refer to those entities
- Multnomah County Behavioral Health:
    - Work with 102 residential programs, ranging from PSH to community support housing, and residential treatment.
    - Vast majority of programs, center between the range.
        - Offer medication management, meals, additional support as needed.
    - Limitations: Legal status does determine access to services
        - Aid and assist: often first to receive services, often at the Oregon State Hospital
        - Civil Commitment: secondary if they are at the Oregon State Hospital.
    - Core Values: Meet individuals where they are at. Interested in treatment and skills training.
        - A number of individuals may not be interested at this time, will serve any one.
    - Can call the MultCo crisis line to speak with the Mental Health Crisis Worker and they will walk through the process with the caller.
    - Choice Model Care Coordination program, make referrals and decide the best path to serve the individual in crisis.
- Multnomah County Behavioral Health (Gero Specialist):
    - Lots of training about aging populations and older adults with different behavioral health conditions.
    - Offer training around skill building
    - Laura will meet individual folks to determine what might be the best program suitable to their needs.
        - Ex: Someone who might have neuro-cognitive conditions and different behavioral conditions. Those intersectionalities require unique systems and programs.
    - Oregon is very under-resourced in behavioral and mental health support/systems.
        - This is due to the nature of the funding in our State

- What approaches have been most effective in working with folks with mental health and/or substance use conditions? What strategies are most helpful in working with pre-comtemplative/comtemplative folks?
    - So much transition and change, particularly for older adults, so many folks may be adherent to those changes. Find a connection to some supportive relationship. Ex: visit Hollywood Senior Center, Peer Company had an older adult peer support specialist. Super helpful in building those connections and understanding “what works for that individual.” Those connections are helpful to increase the reach of their community and envision a future that is different from their current status quo.
    - Working in residential services, enter clients live at such different points in their lives. This can include, exiting from the State Hospital where they have been on their medication, some households using substances and not on medications. All these residential programs are 24/7, can intervene and have a positive impact on the client’s life. This can include doing an activity together that the client enjoys. More than half of the clients in residential services are in the early stages of change. Engage more of ADLs, finding things they enjoy.
    - From a peer’s perspective, it doesn’t matter what stage of change someone is at. It’s about meeting them where they are at and building an authentic relationship. Build an opportunity to listen, honor the voice, and choice of the client. Just try to meet that person to build trust and rapport. At the end of the day, people’s circumstances change all the time. Building authentic and strong relationships, so when someone is ready to do something different they will come to that peer support specialist. Offering harm reduction strategies to help keep people safe, so they can engage in those choices in the future. The client creates their goal and the PSS helps navigate the system to meet their goals.
    - Meet someone where they are at. If the client is unable to come to the clinic, or make a call, the team will come to the client. The path is not linear. Working with an individual, anticipate that the path is not linear. The flexibility around that is meeting someone where they are at. Offer patience and pivot when things don’t go the way the provider or anyone anticipates. Talking about hope and support. Being authentic does take time, show up how you can. Call out your feelings to be able to move forward. Remember it’s not on the client. Be patient with the client. Have supervision to be able to work through additional feelings so that’s not on the client.

- Research shows that a person with a mental health condition is more likely to harm themselves or be a victim of violence. However, we know that some people may be harmful to themselves or others. How do we work with these individuals?
    - Behavioral health crisis, call the crisis line. Three prong approach: someone to call, somewhere to go (urgent walk in), someone to go to the person (mobile crisis team). Evaluate harm to self and harm to others. There is time in between before help can arrive. How does one evaluate harm to self and harm to others?
        - Always evaluate the safety of yourself first. Most intimidating is to ask the questions.
        - Example: Someone is saying, “I’m going to kill someone” or more vague “I’m going to do something harmful/bad”
            - If you are not confident in asking the follow up questions, call 911, call crisis line
            - Follow up question, **“Will you tell me more about that?” or “I heard you say that you were going to hurt someone”**
                - If you can get more detail to understand the situation. Ask more follow up questions: How would you go about doing?
                - If they don’t have a plan or don’t know. 99% of the time, the individual is not going to act on it.
                - However, they want someone to engage with them and have a conversation.
            - Trying to determine likelihood of follow up from the claim.
            - The more likely someone is saying they have a plan, or they continue to repeat that they are going to hurt someone, you will probably need back up. This is where you want to call emergency services.
            - Highlight for the individual they are not alone.
    - From a peer and street outreach perspective:
        - To maintain safety, you need to trust your gut and how you feel.
        - Recognize there are environmental challenges that individuals who are living on the street are experiencing.
        - Engaging with these individuals: be calm, non-confrontational body language, active listening, avoid judgmental language, don’t want to argue. Goal to de-escalate the situation
        - Goal to meet that person where they are at. Assessing the situation, and lots of experience with working in a lot of different situations. Ensure safety of self and others around.

        - When you start asking questions and having a conversation it will help de-escalate the situation.
        - Focus on immediate needs. What are things you can do in that moment?
        - Important to establish clear boundaries and when you need additional support, i.e. calling 911 in emergency
            - Balance safety and trauma informed approach to connect the individual to the support they need.
    - In residential settings, it differs from street outreach and other environments.
        - Working with folks for an extended period of time. Often have crisis plans for each individual. Increase of people from aid and assist, recognize the risk, however naming stigma. There is no considerable increase in violence at residential programs even though there are increases of people from the aid and assist populations.
        - Come from a place of non-judgmental. Work from a place of trust and rapport, utilize resources available.
        - Call Project Response, AMR.
    - I don't trust your gut. We have an obligation to assess biases before doing any type of outreach. If we don't evaluate those biases (particularly of race, mental illness symptoms), we will act in a way that harms, increases institutionalization, etc.
    - Need to really evaluate the difference between unsafe and uncomfortable.
        - Without evaluating that there is significant harm that will be done.
        - First question: Is this an unsafe situation? Or is this person making people uncomfortable? What is the harm that is happening?
        - If someone is not in the shared reality, do not argue about that.
        - If there is actual harm happening, clear the space. Removing the extra stimuli is easier than removing those who are engaged in an altercation.
        - Unity Hospital (5 sobering hold beds, folks can be held up to 48 hrs)--this should be a last resort.

- Questions:

- Are police going to show up from Project Respond?
    - Police have only shown up on less than 10% of calls. Crisis line asks questions: safety concerns, what is the person going through? Are

weapons present? (If there are weapons or harm, more likely law enforcement will arise)
    - Do you know how this person will react if law enforcement shows up?
    - Trying not to bring police because often that escalates the situation, unless there is imminent harm.
- Assertive Community Treatment (ACT) programs and eligibility
    - Highest level of community outreach and behavioral support.
    - Live on your own but get daily visits to help with different tasks.
    - Very limited, CHOICE eligible, much more likely to connect with the ACT team.
    - Independent and meaningful life on their own instead of being in a residential space.
- Hear about 5 Triage groups available, review prioritized populations for licensed residential treatment programs
    - 1: State Hospital under Aid and Assist or PSRB order
    - 2: State Hospital under civil commitment
    - 3: Individual who are most likely incarcerated and can access the State Hospital (likely under aid and assist, divert them from the State hospital)
    - 4: individuals in licensed residential programs, and have any of the above mentioned legal orders. Guardianship, civil commitment, etc.
    - 5: Everyone else, unlicensed residential, community based structured housing, PSH, unhoused folks, etc.
- Legal frameworks, what are the rights for someone civil commitment, director's hold, etc.
    - Civil rights: evaluate an individual in imminent danger (harming themselves or others), the bar is very high.
    - Have the right to deny treatment
    - Seeing intent, the person has means, and there is a date. If there is no way to intervene, I need to file a director's hold.
    - Requirements, have to have a masters degree and have training to file a director's hold. Training provided by Multnomah County.
    - Only a transportation hold, intermixed with the hospital being able to do the same thing
    - Have to have AMR take them to the hospital and someone at the hospital evaluates them (24-72 hr holds)
        - Go to court to defend them.
        - Taking someone's civil rights away.
    - This is not trauma informed because you are taking someone's civil rights away. Often involve emergency services such as ambulance and law enforcement.