

CLINICAL CHALLENGES IN PERMANENT SUPPORTIVE HOUSING

POLICY & PRACTICE BRIEF

OCTOBER 2011

Overview

Much of the current policy discussion surrounding permanent supportive housing (PSH) focuses on funding models, employment strategies, life skills management, service structure, and program cost-effectiveness. These aspects of administration and financing are critical components to the viability of existing PSH programs and key to building the community and political support needed to expand further. Likewise, there is much to be gained from describing the clinical challenges to providing integrated mental health, addictions and primary care services to newly housed persons who have multiple chronic illnesses in addition to significant social impediments. The client-provider relationship is the building block behind the day-to-day practice of maintaining housing. This policy & practice brief describes the clinical challenges that clinicians and care teams frequently encounter while supporting clients in PSH, and includes policy recommendations that will help strengthen PSH models. Clinicians reading this brief will see common themes experienced by others working in similar roles. Administrators and policymakers will appreciate the significant difficulties faced by PSH providers and can use the recommendations to reduce barriers. Overall, PSH is a model that should be part of the range of housing programs in all communities to prevent and end homelessness among those with significant disabilities.

There are three central, inter-related areas of concern regarding PSH: financial/administrative, partnerships with other service providers, and the direct provider-client relationship.

- **Finance & administration:** Provides the funding needed to support a wide range of staff (clinical and non-clinical); financial/reimbursement policies and regulations determine what constitutes a billable service, which in turn guides how clinical interventions need to be structured to remain financially sustainable and in compliance with funding requirements.
- **Partnership with other service providers:** Strongly influences the client's treatment plan and the coordination of care that is essential to housing stability. Depending on the individual program, these relationships can be among multiple partners, with one entity providing the housing, another primary care services, and still others providing behavioral health services such as addictions and mental health. Working with a wide array of clinical social workers, case managers, employment and benefit specialists, peer navigators, and others who work with teams to support clients in housing is essential to these partnerships.
- **Relationship between clinician and client:** The success of the PSH model ultimately depends on the clinician-client relationship. Client physical and mental health status, participation in (and adherence to) the treatment care plan, hospital/ER admissions, jail diversion, disability status, and other key elements that keep the client stable while in housing all rely on this working partnership.

While certainly each of these areas are mutually influential, this policy & practice brief will highlight issues related primarily to the third aspect: the relationship between clinician and client. The themes contained in this brief are synthesized from interviews with PSH team clinicians and clients living in PSH projects across the country. The policy recommendations contained in this brief aim to improve a model of care that is a key to preventing and ending homelessness among those with many social and health needs. For those service providers looking to start a PSH program and those policymakers hoping to better understand and support PSH as a growing model, the issues outlined in this brief should help clarify the staffing, resources, expectations and other clinical aspects needed in order to end homelessness among a complex, yet fragile, population.

Background

Research regarding the importance of the relationship between clinician and patient has shown that there is a correlative association between quality of provider relationship and health outcomes. For instance, increased provider information giving, engagement in discussion about psychosocial issues the patient may be facing, and expressions of partnership have been associated with increased patient satisfaction and improved patient health outcomes.^{1,2} Additionally, the literature demonstrates that the relationship between patient and provider can have a profound effect on the patients' ability to adhere to treatment regimens which can impact an individual's health status.^{2,3} The therapeutic relationship can provide additional social support to lessen the impact of social barriers such as lack of material resources, health insurance and transportation and improve health outcomes.^{4,5} For vulnerable populations that often have co-occurring mental health and substance abuse issues, a therapeutic relationship between health care provider and client can improve the rate of successful recovery by up to 30%.⁶

While there is certainly empirical evidence as to the importance of a quality relationship between provider and client in the literature, there are also several practical guides that explain the most important and integral tenets of the relationship. These include effective client-provider communication, providers' openness to their patients' requests, partnership in decision making, demonstrated provider empathy and a patient-centered approach.^{7,8,9,10,11} Additionally, these tenets appear to be more instrumental to patients who are especially vulnerable and who face a multitude of psychosocial and structural barriers to healthcare access. A number of the themes and recommendations presented in this brief have been recognized by the American Psychological Association, especially related to the need to build trusting relationships with clients, particularly those without homes.¹²

The PSH Model

PSH is a combination of housing, health care and supportive services that help people live more stable lives, and is usually targeted to a person or family who has been homeless (or is at risk of homelessness) and has multiple barriers to employment and housing stability. Housing units usually are subsidized (tenants pay no more than 30% of their income), are leased with no limits on length of tenancy, and are managed through a team of housing and service providers who actively engage clients in on-site and community-based services.¹³

Clients who participate in PSH programs tend to have been homeless for a long period of time and have multiple chronic health conditions that are disabling. A 2007 survey taken of six PSH programs indicated a concentration in PSH of people with serious mental illness (67% of all tenants), but also those who have alcohol or substance use disorders (35% and 37%, respectively), or both (34%).¹⁴ PSH addresses numerous factors associated with prolonged homelessness (and does so in a cost-effective way) in that it fosters the retention of stable housing, even among those with serious behavioral health issues (i.e., those with mental health and/or substance abuse disorders). People who are homeless with disabilities who move to low-barrier permanent supportive housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated, resulting in a significant reduction in the cost of public services.¹⁵

PSH models are staffed with an interdisciplinary team of both clinical and non-clinical staff to help support clients in their daily life. Teams are usually comprised of clinical social workers/mental health clinicians, addictions counselors, psychiatrists, physicians/nurses/medical assistants, employment/benefits specialists, peer navigators, and administrators. PSH team composition varies depending on the model—the evidence-based practice Assertive Community Treatment (ACT) is one example—but in general, consist of eight to twelve people. Each team member fulfills a defined and appropriate support role for each client in the caseload, and the team engages in regular (sometimes daily) case conferences on every client so that a plan of service can be formed for each day. This includes everything from accompanying the client for grocery shopping or to appointments to conducting a psycho-social assessment to crisis intervention.

Methods

In-depth interviews were conducted with clinicians (individually and as a team) at six different PSH projects located at diverse geographic locations. Staff of the National HCH Council and the Corporation for Supportive Housing hosted a focus group among 16 members of the PSH Working Group, a provider-focused committee, to gain additional perspectives. Clients from four of these PSH sites were also interviewed about their experiences adapting to housing after a long period of homelessness. Common themes from both groups were synthesized, and recommendations formed based on this feedback.

Provider Themes

Many of the providers interviewed cited similar challenges in working with their PSH clients. While specific PSH clients and dynamics will be unique in every community, many of the clinical characteristics are similar (perhaps due to the majority of federal funding for PSH directed toward those with mental illness and/or substance abuse disorders). Overwhelmingly, clinicians described the daily difficulties of maintaining clients in housing as a process akin to changing one's entire culture of living, especially for those clients who have been living on the streets for long periods of time. Very different skill sets are needed to survive on the streets compared to living in housing; the "core competencies" needed to live stably in housing must be taught or re-taught and not taken for granted.

Street survival mode generally operates on a day-to-day manner where future planning is of limited use because so much is out of one's control, and the level of sensory stimulation is normally quite high (e.g., street noise, people, cars, animals, weather conditions, etc.). Sleep and food deprivation, violence and assault (actual or the imminent threat), a constant need to move, an inability to keep belongings and medications safe, strangers or police as threats, isolation from the general public, and a myriad of other factors inhibit one's ability to maintain mental health, sobriety, and/or adherence to medical instructions. Immediate daily needs include finding food, a safe place for sleeping, and a way to travel between these locations (in some areas of the country, this alone can take most of the day).

Once in housing, all of these factors change immediately—along with the need to change one's behavior accordingly. This can be an overwhelming process, especially for behaviors that have been ingrained for 5, 10, 15 years (or more) and are compounded by addictions or mental illness. Stable housing also introduces the need for individual decisions not normally feasible when living on the street. For example, sleeping and eating patterns are no longer dictated by others, the need to plan ahead (paying bills or shopping for food) combined with greater control over one's space and a much lower sensory stimulation is a significant adjustment not easily made. Hence, there is a transition period where the stress of these changes impacts on behavior, which may become even more erratic than when the client was living on the street. This is an irony not lost on clinicians, but a factor important for administrators and policymakers to understand.

"The hardest part isn't getting someone into housing—it's keeping someone in housing... the real work begins after we get the house key."

~ Social Worker,
Washington, DC

The following themes were consistently mentioned as clinical challenges during interviews with multiple clinicians in projects across the country, to include addictions counselors, licensed clinical social workers, psychiatric nurses, nurse practitioners, physicians, and psychiatrists:

- 1. Adhering to medications and treatment plans:** Clients usually have multiple prescription medications and a treatment plan to address a wide range of acute and chronic conditions, but retain the right to refuse them. Some clinicians noted that feelings of euphoria about obtaining housing or the improved energy that comes from getting uninterrupted sleep can mask depression and other illnesses, causing clients to feel that these medications and other medical directions are not needed now that they are in housing. Hence, there may be periods of increased volatility after becoming housed that need to be anticipated, which may include

psychiatric distress, increased substance use, and unpredictable behavior. This might be especially difficult after the excitement of attaining housing.

2. **Planning for relapse and creating reasonable goals:** Housing itself does not solve all problems, but for those living on the streets for long periods of time, there are frequently ambitious self-made promises of sobriety, re-connection to family, employment and other goals based on pre-conceptions of what life will be like once housed (e.g., “once I get housed, life will be good and I’ll get clean.”). Clinicians frequently reported the difficulties in re-framing these goals and helping clients through relapse, which is often caused by existing illnesses exacerbated by the stress of many changes. This cycle is made even more clinically challenging because of the immense personal disappointment clients can experience because they did not adhere to their own expectations of what changes would be immediately possible after housing. Planning for the likelihood of relapse and multiple housing placements is a significant clinical challenge and needed for residents to achieve stability over time.
3. **Building confidence:** Clients who participate in PSH programs tend to have been deemed “not housing ready” by numerous programs that base housing on achieving sobriety and following a strict set of rules. For those living with serious mental illness and/or substance use disorders, it is much more difficult to achieve these goals while living on the street or in and out of emergency shelters. Hence, many clients have “failed” numerous homeless programs. In addition, many clients come from traumatic life circumstances that include incomplete education, dysfunctional and violent childhood experiences and adult personal relationships, children of their own taken by social services agencies, inconsistent employment, and isolation from general society. The terms “broken,” “low self-esteem,” and “expectations of personal failure” all were used in interviews with clinicians, who described a self-fulfilling prophecy: clients feel they have “failed at everything in life” and “do not deserve housing,” or they lack confidence and do not believe this current opportunity will last, leading to less engagement in treatment or self-sabotage. Building the confidence needed to address the daily struggle to remain housed is a regular clinical challenge.
4. **Addressing cognitive and developmental delays:** Mental illnesses, substance use disorders and medical conditions are usually manageable through treatment and medications; however, cognitive/developmental delays are generally not. Traumatic brain injuries and developmental disabilities in particular are common among PSH clients, and make clinical treatment plans more difficult due to an inability to remember or understand directions, make informed decisions, or navigate personal situations. Hence, all members of the PSH staff, to include clinicians, must constantly repeat instructions for basic tasks, which may involve making phone calls or visits to the client multiple times a day.
5. **Teaching life skills:** Remaining housed requires learning basic household skills, safety mechanisms, and health guidelines. After many years on the streets, clients often need to re-learn how to regularly shower, shave and conduct other person grooming. Especially for women with prior trauma, even the act of getting undressed to bathe can be difficult. Learning to close and lock the front door, how to use and keep a house key, when to open the door to strangers, how to cook and use gas or electric appliances, and how long to keep milk and other food before it spoils—all of these are skills specific to being housed that must be re-learned. Clinicians report arriving at a home visit, only to discover the client not at home but the shower has been left running, stove burners left on, strangers have entered through unlocked doors, or the heat is on but the windows are open. While some of this dynamic is common among those individuals with serious mental illness (even those with

“We need to expand the concept of a ‘visit.’ Installing an air conditioner or hanging curtains with a client affords me more clinical knowledge and opportunity for therapeutic intervention than any office visit can.”

*~ Psychiatric Nurse,
Washington DC*

no history of homelessness), each of these scenarios compromises health and safety (and also may jeopardize relationships with landlords), and serve as additional clinical challenges to retaining housing.

6. **Needing TIME:** Universally, clinicians reported that developing relationships of trust with clients took a great deal of time, and—while every client is unique—most PSH clients require two to three years of intensive services before achieving consistent stability. In an environment where there is pressure to be as efficient with clinical time as possible, PSH clinical staff are often challenged to find the time required to build and maintain effective individual relationships while also meeting the needs of the entire caseload.
7. **Keeping supports flexible:** While some clients may go on to independent living with no need for specialized programming, many clients will still need some level of support, which would vary based on circumstances. Clients can achieve stability, but it is often a fragile and temporary state where a myriad of factors can compromise progress. For example, a client who is in the program for two years may see her social worker once a week, but the sudden death of a family member put her into such distress that visits by various team members were increased to three times a week for several months. Unexpected injuries, illnesses, mental health and/or substance use relapses, and changes in personal relationships all can require sudden adjustments to treatment plans and team member involvement, which requires ongoing flexibility in service delivery and staff member availability.
8. **Redefining clinical interventions:** Due to the range of medical and behavioral challenges, office visits can be difficult venues to evaluate personal status or to elicit effective communication. Home visits are frequently the best way to teach activities of daily living, address issues occurring in the home, and develop a relationship that is based on trust. However, these goals are quite difficult to attain in 15-, 30- or 45-minute “billable” increments. Those clients living in PSH-facilitated housing require longer, hands-on segments of time that may be spent engaging in household activities such as alphabetizing a video collection, installing an air conditioner, or cleaning the bathtub. While these activities are traditionally not considered “clinical” time, they are critical because observations of real-life scenarios are possible at home (compared to an office visit) where the ability to engage in decision-making, build confidence and skills, and help follow a set of directions is the key to helping the client achieve greater life stability. As one clinician indicated, “the goal is to use time with people in a therapeutic way.” The challenge is to expand traditional clinical definitions to help clients manage practical life situations.
9. **Navigating client relationships:** Clients in PSH have the right (and desire) to engage in the same relationships as anyone else, which includes intimate partners, friends, and family members. Stable, positive relationships can be helpful to healing and housing retention, and these individuals can serve as informal partners with the PSH team/clinicians. Unfortunately, when these relationships are not positive or stable, clinicians have additional challenges to overcome. Boyfriends who are abusive, friends who come to “visit” and never leave, family members who take advantage of vulnerable situations—these can be opportunities to develop confidence, decision-making, autonomy and self-control—but can also impede clinical progress and lead to new or returning unhealthy relationships. Clinicians frequently noted that they are not in a position to dictate who lives in the house, but to empower clients to make decisions based on their own desires and goals.
10. **Navigating neighborhoods:** One of the primary administrative challenges is finding affordable housing for clients who may or may not have housing assistance through a Section 8/Housing Choice voucher, and may or may not have any additional income (e.g., SSI/VA income or state disability assistance). Especially with models that rent units on the private market (i.e., “scattered-site”), the only affordable housing units available

“How do you engage a client in the community when the community just isn’t that engaging?”

~ Psychiatrist,
Washington DC

may be in neighborhoods that have high rates of crime, poverty, violence, and drug activity—precisely the kind of environments that can undermine personal goals and clinical progress. Endemic drug activity can compromise substance abuse treatment, and the sounds of gunshots, arguments, fights, and police activity can aggravate post-traumatic stress disorder, serious mental illness, and other disorders. Frequent robberies and break-ins threaten clients in their housing units and compound the situation. Difficulty sleeping, increased stress, chaotic environments, and lack of safety can unravel even tenuous progress toward better health and stability. Note also that these are the same neighborhoods clinical staff must travel—often alone—to see clients. Apartment buildings that have throngs of gang members and/or drug traffic outside the front door, in the stairwell, and in the hallways can be intimidating to both clients and staff, and serve as a further challenge to services.

11. **Being a representative payee:** Clinicians were divided in their view of handling client finances. Some of those interviewed reported that it was nearly impossible to conduct any clinical interventions when the client is constantly focusing the discussion on money; others said they used these discussions to guide agreements about behavior and goals. All clinicians said that negotiations over money complicated the clinical interaction, causing stress and for some clients, exacerbating manipulative behavior patterns.
12. **Avoiding burnout:** There is a tremendous amount of time and personal investment in client care, and the nature of PSH work leaves all members of the team vulnerable to burnout. All clinicians reported experiencing stress related to difficult client interactions, occasional physical threats or assaults, high client death rates, and the daily challenge of caring for a high-needs caseload. Because clients in PSH tend to be in poor health, premature death is not unusual. Arriving at a home visit to discover a client death—stemming from violence, self-harm or natural causes—is particularly distressing. Burn out results from this daily stress and can compromise client care, reduce job satisfaction, and exacerbate conflict on the team. Attending to the likelihood of burnout is essential to retaining clinical staff.

All of these themes reported by clinicians converge in various ways to create a dynamic work environment. Navigating this environment is certainly demanding, but clinicians consistently reported satisfaction when they could help improve the lives of vulnerable clients.

Client Themes

PSH clients reported many of the same challenges as clinicians, though obviously from a different viewpoint. Understanding patient perspectives is vital to policymakers so a better understanding of the process behind maintaining housing can be appreciated, adequate resources and supports allocated, and realistic expectations maintained.

1. **Being lonely and isolated:** Many clients came to PSH after a long period of homelessness, with some reporting lengths of time on the street exceeding 20 years. During this time, many lived together with small or large groups of people, with a regular stream of new and returning faces. There was more safety if you stayed with a group, especially for women clients. Many clients reported a strong connection to nature—sleeping under the moon and stars; having squirrels, rats, cats and dogs as pets; and feeling the changing seasons through snow, rain and fall leaves. While certainly isolated from the general public and at constant risk of being the victim of violence, there was a camaraderie among “street people,” constant noise and activity, and a connection to the world around. Nearly all clients reported feeling lonely in their new housing unit where they were unaccustomed to being by themselves for long periods of time, closed in by the quiet and “the four walls around them,” bored because their day no longer involved a constant search for food and other basic needs, and now isolated from both the general public and their former acquaintances. In many cases, they were living in unfamiliar neighborhoods where they did not feel safe outside their apartment, did not understand how to navigate public transportation, and were not familiar with the dominant culture of the area. Some clients responded by leaving their housing unit and returning to familiar places on the street to

sleep or spend time (this is particularly puzzling behavior to policymakers). Others respond by not leaving their housing unit at all. Addressing loneliness and finding positive and constructive activities is a challenge for both clinical teams and clients.

- 2. Experiencing “housing guilt”:** Living on the street often requires relying on others for safety, food, sleeping space, and other basic needs; some of these relationships can be long-term. When a PSH client gets a housing opportunity, the others are left behind. This puts the client in a difficult position: why were they chosen for housing and not others? How can they leave friends out in the rain or without food when they now have a roof and a kitchen? How can they sleep in a bed at night knowing that long-term comrades are still on the street? Feelings of inadequacy, low self-esteem, and doubts about the ability to make personal changes combine with promises made to extend hospitality to one’s friends. These are all reasonable responses, but ones that carry significant consequences. It is not uncommon for “friends” to request help with a shower, a meal or a brief stay only to become permanent fixtures. These situations create complications in household dynamics, drain resources, jeopardize client goals for health and stability, and possibly risk breaking rental agreements. At times, clients can lose control of their new space and need help re-establishing boundaries. Clients also reported the awkwardness of going to their health center or to a soup kitchen and seeing former friends who now shun them for abandoning them (e.g., “being too good for us now”), or worse, offer them drugs or alcohol to have one “for the good old days.” This dynamic not only complicates service delivery but also compromises clinical and personal goals.
- 3. Relapsing and Failing:** Many clients reported not appreciating “how hard it was to be housed” and that they had long held a grand vision of what life would be like after they had a place of their own. Some said that the first day was the hardest (“after the social worker left, I was left with only my thoughts and I was scared”) while others said an initial honeymoon phase later turned to depression when they realized housing itself did not resolve issues with addictions or mental illness (“I realized I was still an addict—just inside four walls now”). Nearly all clients reported a relapse after becoming housed often followed by severe self-recrimination, a belief that they fail at everything and “don’t deserve housing,” and possibly even actions to jeopardize the lease itself (whether conscious or unconscious). All struggled to adapt to a completely different lifestyle and all agreed that housing brought its own “culture” and changes that had to be made.

“Friends are a double-edged sword—it’s tough to say no. My friends need a shower but I can’t say yes because it just leads one thing to another.”

~ PSH client,
Denver

Discussion

There are significant clinical challenges involved in keeping PSH clients in housing. Both clinicians themselves and the clients they serve cite difficulties in transitioning from a culture of homelessness to a culture of being housed. While most of these themes are related to the trauma of homelessness and the impact of years spent living on the streets, other themes are related to behaviors associated with serious mental illness and significant substance use diagnoses—ones that would impact clients without a history of homelessness. An overriding theme appears to be the need for more people to understand this process of “becoming housed” can be a complex, long-term journey full of ups and downs, requiring some fairly intensive clinical support. The recommendations and ideas for improvement that came from those interviewed fall into two categories: those approaches and “lessons learned” that providers can share with one another to improve their program; and macro-level policy changes at the federal and/or state level.

Recommendations for Clinicians

- **Establish client groups:** A number of teams conduct client groups as a way of eliciting a greater level of discussion about personal feelings, adjustments to housing, comparing experiences, building new social support, and learning new skills together. Some projects started clients in such groups even before entering

into housing as a way of adjusting expectations and hearing from others who had similar challenges. Clinicians found clients to be more willing to talk with each other about self-doubt and ask questions, and used this time to facilitate ideas for overcoming loneliness, finding community activities, and learning from each other how best to overcome personal struggles. This was also a forum for identifying peer-mentors among those who were achieving stability as a way of helping those new to the program.

- **Establish team support groups:** Preventing burnout is vital to the health of the team. While case conferencing and team meetings occur regularly, periodically having an offsite retreat—perhaps facilitated by a third party like an Employee Assistance Program (EAP)—can help support team members with a wide range of stress management techniques. Teams might also consider teaching secondary trauma care as an ongoing preventive care service and incorporate into regular team routines.
- **Develop relationships with landlords:** Evictions undermine stability for an individual client or for future clients. Many teams had success not only in identifying available housing but also in getting more leeway to work with difficult situations by meeting regularly with landlords and educating them about the challenges that clients face when adapting to housing. Often, landlords were receptive and preferred working with an agency that could ensure timely rent payment and serve as another pair of eyes and ears onsite at their property. Building these relationships can be beneficial to the program, its clients and even lead to opportunities for additional housing units.
- **Set reasonable goals and expect multiple placements:** Clients may need several placements before achieving stability. This may be due to the evolution of clinical symptoms, or it may be the result of external factors (relationships, community events, changing service locations, etc.). Creating reasonable goals for both the client and oneself as a clinician is key to avoiding burnout and chronic disappointment.

Recommendations for Policymakers

- **Maximize Medicaid reimbursement:** States have the option of including in their state plan those clinical services provided in PSH since they match many home and community-based services already provided to other populations [through a 1915(c) waiver, a 1915(i) option, a health home, the Community First Choice option, etc.].¹⁶ This would not only make service funding more stable (rather than relying on grants), but it also could expand the types of services available to this population. These service models might benefit from a bundled payment mechanism. Medicaid (or other funding sources) should also reimburse for the time spent in multi-disciplinary meetings, recognizing that this time is specifically focused on coordinating care across numerous service types.
- **Establish manageable caseloads:** While much depends on the clinical characteristics of the PSH program participants, caseloads should remain manageable to allow for the time needed to develop relationships, and respond to unanticipated emergencies, periodic crises, and other situations. Assigning too many clients to a team risks burning out all team members, leaving clients unsupported, and compromising the very stability the program seeks to promote.
- **Identify resources for household items:** Clients come into housing with very few personal belongings, such as dishes, towels, sheets, a bed, a microwave, etc. Identifying funding for these items would be an immense help to PSH teams so they can rapidly establish as much normalcy and self-sufficiency as possible.
- **Plan longer funding cycles:** Depending on the financing structure of an individual program, grants and other time-limited funding sources should anticipate several years of services for each client (with strong intensity in

“We have to maintain the ratios in order to maintain our sanity. There’s a relentlessness to the work and you can burnout fast.”

~ Addiction counselor,
Denver

the beginning, a gradual decline over time, but allowing for fluctuation). This may involve issuing grants for longer than three to five years at a time, and instead look to more permanent and stable sources of funding.

- **Conduct intensive training:** All the clinicians interviewed said that little in their training prepared them for the challenges of working with PSH clients. Because budgets are usually structured conservatively, salaries may have greater appeal to those just coming out of school. Newer clinicians may not have had much (if any) exposure to the challenges illustrated in this brief. At the same time, most funding mechanisms do not allow for much on-the-job training, and Medicaid specifically prohibits reimbursement to two clinicians for the same service. Hence, a newly minted social worker has little time to “shadow” a more seasoned team member as a way of orientation to the demands of the job. Without such training—and the funding to support it—clinicians do not get the benefit of being mentored by others on the team and may feel ill-equipped to address the range of behaviors exhibited by clients. There should also be a mechanism to fund training on evidence-based practices such as trauma-informed care and motivational interviewing—currently this involves the cost of the training plus losing a day of billing (when using Medicaid).
- **Expand the definition of “visit”:** To be effective in PSH, clinical interventions must be able to occur in non-traditional settings (on the street or in a home visit) and allow for a broader interpretation of what a visit can entail. For example, a nurse might have to visit a PSH client eight times before he is able to conduct a physical exam, yet each of these eight visits should be considered appropriate for reimbursement. This is especially applicable in states where Medicaid is reimbursing the clinical services.
- **Assist staff recruitment:** It is difficult to find physicians, nurses, psychiatrists and other clinical professionals who are willing to work in “non-office settings” (i.e., under a bridge, in an encampment, etc.) with clients who may need a bath, may be under the influence of substances, may resist every attempt at clinical assistance, and/or who may present risks to personal safety. It is equally difficult to recruit clinicians who are willing to clean toilets, hang curtains, or engage in other routine household chores as a mechanism for building trust and/or seeking a therapeutic interaction. Recruitment efforts should address the challenging aspects of the position to help ensure new members are a good “team fit” for this model of care. Also, professional schools should include issues related to poverty and homelessness in their curricula to promote an early interest in serving an especially high-needs population.
- **Ensure staff retention:** Burnout can not only compromise the relationship with an individual client, but it will impact the functioning of the entire team and caseload. Setting manageable caseload numbers and allowing sufficient time to achieve clinical goals are good prevention measures, but also the funding structure should allow for self-care strategies, team support mechanisms, and other professional approaches that prevent burnout and provide emotional support, especially after difficult client experiences. Low pay and inexperienced staff can also lead to frequent staff turnover, which compromises both client and team stability.
- **Assess the housing model:** There are a number of benefits to scattered site models, but the transportation time needed between clients will reduce the number of visits a clinician can make in a regular shift, and ultimately impact team response time, the amount of “billable visits” (when using Medicaid), and the number of team members needed for coverage. PSH planners might consider a congregate setting at first when the most intensive services are needed, with a “graduation” to a scattered site location as more stability is achieved over time. Another option would be to incorporate the extra time needed into caseload ratios and funding streams to allow for additional staff.
- **Include housing subsidies:** Finding quality and accessible housing that is affordable in a safe neighborhood is often one of the greatest challenges. Most programs couple a Section 8/Housing Choice voucher with 30% of a client’s income to cover housing costs (possibly supplemented by other funds when available)—the risk is only being able to find affordable housing units in areas not conducive to therapeutic interventions. There

should be a balance between client safety and stability and the need to be cost-effective; hence, additional funding for housing may be necessary so that higher quality units are affordable.

Conclusion

While financing, administration, and the partnerships between participating providers are all essential components of creating and maintaining effective PSH programs, it is also critical to understand the daily clinical challenges that providers encounter as they endeavor to keep their clients from relapsing into homelessness. Working with clients who often have significant, long-term behavioral health disorders coupled with the trauma of homelessness requires a considerable amount of clinical care. Policy makers who are seeking to support PSH projects should appreciate this process and understand that “moving day” is only the end of one story—and the beginning of another. While it is clear that patience is a clinical virtue when working with PSH clients, housing does not remedy a decade of homelessness overnight. Hence, policy makers are also encouraged to be patient when determining funding timelines, outcome measures, resources for staffing, and reimbursement guidelines. As the PSH model expands in communities nationwide and becomes a key model that ends homelessness among those with significant disabilities, there is increasing attention to the outcome measures associated with this approach to housing and health care. At the same time, national economic conditions are compounding the pressure on all funding streams to demonstrate cost-effective results. We would strongly urge resisting any attempt to pare down the resources going into PSH due to its success with reducing public expenditures in other areas of the community (e.g., hospital, jail, etc.) and its effectiveness in ending homelessness. The clinical work that supports PSH clients in housing cannot be rushed, and must be properly understood in order to be sufficiently supported.

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