Clinical Challenges in Supportive Housing

National Health Care for the Homeless Fall Symposium

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Learning Objectives

- Gain an overview of Baltimore and Louisville projects
- Review major theoretical frameworks that undergird permanent supportive housing (PSH) services
- Engage in candid reflection of common challenges in PSH and interventions to address them
- Develop strategies to promote staff self-care

Who is HCH-Baltimore?

- A multi-site homeless service provider with:
  - Locations in downtown Baltimore, West Baltimore, an administrative office in downtown Baltimore, Baltimore County, Harford County, and a dental clinic at Our Daily Bread in downtown Baltimore
  - A mobile clinic and convalescent care program co-located in the City's largest shelter
  - A staff of over 220 staff members, 80% of whom are direct service providers
  - Services include medical, pediatrics, behavioral health, psychiatry, outreach, case management, benefit assistance, advocacy and supportive housing

Guiding Assumptions

- Recovery is possible for everyone.
- Nearly every person experiencing homelessness has experienced trauma.
- Everyone is doing the best that s/he can at the moment.
- Everyone is ready for housing.

Click icon to add picture

Family Health Centers – Phoenix

- Louisville, Kentucky

University of Louisville
Kent School of Social Work

UNIVERSITY OF LOUISVILLE

Realities in PSH

- Providing supports to maintain housing is rewarding, yet hard work.
- Often, this endeavor takes a team of dedicated and highly qualified professionals.
- Myriad client presentations create both opportunities and challenges to housing stability.
- Service delivery must be client-centered and plentiful.

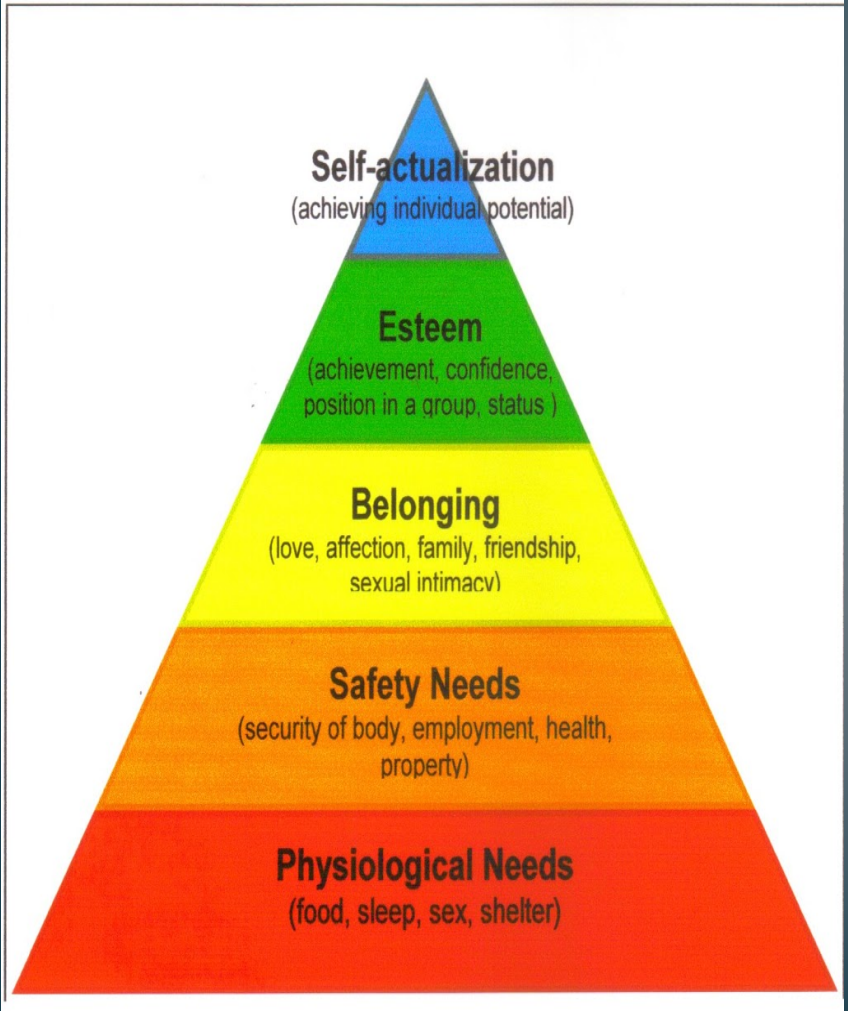
Theoretical Frameworks

- Trauma-Informed Care
  - Trauma is an unavoidable component of the homeless experience
  - Trauma serves as both an antecedent of homelessness and as a direct result of living on the streets
  - Considered a best practice that recognizes the impact of violence on an individual's wellbeing and development, and that helps to heal the social and psychological wounds violence leaves behind
  - Move away from “What's wrong with you?” to “What's happened to you?”

- Housing First
  - Housing First is an approach to quickly and successful connect individual and families with permanent housing without preconditions and barriers to entry
  - Supportive services are offered to promote housing stability and prevent returns to homelessness
  - Began as a oppositional response to the “housing readiness” model
  - Evolved into a distinct evidence-based approach for delivering PSH to homeless populations

- Housing First
  - Providing supports to maintain housing is rewarding, yet hard work
  - Often, this endeavor takes a team of dedicated and highly qualified professionals
  - Services must be plentiful and flexible enough to meet the comprehensive needs of vulnerable populations
  - Applying Housing First principles in PSH is not an inexpensive endeavor and takes time to demonstrate long-term financial benefits

Housing First

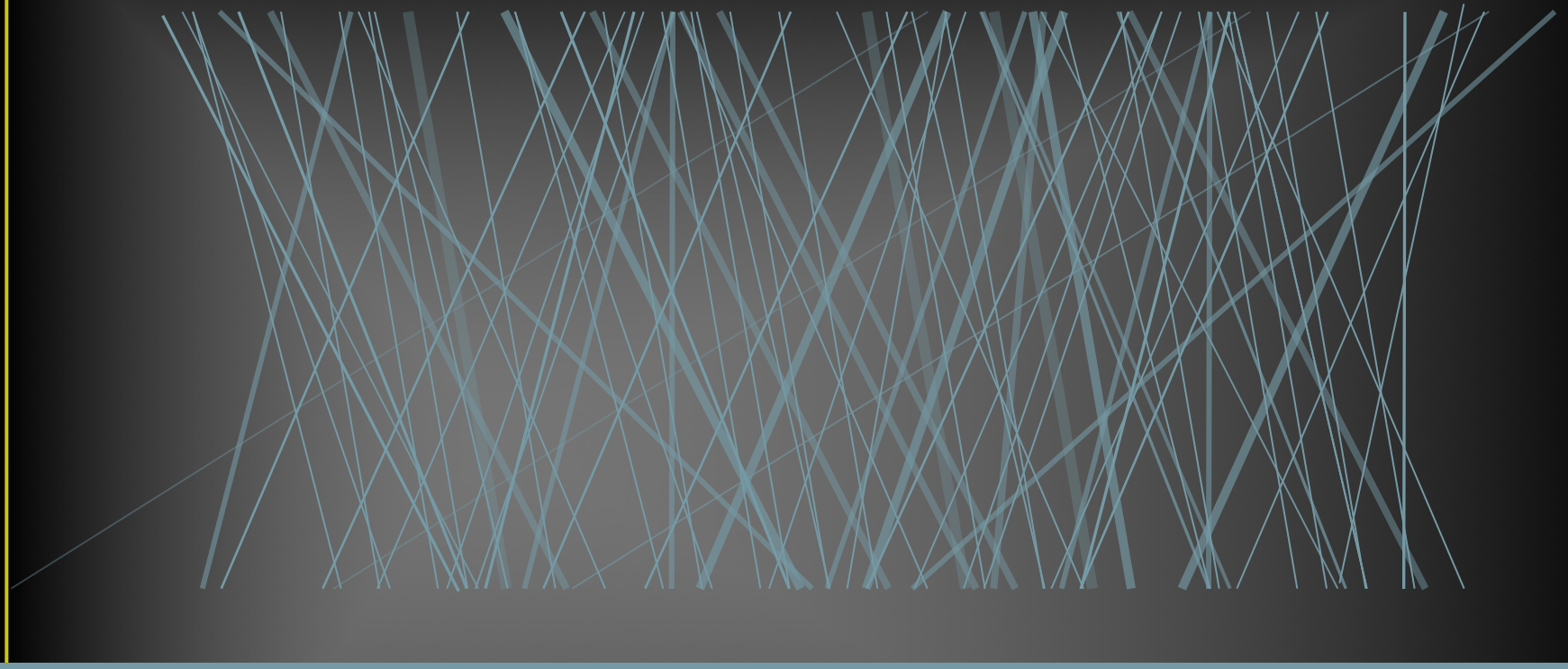


- The approach is grounded in Maslow's Hierarchy of Needs
  - Basic needs must be met before people can attend to less critical areas.

- Housing First
  - Services are informed by harm reduction and motivational interviewing
  - Project-level policies and procedures are developed to prevent lease violations and evictions
    - Provision of representative payee services
    - Evaluating when Reasonable Accommodations are appropriate

Therapeutic Challenges in PSH

- Housing guilt
- Loss of community
- Tenant-Landlord negotiations
  - When you're a harm reductionist, but the landlord isn't
  - When the tenant refuses to pay the rent
- Balancing individual risk vs. community harm
- Severe MH symptoms



Putting Harm Reduction in Proper Context

- Clinical Challenge #1

Some things Harm Reduction is NOT…

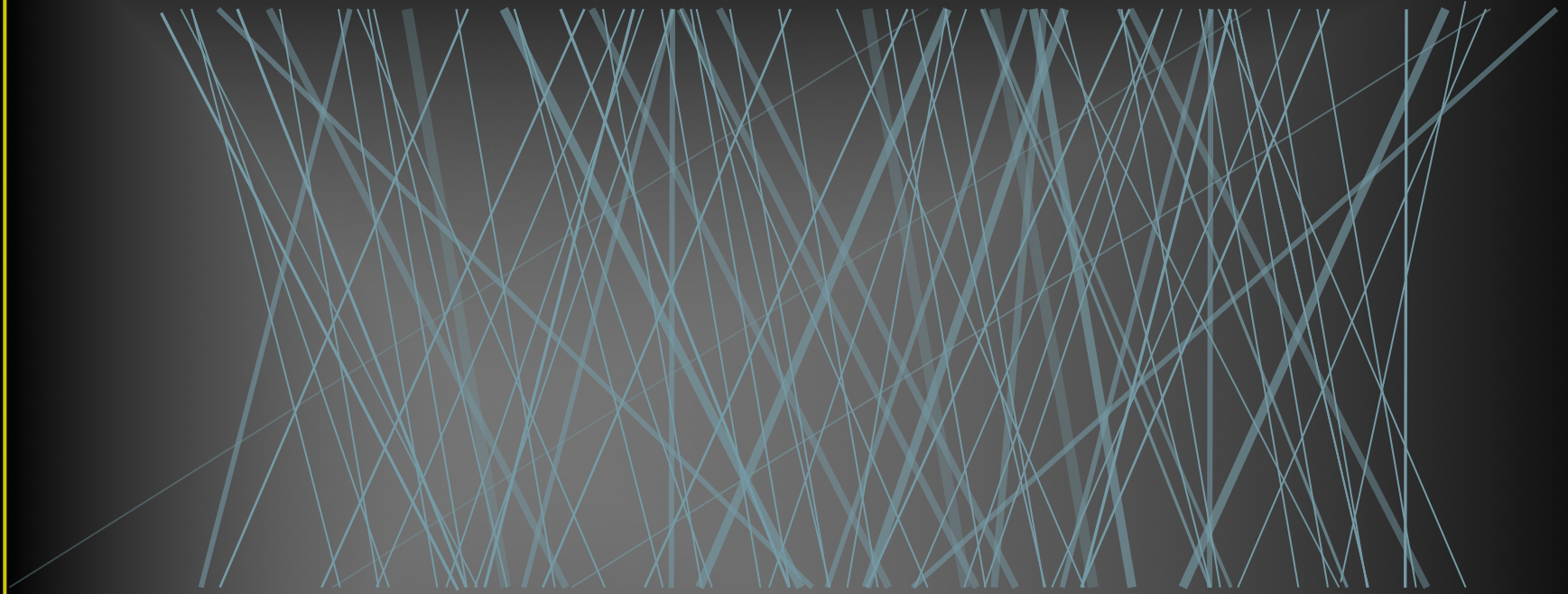
- Harm Reduction is NOT a policy.
- Harm Reduction is NOT pre-treatment.
- Instead, Harm Reduction is treatment.

SAMHSA's definition of RECOVERY

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Many Ways Up the Mountain

- If you are working toward recovery, you are doing treatment.
- If you are working toward getting your life back, you are doing treatment.
- You can have substance use in your life and still be in recovery.
- You can have substance use in your life and still get your life back.



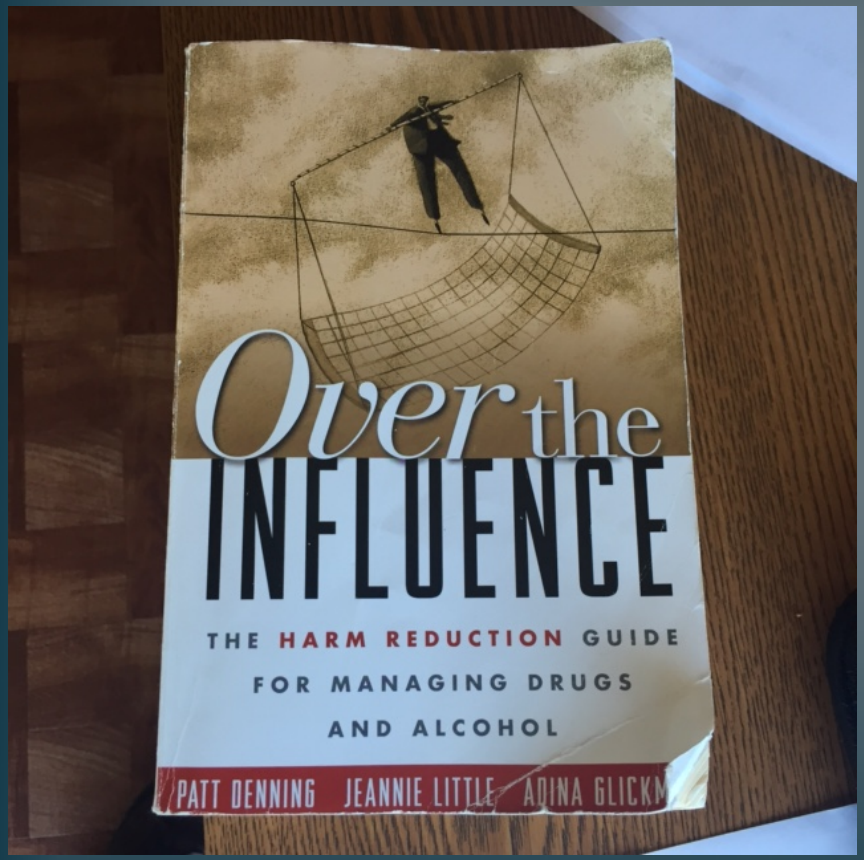
If Harm Reduction is treatment, it needs to be on the menu.

- Clinical Challenge #2

Treatment Today = Limited Menu

- 93% of treatment programs – inpatient, residential, or outpatient – are based on the 12-Step philosophy of Alcoholics Anonymous.

Where are you getting this information?



- *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol.* (Denning, Little & Glickman, 2004).

Is it working?

- Doing something 93% of time is fine…if it is working.
- When abstinence-based treatment programs work, they work.
- But how often do they work? What are their success rates?

Is it working?

- "Outcomes of drug treatment have always been measured in terms of abstinence rates. They are not impressive. They usually hover around 25%. The only scientific survey of drug treatment in the United States, conducted by the federal Substance Abuse and Mental Health Services Administration and completed in 1998, found abstinence rates of 21% several years after the completion of treatment."

- "It is much more difficult to find out how many people *never complete* the treatment programs they enter, but it is the majority."

Why isn't it working?

- Why doesn't abstinence-based treatment produce higher success rates?

NOT because those treatment programs are poorly designed.

NOT because those programs are staffed by poorly trained or ineffective providers.

Why isn't it working?

- Because most people don't want abstinence.

Another problem with our limited menu

ONE
ITEM
on the
MENU

We need to listen to our customers better.

- The for-profit world would never continually do something that only works 25% of the time.
- The for-profit world would never dig their heels in and ignore what their customers actually want.
- The not-for-profit world has to improve. Innovation is okay. We can do better than being unsuccessful 75% of the time.

Why do we continue to do the same thing?

- Are we afraid?

- Defining treatment success as abstinence-only is incredibly powerful (history, funding, dominant market share).

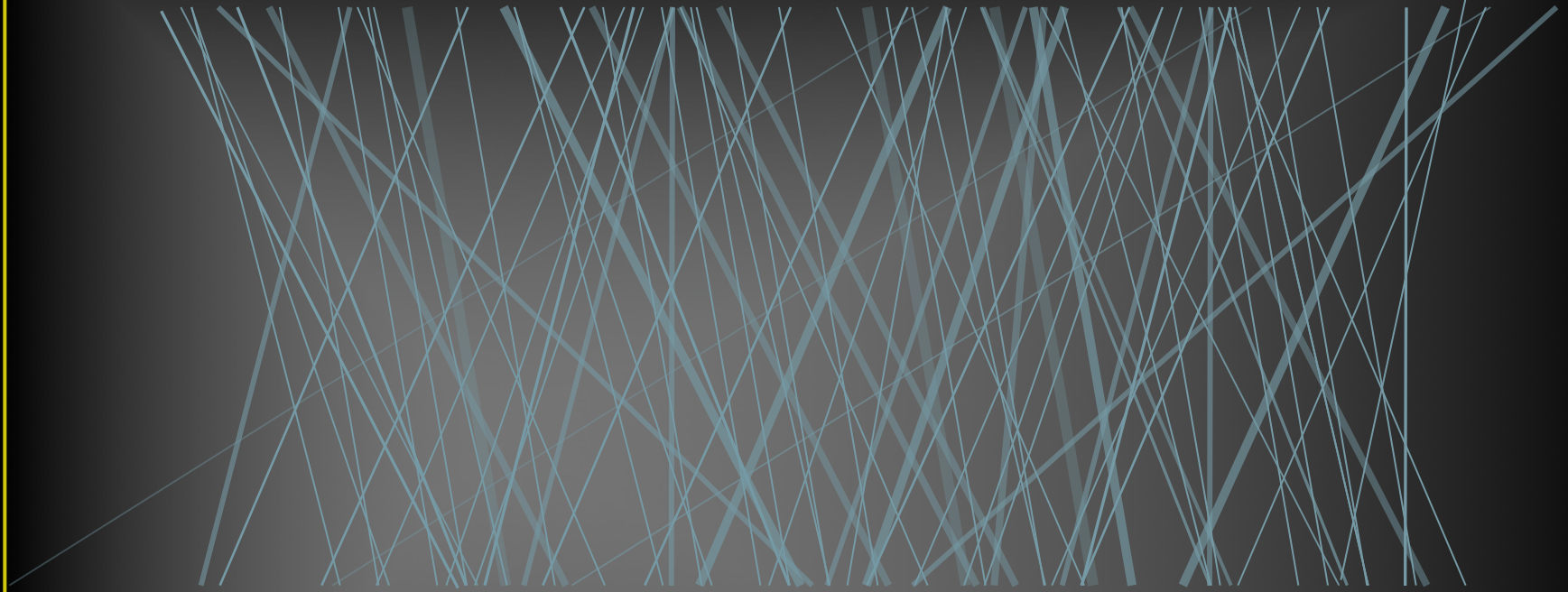
- When it works, it works.

Fine, let's put it on the menu. Now what?

- Individual and group harm reduction practice.
- Individual = substance use management plan (treatment plan).
- SUM plan based on 3 principles:
  - Being honest with yourself about your drug use and the impact of drugs in your life
  - Being willing to make some changes
  - Learning the skills to help you make concrete, beneficial changes in your alcohol or other drug use

Harm Reduction Group

- Every Thursday at 10:30
- Message different than abstinence-only groups like AA or NA
- Many clients attend AA or NA because they want to make *some* changes… but don't want to stop using completely



Re-thinking Use of Stages of Change

- Clinical Challenge #3

Stages of Changes (Prochaska & DiClemente)

- 1. Pre-contemplation
- 2. Contemplation
- 3. Preparation
- 4. Action
- 5. Maintenance
- 6. Relapse (optional)

Motto of Harm Reduction

Any positive change

Re-thinking stages of change

- Use Motivational Interviewing to get people interested in change.
- Problem = "change" defined only as abstinence.
- Problem = "action" defined only as action toward abstinence.
- What if goal is not abstinence?

Re-thinking stages of change / Relapse

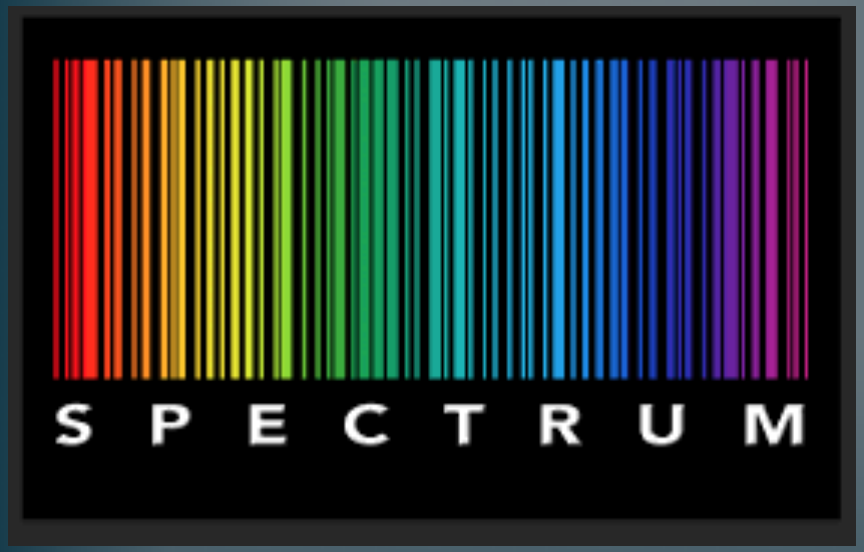
- Re-thinking “relapse” can be extraordinarily powerful with our clients.

- In the abstinence-only world, relapse carries a great deal of SHAME (sense of failure, negative self-talk, added to existing shame, debilitating).

- In the harm reduction world, substance use is called substance use. Term relapse not used. Powerful experiences watching clients be gentler with themselves, practicing new self-talk.

What can we do today? Everything is action.

Harm Reduction is a spectrum of strategies from…

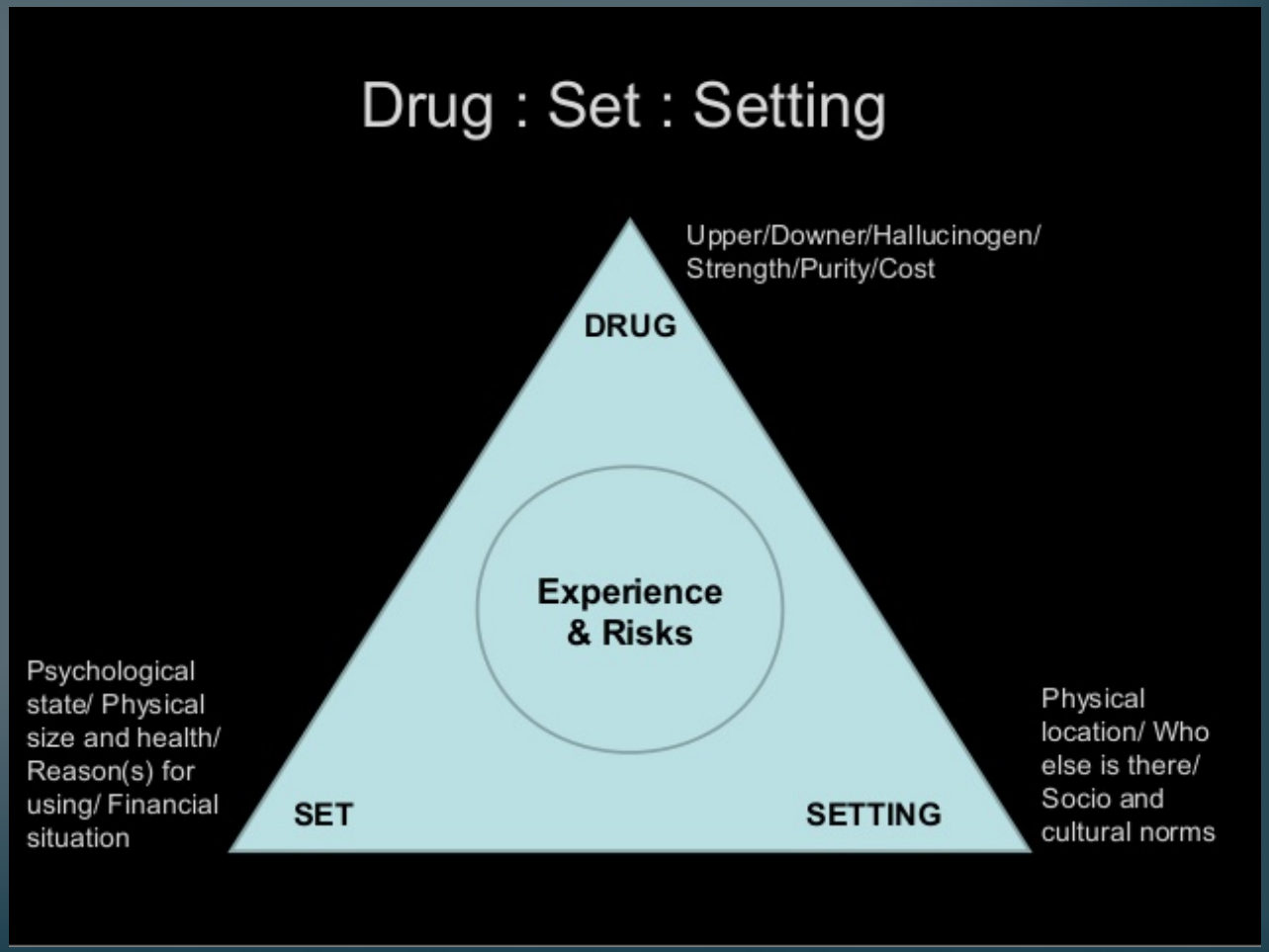


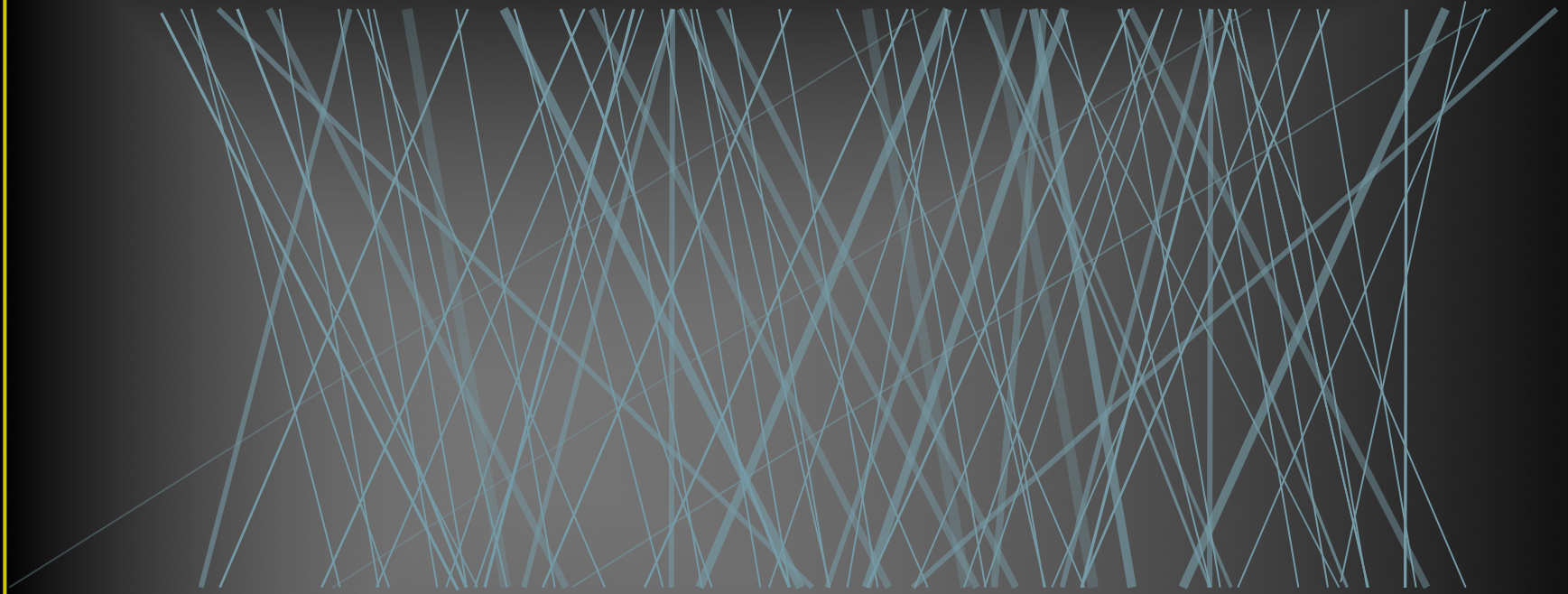
Safer use

Managed use

Abstinence

Everything is action.



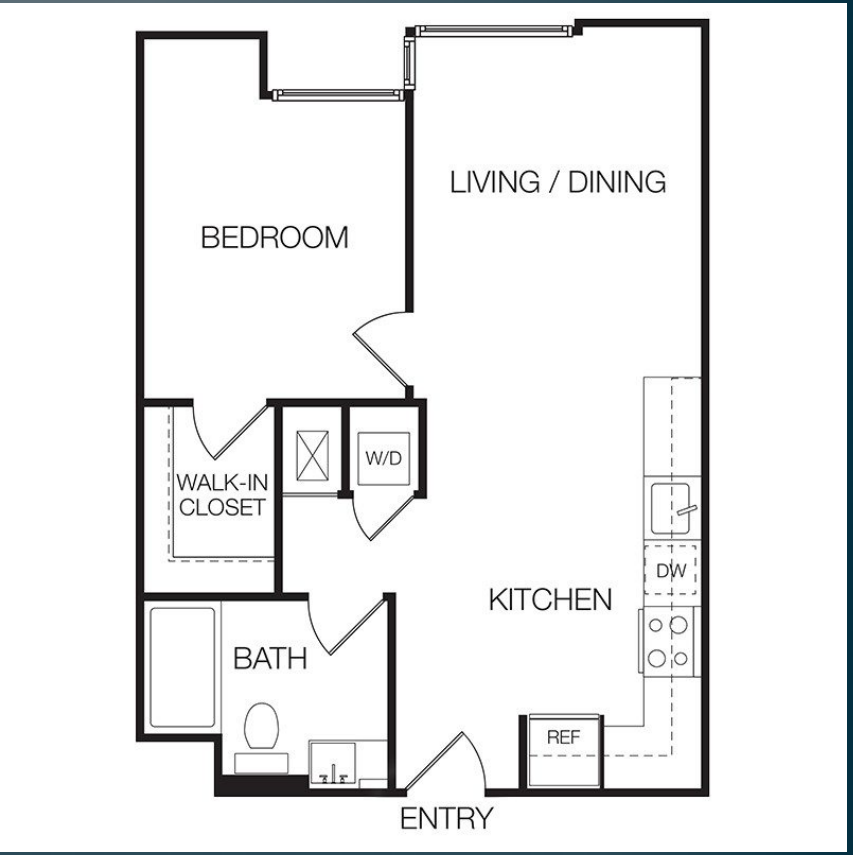


We need a richer menu of housing options too

- Clinical Challenge #4

Again, only one item on the menu.

ONE ITEM *on the* MENU



You want housing? Live by yourself.

- We know human beings are social creatures.
- We know people get better when they get connected to other people (at least to some degree).
- Many of our clients lived with other people when they were living on the streets.

Consequences of limited housing menu.

- What happens when we force our clients to live by themselves in a 1-bedroom apartment?

Maybe they get better because housing is health care.

Maybe they struggle with social isolation.

Maybe they struggle being connected with other people (what LLs call “too much traffic”).

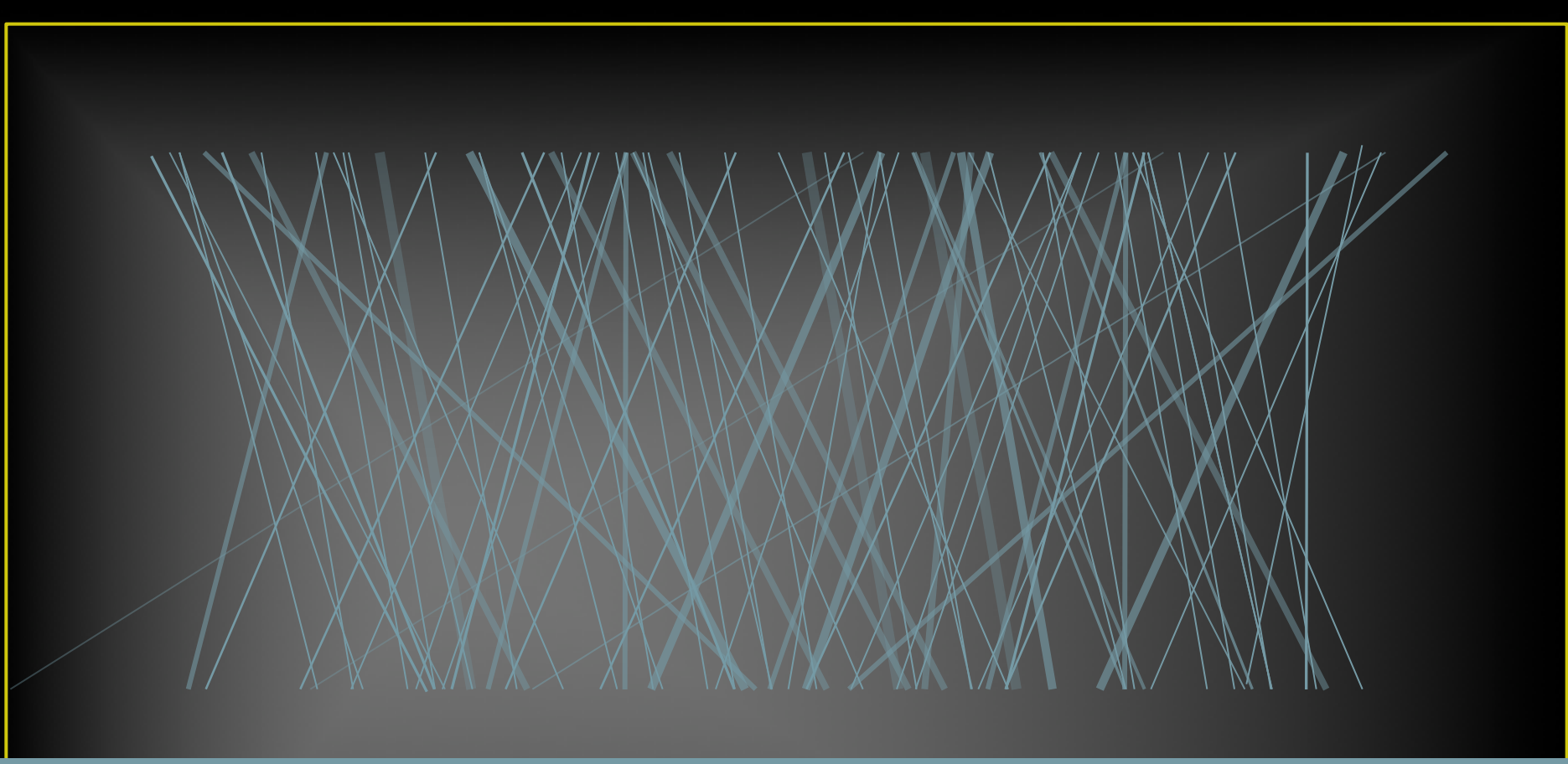
Growing momentum for shared housing

- Conversation gaining momentum nationally (particularly in projects working to end youth homelessness).
- Both CoC and ESG programs can be used to support project participants who want to live in shared housing.
- Instead of making a LL enforce 4 separate leases in a 4-bedroom house, programs can use a master lease.
- Housing provider can negotiate 4 separate occupancy agreements with the 4 separate clients.
- Housing program can take lead on finding new tenants, ensuring that all 4 bedrooms are generally always filled.

Shared Housing Learning Clinic

- Offered by OrgCode
- November 27 and 28 in Phoenix, Arizona

- Learning clinic will "provide an understanding around promising practices for the development and implementation of a shared housing program. The focus will include strategies for exploring the option of shared housing, engagement in services, and long-term stabilization within this housing model. Additionally, we will explore landlord recruitment, matching, subsidies, and appropriate staffing."



Finding and Keeping Talented Clinicians

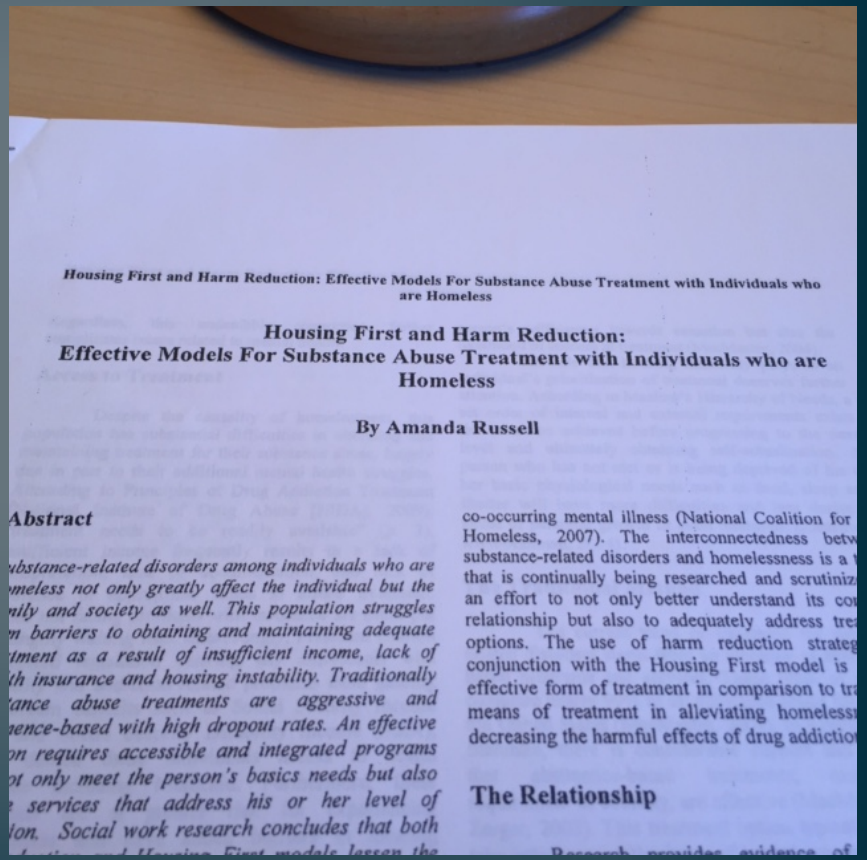
- Clinical Challenge #5

FHC Phoenix: Building the Team

- Values-Based Hiring
- Values-Based Evaluation

Values-Based Hiring

- Applicants for housing team positions are given an article on Housing First and Harm Reduction.
- Applicants are evaluated not only on education, work history and references… but also for *values* (compatibility with our work and our team).



Housing First and Harm Reduction: Effective Models For Substance Abuse Treatment with Individuals who are Homeless

Housing First and Harm Reduction:
Effective Models For Substance Abuse Treatment with Individuals who are Homeless

By Amanda Russell

Abstract

ubstance-related disorders among individuals who are meless not only greatly affect the individual but the nily and society as well. This population struggles n barriers to obtaining and maintaining adequate tment as a result of insufficient income, lack of h insurance and housing instability. Traditionally tance abuse treatments are aggressive and ence-based with high dropout rates. An effective on requires accessible and integrated programs ot only meet the person's basics needs but also services that address his or her level of lon. Social work research concludes that both

co-occurring mental illness (National Coalition for Homeless, 2007). The interconnectedness betw substance-related disorders and homelessness is a that is continually being researched and scrutiniz an effort to not only better understand its co relationship but also to adequately address tre options. The use of harm reduction strateg conjunction with the Housing First model is effective form of treatment in comparison to tra means of treatment in alleviating homeless decreasing the harmful effects of drug addictio

The Relationship

How to keep talented clinicians?

- By finding people who are fed by the work we do.

Meaningful supervision

- Regularly scheduled supervision always begins with a conversation around the clinician as a person ("the work part of you").
- Conversation always includes:
  - Job satisfaction
  - Do you feel proud about the work you are doing?
  - How do you respond when someone asks you "So what do you do for a living?" at a dinner party?
  - How do you think the team is doing?

How to keep talented clinicians?

- Keep self-care front of mind in supervision. Always.

How to respond to after hours care?

- Some Housing First fidelity tests demand after hours care (for example: 2nd shift coverage from 4pm – midnight or 24/7 on-call coverage).

- We want to be the best program we can be. We considered both options.

- 24/7 resources for crisis and emergency needs already exist in our community.

How to respond to after hours care?

- We chose to let existing community resources meet our clients' after hours crisis and emergency needs.
- We have no after hours coverage from our clinicians at all.
- Clinicians are encouraged to turn their phones off when they go home. We are never on call.

How to respond to after hours care?

- Balance

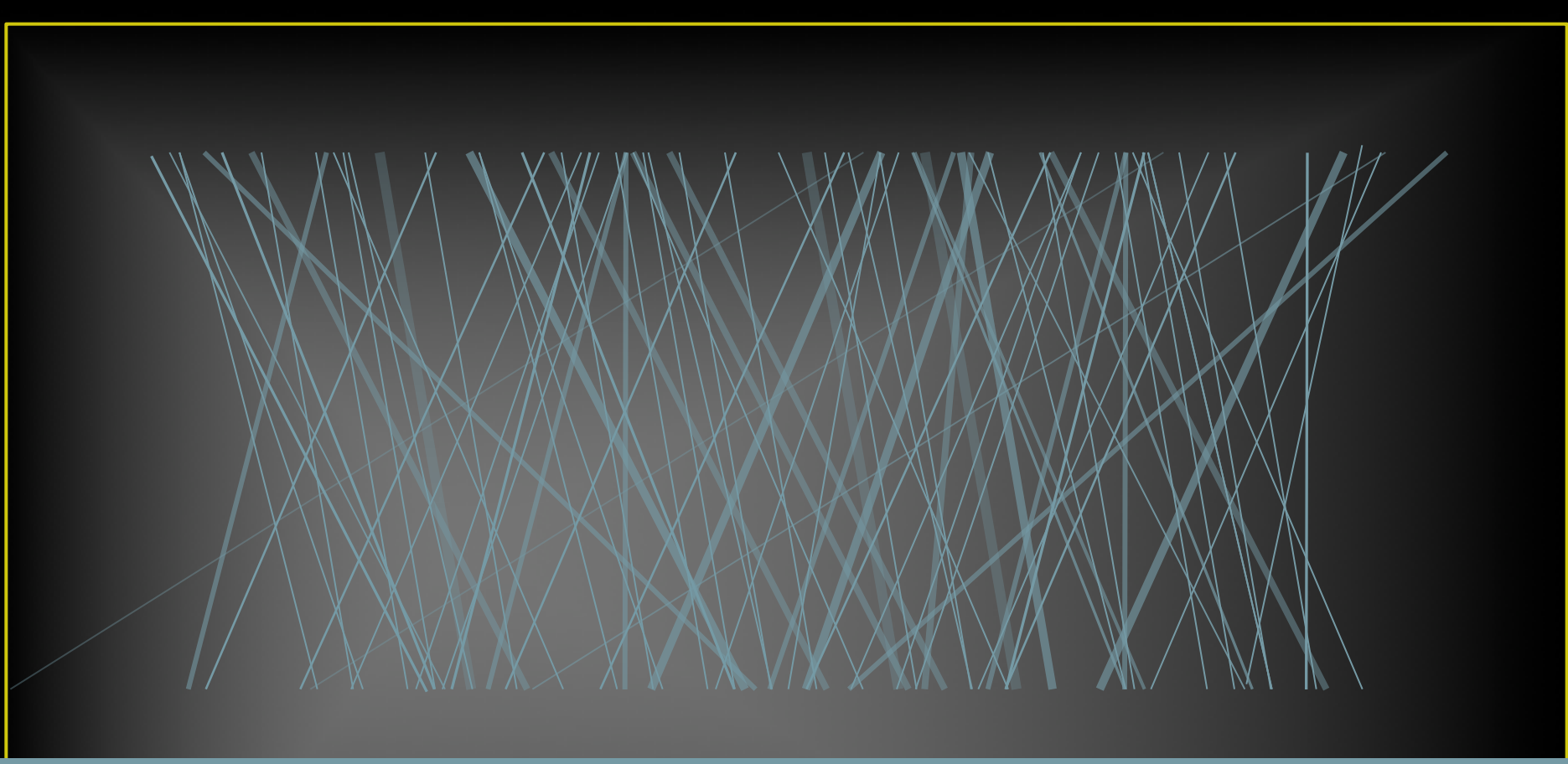
8 hours = work

8 hours = play

8 hours = sleep

How to keep talented clinicians?

- Build programs where clinicians can best do self-care. Always.



Case Study

- Coda (Time Permitting)

Case Study: Nick

- 56 years old
- Supportive Housing participant since January 2011
- 2 previous failed housing placements
- Heavy alcohol use
- Chronical medical condition

Harm Reduction: Housing Type

- Previous apartment
- Unit located downtown, blocks away from dozens of service provider agencies
- 1st floor unit
- Front door opens to street
- Only couple of feet from sidewalk

Harm Reduction: Geographical Cure?

- Current apartment
- 9 miles from downtown
- “Outside the Watterson”
- 2nd floor unit
- Front door opens to side of house
- Very removed from sidewalk

Housing Type Matters: Before and After

- Chestnut / Downtown

- Hazelwood / South End

Harm Reduction: Safely purchasing drug

Harm Reduction is a *practice* not a *policy*

- Home visit every Tuesday at 10:00am
- Social Worker and Peer Supporter go shopping with Nick
- Using Nick's own money, service team helps Nick purchase food, beer and cigarettes for the week

We Finally Figured It Out…

- Nick very stably housed
- Rent is paid on time
- No landlord complaints!
- Nick able to build positive support system
- Attends Harm Reduction Group every Thursday
- Participates in home visit every Tuesday
- Connected with primary care provider (PCP)
- Alcohol use is managed
- No need to borrow money
- Nick does not struggle with visitors taking over his unit