

# CLINICAL CHALLENGES IN PERMANENT SUPPORTIVE HOUSING: TWO CASE STUDIES

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## Overview

Much of the current policy discussion surrounding permanent supportive housing (PSH) focuses on funding models, service structure, cost-effectiveness and other administrative aspects. While these aspects are essential, it is the clinical relationship between a provider and client that is the building block of the day-to-day practice of successfully supporting vulnerable individuals in housing. Clinicians are striving to treat a complex combination of illnesses, navigate client relationships and finances, and build greater stability often with fragile people living in tenuous circumstances. Clients are working to manage their own expectations and set realistic goals as they transition from homelessness into housing. Together, this is a process that is both an art and a science, but one that policymakers should understand in order to better inform the policy decisions that determine the structure, resources and supports needed to ensure ongoing housing stability.

In October 2011, the National Health Care for the Homeless (HCH) Council published a policy and practice brief, *Clinical Challenges in Permanent Supportive Housing* that outlined the key themes clinicians and clients describe as typical challenges and offered recommendations for policymakers and practitioners.<sup>1</sup> As a way of complementing that brief and illustrating these challenges more personally, these case studies describe two specific clients who are currently participating in a PSH program and manifest some common traits that make ongoing housing stability a challenge for care teams. While these cases do not reflect all PSH clients, or all HCH consumers, they do illustrate the level of complexity that can characterize those who have been homeless for long periods of time. As local jurisdictions increasingly target PSH to the most vulnerable individuals, programs need to be prepared to accommodate more of these “hardest cases.”

## Case Description #1: Targeted for Takeover

Ms. G is a 47-year-old African-American female who was homeless for over 25 years, staying on the street and in shelters in Baltimore City. She entered a supportive housing program in 2007 where she continues to struggle with housing retention.

**Diagnoses:** Ms. G is formally diagnosed with schizo-affective disorder, polysubstance dependence, cocaine dependence, hypertension, tobacco dependence, back pain, overweight, high-risk sexual behavior, and visual impairment

**History prior to PSH:** Ms. G comes from a fairly stable family background, has a high school diploma, and was employed at a record shop until losing her job around age 20. During this time, she began using alcohol. With no income, she was unable to live independently and moved back with her mother and stepfather. At this time, her mother also lost her job and with only one source of income, Ms. G’s stepfather asked her to leave. It was at this point she first experienced homelessness.

Ms. G indicates she had emotional disturbance as a youth and reports using alcohol to cope with anxiety. After she lost her housing, her mental health further deteriorated into psychosis and mania. With her mental health unmanaged, she began to engage in behaviors that left her extremely vulnerable. For example, when she is

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<sup>1</sup> That brief is available at: [http://www.nhchc.org/wp-content/uploads/2011/10/Clinical\\_challenges\\_PSH\\_policy\\_paper\\_FINAL1.pdf](http://www.nhchc.org/wp-content/uploads/2011/10/Clinical_challenges_PSH_policy_paper_FINAL1.pdf).

experiencing mania, Ms. G will be up all night walking the street, where she encounters people affiliated with the drug trade or those who may assault her.

Her persistent and severe psychosis and mania resulted in multiple inpatient hospitalizations. Keeping follow up appointments was difficult because she was highly disorganized. When she was able to keep an appointment, her unpredictable communication and behavior challenged staff. For example, Ms. G would frequently remove her clothing in public spaces (to include the HCH patient waiting area) and run naked down the street, creating hazards to her, the staff running after her, and for traffic.

Ms. G engages in commercial sex work and trades drugs for sex, which further exposes her to disease and assault risk as well as exacerbates her pre-existing trauma. She was not receptive to discussions about HIV or other STIs, pregnancy, condom use or other safe sex practices. Overall, Ms. G was highly unstable, engaged in high-risk drug and sexual activity, and became severely fragile and traumatized after 20 years of homelessness.

**Transition to housing:** Housed now for six years, Ms. G still struggles with serious and persistent mental illness and addiction to crack cocaine and alcohol (and occasionally heroin). Building rapport and trust with case managers has been slow because Ms. G has difficulty distinguishing between harmful and non-harmful people. She still refuses addictions treatment though she has become engaged in others services such as the art group at the HCH. At one time she was court-ordered to attend addictions treatment as a condition to avoid a jail sentence, but was found inadmissible to the program due to her mental health. She has not been arrested in nearly one year.

She continues to visit the emergency department when she is in a manic state or for minor issues but at less frequency now that she is housed. Her medication regime is difficult to manage because she frequently does not take them with consistency and the prescribing options are more limited due to her cocaine use and the potential for harmful drug interactions. She sometimes will combine alcohol with an overdose of Zyprexa, which makes her behavior unpredictable.

Peer advocates help her organize, go grocery shopping and do laundry, which help keep her organized. Ms. G frequently comes to the clinic to pick up medications or money (HCH is her representative payee and she receives \$10 three times a week from her SSI benefit) so she is seen at least three times a week as a walk-in client and once for therapy sessions.

In addition to medication and behavioral health challenges, Ms. G has been moved to a different apartment nearly every year for the last 5 years, mostly due to the high volume of visitors and loss of control in the apartment, which leads the landlord to evict her. Kind and generous by nature, Ms. G will invite people to live with her so they are not homeless as well, but this inevitably escalates into “drug dealers hijacking the apartment.” Because she is so vulnerable, she is preyed upon by others in the community. Although Ms. G is afraid of being homeless again, it is not unusual for her to be back sleeping on the street or in shelters because others have taken over her apartment and will not let her back in. Clinical staff report having to go to her apartment “countless times” to clear out the drug dealers, which is stressful and risky given the high potential for violence.

A contributing factor to this problem is the high-risk neighborhoods that frequently are the only rental options available for clients with Section 8 housing vouchers. Staff visits to the home previously were once every two weeks because it was so unsafe for staff (especially women) and there were frequently a number of threatening people in the house and the immediate surrounding area. This was challenging for staff because Ms. G really needed to get a check-in visit every day. Team members often went in pairs to do home visits, but this was not always possible given available staffing.

When Ms. G is doing well with medications and limiting her drug use, her apartment is neat and orderly; but when her mental health declines and/or her substance use escalates, her apartment will have the heat turned way up, spoiled food will be in the refrigerator, the oven will be on, the countertops full of trash, and a once there was a giant tree branch in the middle of the floor. Sometimes the electric bill reached \$400 a month (she has a past due balance over \$1,000 for utilities). She has a significant need for personal therapy, but staff usually has to prioritize more urgent needs (like evicting strangers from her house). Consequently, it is challenging to find time for the amount of in-depth counseling required.

**Current status:** Currently in her fifth housing placement, Ms. G is making a new start in a location that is further removed from drug-infested areas, and time will tell whether the new area will work out well. Her lead therapist meets with her twice a week for both therapy and home visits, and she continues to present at the clinic several times a week for a small allowance. Ms. G continues to refuse drug treatment, but therapy sessions have continued to focus on setting goals and building value for herself. Her hospitalizations and arrests have declined significantly since being housed, and while she still has very challenging behavioral health conditions, she is more stable and is building greater supports compared to her earlier years in housing.

**Key clinical challenges:** Severity of behavioral health conditions, losing control of housing unit, and lack of trust and engagement

## Case Description #2: Frail and Forgetful

Mr. B is a 51-year old Caucasian man who was homeless for nine years living primarily on the street in Baltimore City. He entered supportive housing in 2009 where he presents significant clinical challenges to his care team.

**Diagnoses:** Mr. B is diagnosed with schizo-affective disorder, opioid dependence, asthma, hepatitis C virus, chronic back and leg pain, chronic gastro-intestinal problems, and degenerative bone disease. Traumatic brain injury is suspected, but has not been confirmed.

**History prior to PSH:** Growing up in multiple foster care placements, Mr. B's birth parents were abusive both physically and sexually to him and his brother, and some of his foster placements were also abusive. His mother suffered from schizophrenia, his father was an alcoholic, and when his mother remarried, his step-father was also abusive. He describes his time in school as traumatic, mentions throwing desks and head banging, and left high school after 9<sup>th</sup> or 10<sup>th</sup> grade. As a young man, Mr. B moved to North Carolina and worked as a painter and construction worker. Two serious falls—one from several stories up and another from a ladder—resulted in chronic pain (and possible brain injuries). Mr. B spent several years in prison for a bank robbery, and while he does not speak of his time there, he has mentioned that experience was also quite troubling for him. Mr. B was married twice, and it was during the second divorce in 2000 that he first became homeless.

Mr. B lived under a bridge downtown and would frequent “the Block” (an adult-themed area also downtown) during the day, where an HCH outreach worker would offer him coffee and sandwiches. During this time, he was actively psychotic and had paranoid thought patterns of strangers wanting to physically and sexually assault him. He experienced auditory hallucinations that he describes as “good and bad” sides of him. When he gets stressed, he has impulses to push people into traffic, though case workers are not aware of him acting on any of these impulses. Uninsured and unaware of options for care, he describes feeling helpless about getting care for chronic stomach pain. Mr. B has a history of heroin addiction and suicide attempts. After months of engagement on the street, he came to the clinic for services, but would not come inside (workers had to meet him on the sidewalk) because crowds upset him. About six months after beginning services at HCH, Mr. B entered the supportive housing program.

**Transition to housing:** His lead therapist describes Mr. B as sweet, but very time-intensive (particularly in the beginning) when he needed help with even the smallest task. For example, he has a friend assist him with cooking because he is scared to cook on his own.

His possible brain injury contributes to cognitive and memory difficulties, particularly with regard to his medication. Due to his chronic pain, he is prescribed opioids and is on several other medications for his other conditions (risperdal, wellbutrin, Depakote, oxycodone, pancreatic enzymes, zantac, klonopin, ambien, ranitidine, gabapentin, devalproex, oxycodone, pancrelipase, bupropion, clonazepam, promethazine, zolpidem, fluticasone, artificial tears, an a fentanyl patch), but it is often unclear how much he's taken, whether he purposefully over-medicates due to opiate addiction, or whether he does not understand how to take his medications as prescribed. Mr. B sits down once a week with a therapist case manager to divide his pills into daily dose boxes and this has helped somewhat.

Because Mr. B has a history of suicide attempts and has trouble managing his medications, his safety is a constant concern for clinicians. At times, he will sleep for two days so it is unclear to his care team whether he is in trouble and needs help since he does not answer the door or the phone during this time (while the care team has a key to his house, the safety contract with him specifies that they will not enter without his consent). Additionally, Mr. B often fails to show up for scheduled appointments because his memory and sense of time are not good. As such, his care team relies on these weekly home visits to assess his health and safety.

Mr. B's kindness leads him to invite others in need to live with him and his cognitive disorder makes it difficult for him to set boundaries, which others then use to their advantage. He especially has a soft spot for women with children, who move in and then invite their boyfriends to join them, which destabilizes the housing quickly. They eat all his food and cause him a great amount of stress that he does not know how to manage, and then asks the care team to "make them go away." At one point, the team needed to facilitate a peace order to get a family out of his apartment, which required several court appearances.

In 2010, Mr. B's mother was quite ill and living several states away, so he traveled to see her and then drove her back in her car to live with him in Baltimore, where he nursed her until she died shortly thereafter. However, the stress of caring for his mother while working to attain his own independence and stability was especially difficult, and in spite of his decision to forgive his parents of past abuse, her presence opened up prior trauma experiences that were challenging to treat while she was living with him.

Mr. B is described as "skittish" about forming relationships with other people, though he does look for opportunities to bond with others and will seek hugs from his care team. Unfortunately there have been a number of changes among his therapists due to program staff turnover, so this has contributed to difficulty transitioning between clinicians.

He has little to no tolerance for stress or frustration, so he is frequently in a state of agitation and it is difficult to calm him down. At one point on a home visit, his clinical lead therapist noticed a weapon on the table and while she did not feel personally threatened, Mr. B became extremely worried about being discharged from the supportive housing program. It took two days to de-escalate him, and there is now a safety plan and therapeutic agreement about the conditions upon which he can retain the weapon in his home (to include notifying police and/or the hospital when necessary). The care team is conscious that Mr. B has not yet worked through his traumatic history, and is aware that his increasing physical fragility will mean he eventually will need more medical supports than the program can currently provide (e.g., a nursing aide or an assisted living placement).

**Current status:** Mr. B has retained his same housing unit the entire time he has been with the program, though there are tensions with his landlord over the invited guests that periodically live with him and there are plans to move him to a new unit due to the stress this has caused.

Crowds still bother him so he continues to call his team upon arrival at the clinic and will wait outside. He has developed more independence with activities of daily living and can do his own laundry, go grocery shopping and care for his cats without much assistance, though he can still be forgetful and lose concentration (e.g., he can forget about things on the stove or will go without eating).

Mr. B is finding therapy an increasingly safe place to process his ongoing stress. However, he is struggling to talk about prior trauma and continues to have suicidal ideations and auditory hallucinations. While Mr. B is making some progress on his behavioral health conditions, his medical conditions are getting worse. He still needs a lot of assistance with medications and has been having seizures, falls frequently, reports feeling weaker and sometimes can't stand on his own. As a result, he has difficulty showering, going grocery shopping using public transportation, and other activities of daily living.

Mr. B continues to struggle with his memory. He cannot remember numerous doctors' appointments, what to ask while with the doctor, or what to report about his current condition. These growing limitations increase concerns over his safety and are challenging for the clinical team to address (e.g., they cannot be present with him 24 hours a day, when appointments are made for him he tends to forget about them, etc.). Mr. B very much wants to be independent and is currently working on how best to ask for needed assistance. Overall, Mr. B's behavioral health conditions are better managed now that he is in housing, but his physical health is worsening as he ages.

**Key clinical challenges:** Severity of mental health and substance abuse conditions, cognitive difficulty and memory loss, possible brain injury, medical fragility, losing control of housing unit, attachment disorder.

## Policy Implications

While these are just two examples that illustrate the clinical work behind PSH caseloads, policymakers can help ensure greater success of these programs by recognizing the fluctuating—and often tenuous—stability that might be achieved even years after entering housing and providing the appropriate resources to meet those needs. Policy changes that could bolster PSH effectiveness include the following:<sup>2</sup>

- **Fund programs adequately to ensure sufficient staffing for manageable caseloads.** Clients rely heavily on both clinicians and support staff to help with daily needs, often needing frequent check-ins that can be time-intensive, but critical to maintaining stability. Having sufficient numbers of clinicians is critical to ensuring the team is not spread too thin and clients can get assistance quickly. Staff new to the field will require additional support and supervision as well.
- **Consider alternative housing models.** Scattered site housing for the most complex of patients may not allow for the increased level of supports needed, especially to help clients control unwanted guests and offer more on-site assistance for more hours of the day. Planners may want to consider a single site (or project based) housing model that can be staffed and designed to accommodate higher needs clients.
- **Conduct intensive training to ensure clinicians are able to respond to a wide range of challenges.** Clinicians report that helpful training topics would include addictions and psychosis, harm reduction and stages of change, traumatic brain injury, de-escalation, gerontology and the aging process, motivational interviewing, and cognitive behavioral therapy.
- **Ensure staff recruitment and retention.** Frequent staff turnover can hinder client ability to engage with therapy and make progress toward health and housing stability, and the risk of staff burn-out is high due to the intensity of the work. Programs should be structured to ensure team stability to the extent possible.

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<sup>2</sup> These policy recommendations are discussed in greater detail in the previous policy and practice brief available at: [http://www.nhchc.org/wp-content/uploads/2011/10/Clinical\\_challenges\\_PSH\\_policy\\_paper\\_FINAL1.pdf](http://www.nhchc.org/wp-content/uploads/2011/10/Clinical_challenges_PSH_policy_paper_FINAL1.pdf).

- **Increase affordable, high quality housing throughout the community.** While some jurisdictions have built state-of-the-art housing options in safe neighborhoods, many communities still struggle to find decent rental options for this high-needs group. Clients who can only find housing in high-crime, high-drug-activity areas not only have their own stability and clinical goals curtailed, but these locations also hinder staff ability to be a regular presence in client homes.
- **Ensure full spectrum of behavioral health services available in community.** Clients who have both severe mental health and addictions issues may occasionally need more intensive services than an outpatient service model can accommodate. When inpatient programs are unable to address co-occurring disorders, PSH clients do not get the intensive care they require to help achieve health and housing stability.
- **Set realistic expectations about success.** Given the personal histories and current struggles of people living in PSH, housing stability may take many years and a great deal of clinical support to achieve. Reductions in arrests, hospitalizations, and other service utilization have been documented within short time periods, but overcoming trauma, working toward recovery, and addressing long-term personal challenges does not occur overnight and “success” will look different for every client.

## Conclusion

Most, if not all, PSH programs have at least some number of clients as complex as Ms. G and Mr. B, but the proportion of such clients will vary significantly with local PSH program design and population targeting decisions. These illustrations of two clients shed light on the clinical challenges that Health Care for the Homeless and other homeless service providers encounter each day in the field. For Ms. G, meeting health and housing goals are complicated by addiction, mistrust, and inability to take prescribed medication as indicated. Her addiction and poor medication management lead to declined mental status, challenging her ability to live independently and often leaving her in extremely vulnerable situations that others exploit. For Mr. B, who suffers from poor memory and deteriorating physical health conditions, health and housing goals are challenged by poor medication management (a serious concern given the amount of medication he is taking for his many ailments).

Ms. G and Mr. B have been in supportive housing for six years and four years, respectively, but despite their tenure, they continue to need intensive engagement from their care teams. Even though each has developed good working relationships with their care teams, they continue to challenge staff by missing appointments, needing frequent visits, and engaging in risky behaviors that compromise both their health and housing. There is no doubt that without ongoing intensive supports, each would return to homelessness even after being housed for some time. While housing as an intervention is absolutely a critical component to achieving the goals of better health, reduced homelessness, increased stability, and a reduction in the use of public resources (hospital/emergency room, jail, courts, etc.), it is not a panacea for the significant problems that clients bring with them. It is the presence of consistent supports and clinical assistance over time will help achieve these macro-level goals. Note that in spite of their challenges, both Ms. G and Mr. B have made progress in their health and recovery. Clinicians who are engaged in the day-to-day work of supporting very vulnerable clients are a key component to the success of PSH programs and need to be supported in their work. Implementing these policy recommendations can help maximize the goals related to increased health status and housing stability, as well as bolster long-term cost-effectiveness.

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