Working with People with Behavioral Health Issues
RRH

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Introductions

- Housing Innovations
  - Liz Isaacs
  - Andrea White
- Goals for the Session
- Housekeeping
  - PLEASE TURN YOUR CAMERAS ON AS MUCH AS YOU CAN
  - Please put your name as you would like to be addressed as your screen name
  - Please put your role/title and program into the chat box
  - We will post materials on the BOS website and attach them in the chat
  - We love interaction – raise your hand, indicate in chat box that you would like to comment or just unmute and talk!
  - To begin, think about what your favorite morning beverage is. Feel free to put it in the chat but most importantly just think about drinking it

Agenda

- Introduction
- Behavioral Health Condition
- Coordinating with Community Partners
- Crisis Prevention and Intervention
- Closing

Behavioral Health Issues

Behavioral health issue bring their own set of challenges and resources. These challenges are often surfaced in shelters and housing because of the structure and expectations. Behavioral Health diagnosis must include how the symptoms interfere with functioning and this is often clear when people use homeless services.

There are a set of resources available to people with Behavioral Health diagnosis in crisis. Here we will focus on the worker in Rapid Re-Housing in helping the person with Behavioral Health Symptoms function well in the programs, connect to needed resources and avoid crisis.

Behavioral Health Disorders

Psychosis is a break with reality. Could be due to schizophrenia, mood disorder or even certain drug interactions During a period of psychosis, a person's thoughts and perceptions are disturbed, and the individual may have difficulty understanding what is real and what is not. (NIMH) Risk of Crisis occurs when persons perception of reality is threatened, perceived and a threat or command hallucinations

Affective disorders are also known as mood disorders. These can include depressive disorders, bi-polar disorder and mania. In the extreme mood disorders can include psychotic features including delusions. Mood disorders can be long term but also situational – and seasonal. We will need to consult with a clinician and describe the symptoms well. The treatments and duration of treatments are different.

The risk of crisis comes through agitated depression, suicidality and through mania which often includes impaired judgment in all areas of a person's life and sometimes substance use to maintain or accelerate the high feeling, leading to all sorts of trouble.

Borderline Personality Disorder

Borderline personality disorder is a mental illness that severely impacts a person's ability to regulate their emotions. This loss of emotional control can increase impulsivity, affect how a person feels about themselves, and negatively impact their relationships with others. (NIMH)

What you may see is splitting of staff and seeing people as all good or all bad and changing that perception often

The person may feel empty and use chaos around them to feel whole

Impulsivity which often exacerbates the self harm or suicidal ideation. People with this collection of symptoms have significantly higher rates of self harm and suicidality than the general population.

This all lends itself to crisis and it is difficult because it seems like it is always something.

Focus on Functioning

People with active symptoms of Mental Illness can stay housed and live full lives in the community, in others the symptoms are a barrier to what they want or to meeting obligations.

We want to help everyone we serve to meet tenancy obligations, to increase their income and to meet their long-term goals of life in the community.

This means teaching tenancy skills, working to help everyone increase income, monitoring tenancy with landlords and offing access to high quality services and supports that are consistent with each person's goal.

Make Critical Connections

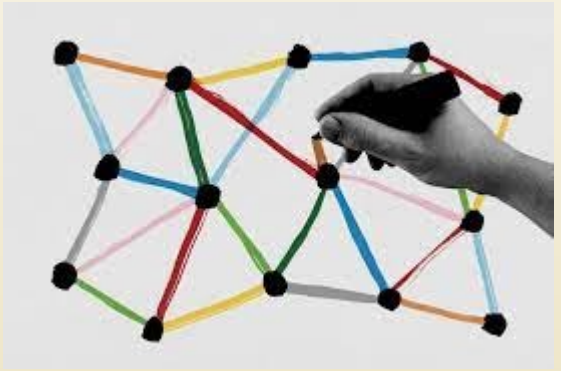
Think about what will help people reach their goals

Consider connecting to peer support

CMHCs may have peer support services available

Example: https://medicine.yale.edu/psychiatry/care/cmhc/clinics/peer/

https://namict.org/resources/peer-based-support-lines/



Consider Club House Models

How does the Clubhouse Model differ from other mental health treatment models?

“In contrast to traditional day-treatment and other day program models, clubhouse participants are called "members" (as opposed to "patients" or "clients") and restorative activities focus on their strengths and abilities, not their illness.” Recovery based, offers opportunities for employment, socializations, leadership development

Establish Eligibility

PSH serve people who are long term homeless and have MH issues

- Verification of Disability Required though ICD diagnosis is not
- Consider Using Modified Mini Screen to demonstrate MI
  - www.ctbos.org/wp-content/uploads/2022/02/Modified-Mini-Screen.pdf
  - www.ctbos.org/wp-content/uploads/2022/02/Modified-Mini-Screen-PATHv2.pdf

- MH Waiver programs
- Connecticut's Mental Health Waiver is a Medicaid program that provides home and community-based services for individuals with serious mental illness, emphasizing recovery-oriented care and compensating eligible family caregivers through a self-directed option. We help families enroll in caregiver pay programs
- https://portal.ct.gov/DMHAS/Programs-and-Services/Mental-Health-Waiver/Mental-Health-Waiver

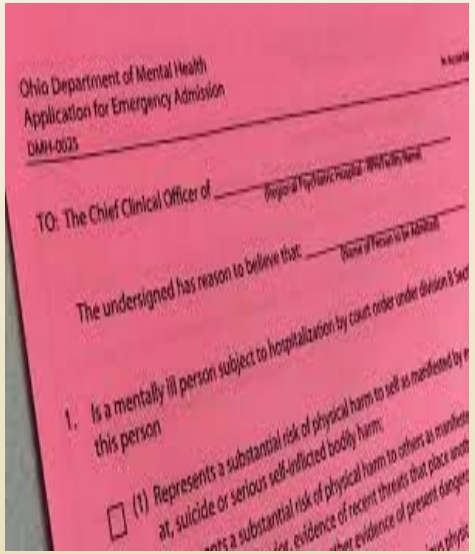
Behavioral Health Crisis

De-escalate conflict and crisis

- Example: Psychosis is a break with reality. During a period of psychosis, a person's thoughts and perceptions are disturbed, and the individual may have difficulty understanding what is real and what is not. (NIMH)
- People generally do not respond well to being confronted with the "reality of the situation" but do respond to engagement over feelings.
  - I can see this is scary. It is hard to make a plan when you are so worried. What can we do to help you feel safer?
  - Ask what has helped in the past, how can we help them feel safer. For instance, sometimes when people believe people are breaking into their unit and they are frightened, sometimes offering extra locks will be helpful.
- Structure: Be clear and consistent about what is not acceptable: Screaming at the front desk, knocking on neighbors' doors in the middle of the night, waking up everyone in the dorm and why this is a problem

Behavioral Health Crises - 2

- Prevention: Offer treatment resources consistently while realizing it is not a requirement unless the person is at imminent risk.
  - Look for things that are bothering them that might give them a connection to services: I notice you are not sleeping at night can we help you connect to someone who can help with that,
  - I notice you are limping can we help you with that?
  - Look for opportunities to connect the resources to each persons long term goals: having a history with a MH provider may help with the SSI application.
  - As people begin to have positive experience with helping professionals, they are more likely to accept treatment, which is likely needed
- Know when to call for help: Discuss at team meetings, put in policies and procedures, consult with clinicians



Risk to Self or Others

- The first choice is always voluntary hospitalization but if a person is a risk to themselves or others, we can compel evaluation and in some cases treatment
- Examples may be overdose: everyone seen by EMS if this occurs, suicidal or homicidal ideation must be seen
- If you are at this point and you can not get the person to see a treatment provider.
- Connect to a clinician who can do a suicidality screen
- https://www.columbiapsychiatry.org/news/simple-set-6-questions-screen-suicide
- There are avenues to pursue involuntary evaluation:
- CONN. GEN. STAT. ANN. § 17a-502(a). Any person who a physician concludes has psychiatric disabilities and is dangerous to himself or others or gravely disabled, and is in need of immediate care and treatment in a hospital for psychiatric disabilities, may be confined in such a hospital, either public or private, under an emergency certificate as hereinafter provided for not more than fifteen days without order of any court, unless a written application for commitment of such person has been filed in a probate court prior to the expiration of the fifteen days, in which event such commitment is continued under the emergency certificate for an additional fifteen days or until the completion of probate proceedings, whichever occurs first.

Housing-Related Crisis

- Most Housing related crisis take a while to build
- There is a process to enforce the lease and address concerns that is set by tenant law
- Prevention: We want to be sure we educate all tenants on the lease and the process to address concerns and receive lease violations with opportunities to resolve the issues
- Assisting tenants to manage the structure of tenancy is a key part of the work and is discussed in more detail in the individual program sessions
- The more common instances of crisis here are someone feeling like they are not being treated fairly or feel they need something they are not getting. We again focus on the expectations of behavior and problem solve with people how to get needs met.
- If someone engages in something egregious such as assaulting other residents or staff or use of a weapon, need clear procedures on engaging the police.

Housing Crisis continued

- Escalating crisis when tenants and residents unable or unwilling to use the process to address lease or rules violations.
- Build trust in the process often achieved through consistency, focused case management that helps with the process and peer support to see that others have used the process and avoided eviction.
- De-escalation is the continuation of these techniques with getting people to a quiet space, giving them things in writing or may even include enlisting an advocate
- If the inability to address the issue is complicated by a serious substance abuse disorder, medical condition or a mental health condition offer treatment in the context of the issue. We also have to look at ways to compel treatment in high-risk situations if the situation reaches the level of high risk.
  - Note that treatment does not ensure compliance the goal is for the person to be sufficiently clear to decide if they want to use the process.
  - If the risk is imminent and it can be clinically documented needs treatment to decrease the risk treatment could be compelled
  - If the risk is not high such as not paying rent and using it for substance but puts housing in jeopardy, we would look for ways to compel compliance such as representative payee once other voluntary means have been tried.

Breakout Discussions

Think of a high risk situation that has happened in your program, this could be in the area of mental health

Talk about what lead up to the crisis and what you tried

Talk about what resources you used

Was there any other resources or strategies that you would think about using now?

Are there concerns about accessing these resources or strategies?

Coordinating with Community Partners

Crisis Prevention includes meeting basic needs and engagement

Look for a relationship with the last services they engaged with get information about what has been helpful, what education was provided, can they transfer some of the trust and engagement

Meet basic needs: do you need assistance from other agencies to increase income and access housing?

Meeting basic needs is a protective factor

What about issues with mental or physical health what do you need in order to help people stabilize and prevent crisis, what do you need to address crisis when it occurs?

What about housing what relationships do you need in order to prevent crisis, what about when there is a crisis where do you need assistance?

Working with Clinical Services

Clinical Consultation: using services or internal program resources to case conference and plan regarding people that may be at risk has been helpful to avoid a crisis situation

Some programs have clinical staff available from a behavioral health clinic or internally to case conference and plan around behavioral health issues

Connecticut has mobile crisis services that accompany the police on mental health calls and the Crisis Team provides information & referrals, the suicide prevention hotline, in-person assessments, crisis services, and wellness checks.

Ct Mobile Crisis Services

Mental health crisis intervention services are provided by teams of mental health workers (psychiatrists, RN's, MSW's, psychologists, psychiatric technicians) who intervene in situations where an individual's mental or emotional condition results in behavior which constitutes an imminent danger to him or herself or to another. Mobile crisis teams visit people in their homes or community sites, and others meet clients in clinics or hospital emergency rooms. Psychiatric emergency rooms and mental health facilities can provide crisis services to people in crisis who can travel or get help with transportation to a facility.

There are mobile crisis teams for Children and Youth (under 18) and for Adults

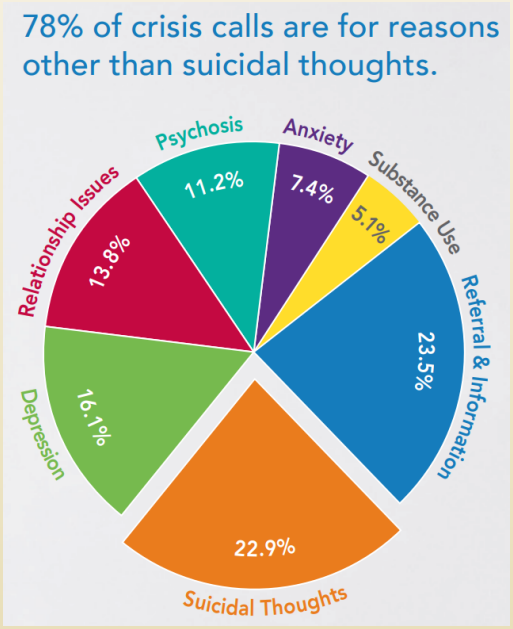
https://uwc.211ct.org/mental-health-crisis-intervention-services-connecticut/

There are BH Urgent Care Services for families with children under 18

https://portal.ct.gov/DCF/Behavioral-Health-Partnership/Home/Urgent-Crisis-Centers-for-Children

There are not BH Urgent Care for Adults, but Mobile Crisis has made themselves available to do BH evaluations for Adults in programs without clinical staff

Working with Mobile Crisis



As with any program you want to meet with them and ensure that the issues
that are coming up in your program are eligible for their services

What can you expect in terms of the initial visit and follow up

What is the time frame once the referral is done?

- This is many cases will decide how you use this service

When is it better to call the police, is it possible to request at CIT officer (trained in working with people with mental health conditions)

How will the information be shared with the program?

How will the follow up with the hospital be handled

Graphic from Frontline Services

What about working with the Police/ EMS?

- When calling the police or EMS in a Crisis, look at your policies and procedures, be prepared to gather the info you will need. Note the call and if behavioral health ask for a trained CIT officer
- Ask staff to note the badge numbers of police and EMS staff
- You want to give all information that you have available, in a crisis situation you can usually share information such as medications

  Describe why you called in behavioral terms

Police and EMS

- It is often a good idea for the program to coordinate with the hospital directly and to visit the person in the crisis program
- Follow up with the hospital or crisis center and coordinate discharge
  - This is a good time to coordinate needed services such as home care or coordination with follow up services
- Check your agency rules about filing an incident report
- Be aware of the racial dynamics with the police this can escalate the crisis. People may have had experience with hospitalization and the police before. Be a presence to help person feel safe and to intervene if necessary

Case Discussions

Discussion Prompts:

- What is your assessment of the situation?
- What is your plan?
- What would you try first?
- What is your back up plan?
- Where would you get assistance?
- How would you follow up?
- What might have been helpful here?

Crisis Intervention Cases

A --- A participant had been admitted to the hospital for evaluation. She had been making threats, was agitated and was not responding to the staff. There was significant risk to safety. Now she is back and demanding to get back in her unit. She left the hospital against advice and is seen as AWOL. She is screaming and beating on the front desk, trying to enter the housing. She is screaming they were trying to kill her at the hospital, and she will get the person who sent her there.

B --- A participant has a history of depression. He was on and off medication for years. He also has a history of suicide attempts. The last one was very serious, and he was in intensive care. He has stopped going to see his psychiatrist and is not responding to outreach from his clinician. He has been in his apartment for a week. Last might he came out and told his neighbor that he was sick of this struggle, and he just wanted to tell him goodbye. He also left a message on your voicemail after hours. The neighbor reported he looked better than before and seemed almost happy.

Crisis Intervention Cases - 2

C --- A woman living in your building had been involved with a partner that beat her. They also regularly used together and sometimes she would engage in sex work to get money to get both of them high. She was able to get out when he was arrested on another charge. She is doing well in housing though is ambivalent about their relationship. She missed him but she is also scared of him. She worked on establishing her safe place in RRH and got an order of protection. He is now out of jail and came to stay with her. One the second day, he beat her badly. The neighbor called for help.

D --- A participant is known for having " a short fuse" he calls people names and often threatens them. He yells and screams and has been known to follow people down the hallway threatening as he goes. He has received numerous violations and is talking with his mental health worker about this behavior. His neighbor had had it. He heard him in the hallway and came out of his unit with a baseball bat. The neighbor had not been violent before but looked like he would be now.

Closing

It takes a village to accomplish the goals of the homeless programs

Crisis is often a challenge to these goals

Crisis services include many levels and require the connection to specialty services as well as agency and program support

Staff has to feel safe and get team support, expectations have to support the goals and the structure of case management

These elements are all part of the plan

Wrap up

Many thanks!

See you next week.

PLEASE TURN ON YOUR CAMERAS TO SAY GOOD-BYE