Housing First and the Role of Psychiatry in Supported Housing

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Introduction

Permanent Supportive Housing provides housing assistance and support services to people living with disabilities including serious mental illness and substance use disorders. The 1987 McKinney-Vento Act, the first-ever federal legislation addressing homelessness and mental illness, established funding within the Federal Department of Housing and Urban Development (HUD) for the development of Permanent Supportive Housing for people who are "chronically homeless." The HUD definition of chronic homelessness is:

> A homeless individual or head of household with a disability that meets the HUD definition of a disability who (a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND (b) has been homeless and living in one of these places continuously for at least 12 months OR on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months…. (Department of Housing and Urban Development 2015, 80 FR 75791)

"Supported Housing" is an evidence-based practice that is a form of Permanent Supportive Housing based on a "Housing First" philosophy. Other forms of Permanent Supportive Housing serve as part of a continuum model of housing to be described below. Housing development based on a Housing First philosophy has been the predominant strategy for moving people who are homeless and living with serious mental illness out of chronic homelessness for the past three decades. Since serious mental illness and substance use disorders are qualifying "disabilities" for admission into Permanent Supportive Housing, mental health care is one of the support services offered in many Supported Housing programs.

The aim of Supported Housing is not only to provide housing, but also to help integrate people into the community as much as possible. Homes are lease-based with the consumer as the leaseholder. Tenancy is contingent on paying rent and abiding by the same tenancy rules governing other renters in the community. Accessing services and participating in treatment are voluntary. Other models of housing for people living with serious mental illness are more structured with programs instead of tenants owning or leasing units and with service and treatment being mandatory. Since the development of the first Supported Housing programs in the 1980s, several studies have demonstrated that the model is both effective at housing retention and also cost-effective (Rog 2004; Rosenheck et al. 2003). Mental health care is a crucial support service that helps many tenants of Supported Housing both to remain stably housed and to be able to work towards recovery. The delivery of mental

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health care in Supported Housing deviates in some ways from care in more traditional brick-and-mortar clinics with advantages and disadvantages described below.

The Need for a New Model of Housing

A significant proportion of single adults who are homeless are living with serious mental illness or substance use disorder or both with estimates ranging from 1/5 to 2/3 (Fazel et al. 2008; Koegel et al. 1988; Roberts 1992; Susser et al. 1993), and serious mental illness is both a cause of homelessness and a factor that causes people to remain homeless (Shelton et al. 2009; Susser et al. 1993).

For the first half of the twentieth century, people living with serious mental illness lived in institutional settings, mainly state hospitals, often involuntarily. In the 1950s and 1960s, two dynamics coincided to trigger a process referred to as "deinstitutionalization" that led to a drastic reduction of this infrastructure. First, the civil rights and antipsychiatry movements spawned a concern about the legitimacy of involuntary institutionalization, especially in the face of some well-publicized abuses at state hospitals (Grob 1980). Second, major changes in the health care economy, including the creation of Medicaid and Medicare, encouraged states to shift some of the cost of care to the federal government (Yohanna 2013). As a result, tens of thousands of people living in institutions were discharged to live independently with family or in "community residences" and were to be served by a community mental health system (Yohanna 2013). Early models of community residences included halfway houses and family foster care but no organized model for residential services for formerly institutionalized people beyond these limited options developed in the first years of deinstitutionalization (Ridgway and Zipple 1990). Over time, community residences became the first step in a "continuum" model which was developed to move people in stepwise fashion from more to less structured and restrictive settings towards the goal of becoming "housing-ready." A person is proved housing-ready by demonstrating insight into their mental illness, compliance with behavioral health treatment, and abstinence from drugs and alcohol.

Operating a residential system based on a continuum model, however, required resources that were never adequate to the need and set a high bar for people to move into less expensive independent housing (Ridgway and Zipple 1990). Moreover, the 1970s and 1980s saw a rise of single, adult homelessness, especially in cities, among people living with serious mental illness with inadequate care or no care at all (Bassuk and Lamb 1986; Cooper and O'Hara 2002; Kushel et al. 2001). Furthermore, people of color have been disproportionately affected by these forces resulting in their overrepresentation among people who are homeless (Fusaro et al. 2018; Uehara 1994). This increase of homelessness in the 1970s and 1980s put pressure on the system to create a different kind of housing.

Coinciding with this increase in homelessness, the mental health community was developing recovery-oriented models of psychiatric care encompassing concepts of consumer choice, harm reduction, and strengths focusing. Out of this confluence rose a "Housing First" philosophy of targeting homelessness. Housing First turned the continuum philosophy on its head proposing that having a home makes it possible for a person to effectively address their mental health conditions which in turn will help a person be successful in housing. The development of Supported Housing, with its emphasis on client choice and community integration, is a logical outcome of this Housing First philosophy and a recovery orientation in general. The prototype of Housing First was a program developed in the 1990s called Pathways to Housing in New York City which placed people in scatter-site apartments with support services delivered by Assertive Community Treatment (ACT) teams (Tsemberis and Eisenberg 2000). Initially there was concern that Supported Housing would not be able to provide adequate support to people who are homeless and living with serious mental illness (Siegel et al. 2006), but numerous studies have since shown Supported Housing programs

to be both effective at providing housing and services and cost-effective (Lipton et al. 2000; Padgett et al. 2016; Rog et al. 2014; Rosenheck et al. 2003; Tsemberis and Eisenberg 2000).

The 1999 Olmstead decision further hastened the expansion of Supported Housing. In 1995, two women living with serious mental illness sued the state of Georgia (Tommy Olmstead was the Commissioner of the State Department of Human Resources) because the women were confined in institutional settings even after being assessed to be better-suited for services in the community. The case made it to the United States Supreme Court which ruled that under the Americans with Disabilities Act, people living with serious mental illness should be cared for in the least restrictive setting possible (Olmstead v L.C. 527 U.S. 581). In the aftermath of Olmstead, jurisdictions have been increasingly looking to Supported Housing to be a "least restrictive setting" for providing housing and care to people who are chronically homeless (Whitley and Henwood 2014).

This chapter focuses on single adults who are homeless. Family homelessness is more often the result of socioeconomic factors like underemployment and domestic violence. Although originally and predominately a practice targeting single, adult homelessness, Supported Housing has been increasingly utilized for families. In 1993, HUD began funding Supportive Housing for families with an adult member living with a disability, and since 2003 HUD funding for families has also been limited to people who meet the chronic homelessness criteria (Gewirtz 2007). Although not yet as widely studied as single-adult Supported Housing, family Supportive Housing does seem to improve housing stability and even reduce emergency department usage among families with an adult living with a disability (Lim et al. 2018).

Permanent Supportive Housing programs are funded in a variety of different ways with some funding coming directly through government contracts and other monies coming from tenant resources. Several different government entities fund housing programs and many programs cobble together contracts from different sources. For example, in New York City, government funders of Permanent Supportive Housing include the federal Department of Housing and Urban Development, the state Office of Mental Health, the city Departments of Health and Mental Hygiene, Housing Preservation and Development, and Homeless Services, and the city HIV AIDS Services Administration. Tenants contribute by paying rent, and there are various ways tenants are supported in making rent including by using Section 8 vouchers or a portion of Supplemental Security Income (SSI) or Public Assistance.

Two Approaches to Supported Housing

Although most Americans who are living with serious mental illness are *not* homeless, an American who has experienced homelessness and is living with serious mental illness often requires housing support, income support, and specialized physical and behavioral health care to remain housed and integrated into the community. As a Housing First model, Supported Housing presumes not only that housing ought to precede other services and interventions, but furthermore that rapidly housing a person in a system where tenancy is not contingent on service participation is a necessary first step towards community integration, psychiatric recovery, and improved physical health. Studies have demonstrated that housing itself is treatment as multiple clinical conditions tend to improve after people are housed even if there is not an accompanying increase in health care utilization (Henwood et al. 2013).

Various features common to all Supported Housing models reinforce housing as foremost above other care and services. Tenancy is contingent on the same laws that apply to any landlord and tenant in the community. There are no curfews. There are few if any limitations on visitors including overnight visitors. Social services, psychiatric care, and sometimes medical care are offered, but there is no obligation to access these services. To support this, having different agencies manage tenancy issues (e.g., rent collection,

building maintenance) and service provision is a common arrangement—the landlord works for a different agency than the social worker.

With all of these features in common, two models of Supported Housing have emerged—scatter-site and congregate (also called single-site or project-based). In scatter-site Supported Housing, a tenant rents an apartment in the community and is offered support services including services that can be offered at home or at an off-site location. In congregate Supported Housing, some portion of apartments in a single building is set aside for consumers, and service providers are often based in the same building. Such buildings typically include units of affordable housing interspersed with apartments for people who are living with an identified disability. There are advantages and disadvantages to each model.

The scatter-site model greatly resembles "normal" housing and offers people more choice. Living in ordinary housing can be a substantial first step towards community integration and sidesteps some sources of stigma. People have more freedom to control their environment and develop their social network, although some report struggling with isolation (Parsell et al. 2015). Start-up and operating costs are lower compared to congregate models as apartments that already exist are utilized instead of needing to manage, or even build, whole buildings. However, scatter-site programs are more vulnerable to the vagaries of the local housing market including fluctuations in supply and rent. An advantage of scatter-site housing for families is the opportunity to locate based on school district (Collins et al. 2016).

The congregate model is more "institutional" and can limit choice, feel restrictive, and contribute to stigmatization (Parsell et al. 2015). Moreover, start-up is expensive and complicated, generally involving building renovation or construction and a cobbling together of multiple funding sources. On the other hand, services are more accessible and easier to provide. On-site project staff can offer social services and psychiatric and medical care to people who might struggle to access these supports independently. A congregate setting allows opportunities for mutual support and community building among tenants living with similar challenges (Dickenson-Gomez et al. 2017; Parsell et al. 2015). Ongoing costs, including rents, can be easier to control. In addition, there can be benefits to the surrounding community. Buildings in disrepair are renovated or empty lots are developed. Programs provide low-income units to the community at large and services to the tenants of those units. The properties sometimes provide storefronts or greenspaces. Program staff patronizes local businesses.

Practicing Psychiatry in Supported Housing

As indicated earlier, many single adults who are homeless or formerly homeless suffer from serious mental illness while at the same time facing many barriers to access effective psychiatric care. Furthermore, serious mental illness often impairs a person's ability to seek and maintain housing. Because of this, many programs serving people who are homeless or formerly homeless place psychiatrists in the field to improve access to care—in drop-in centers, shelters, food pantries, housing programs, and even the streets. As described below, psychiatrists in these settings engage in a lot of activity that is not billable to health insurers, and billable patient encounters do not generate enough revenue to support on-site psychiatry. So, on-site psychiatry practice at programs that serve people with lived experience of homelessness is typically directly funded through the contracts that fund other support services at these programs.

Practicing psychiatry in the field is different from practicing in more traditional clinical settings and there are advantages and disadvantages to practicing in these settings.

Role and Activities of an On-Site Psychiatrist in Supported Housing

A psychiatrist serving a Supported Housing program has a more varied role compared to a psychiatrist at a clinic or other more traditional

treatment setting. A Supported Housing psychiatrist is not only a provider of evaluation and treatment, but can also provide outreach, training, consultation, and technical assistance to help a program's clinical operations. Understanding the different scope of this role ideally enables a Supported Housing psychiatrist to determine how best to harness their expertise to not only deliver state-of-the-art psychiatric evaluation and treatment to this underserved population, but also to influence the processes and culture of program sites.

Outreach and Engagement

People with lived experience of homelessness are often unable or unwilling to access traditional psychiatric services. For example, some people who are formerly homeless, although often eligible for Medicaid or Medicare, still face obstacles to obtaining medical insurance and therefore have no way to pay for psychiatric treatment. Also, many people with lived experience of homelessness are apprehensive about or frankly suspicious of psychiatrists and therefore actively avoid contact with traditional treatment settings. Many people experience offers of services as condescending and believe services available to them to be of low quality (Hopper et al. 1997) or are frankly mistrustful of outreach workers (Kryda and Comptom 2009). Overcrowding at clinics and having to change psychiatrists annually at many clinics also deters people from community mental health clinics. Experience has shown that many people with lived experience of homelessness, however, are more open to contact with a psychiatrist in familiar settings.

Outreach to people with lived experience of homelessness requires a psychiatrist to have a flexible clinical approach and to be able to address people's low expectations about the quality of services offered to them. There is a famous story of a psychiatrist running a bingo game at a shelter that exemplifies the kind of activity a psychiatrist may engage in to build trust among a community of tenants in Supported Housing. Supported Housing tenants who are unwilling to travel to see the psychiatrist, even in congregate programs where the psychiatrist sees patients in the building, may be more receptive to being visited in their apartment. People value their autonomy and so outreach and engagement approaches that respect a person's "expertise concerning his/her situation" have been shown to increase trust of service providers (Piat et al. 2020). People want to be offered services that are professional, expert, and respectful. When people believe this is the case and even begin to expect it, effective working relationships form.

Evaluation

There are significant advantages to performing psychiatric evaluations in Supported Housing settings. Housing staff know tenants very well and are a rich source of information. Interacting in a familiar setting often helps people be more forthcoming with a psychiatrist. Even if a person refuses to meet with a psychiatrist, a fairly comprehensive evaluation is possible based on staff knowledge and psychiatrist observation.

When evaluating a person with lived experience of homelessness, attention to social history can be an invaluable source of insight. Investigating the circumstances that resulted in and maintained a person's homelessness often provides clues about a person's psychiatric condition. For example, a person who denies having paranoid ideas will sometimes speak in great detail about an elaborate conspiracy that led to eviction. Homelessness and unemployment can be conceptualized as symptoms like depression or psychosis that may provide clues to psychiatric conditions. For example, a person who does not complain about depression may reveal periods of anergia and amotivation leading to unemployment. People with lived experience of homelessness also frequently have histories of trauma, education difficulties, and legal troubles that may be clues to psychiatric illness.

Treatment

There are advantages and challenges to providing psychiatric care in Supported Housing. Supported Housing programs offer more support of psychiatric treatment than a home without supports, but less than a hospital. A psychiatrist who is flexible about the frame of treatment can mitigate the

challenges and take advantage of opportunities that are unique to this setting.

In clinics and hospitals, the psychiatrist has a lot of influence or leverage. Most patients either have demonstrated a motivation for treatment by virtue of coming to the office or are involuntarily engaged in treatment. In Supported Housing, on the other hand, where participating in services including psychiatric treatment is voluntary, the psychiatrist must rely more on their ability to convince a person to participate in treatment. This challenge naturally lends itself to a more "person-centered" approach to practice which conceptualizes a patient as a more active consumer of services rather than a passive recipient of treatment. A person-centered approach assumes that people are more likely to participate in, and benefit from, the opportunity to be a partner in care.

Even though most Supported Housing tenants take their own medication, many programs offer medication monitoring to help tenants take medications as prescribed when needed. This has the added benefit of tracking medication usage. Housing staff, however, are generally social service professionals with no training in handling medication, so some programs hire nurses to administer medications.

Most Supported Housing programs do not have blood-drawing capability and many people will refuse to go for blood tests in the community. So prescribing medications requiring blood monitoring is challenging.

Many people may be willing to engage in some kind of treatment but are unwilling to take medication or are only willing to take doses of medication that may be inadequate for therapeutic effect. Because of this, psychotherapy becomes a primary treatment more frequently and for more indications than in other, more traditional settings.

Treatment of psychiatric symptoms is often not a primary concern of Supported Housing tenants. Many people, understandably, identify poverty or unemployment, not psychiatric illness, as their primary problem and attribute this to primarily social, economic, and even political circumstances. Because of this, the extent to which a psychiatrist can convince a person that psychiatric treatment can help a person move towards income and employment often determines how much treatment a person is willing to accept.

Consultation

In addition to having expertise in treating mental illness, psychiatrists also ideally have some expertise in advising social service staff how to effectively work with Supported Housing tenants—psychiatrists are not only treaters of individual "patients" but also are behavioral consultants and system analysts. Thus, a social service team may have difficulty working with a tenant because of some systemic practice that exacerbates that tenant's symptoms. The psychiatrist, not only by virtue of being a behavioral expert, but also by being able to consider a situation from a somewhat outside, objective perspective, may be able to offer valuable insight and advice. For example, a case management team might have difficulty engaging people with schizophrenia because of rigidity about keeping appointments. The psychiatrist might identify this and offer possible ways for the team to be more flexible about scheduling.

Individual case managers also frequently consult with psychiatrists about engagement with individual tenants. These "curbside" consults can be opportunities for the Supported Housing psychiatrist to learn more about the program and its tenants, to contribute to the overall care of tenants, and to provide education.

Liaison

The Supported Housing psychiatrist can be quite valuable in serving as a link between the Supported Housing staff and a tenant's other medical providers in the community. A psychiatrist can often be more successful at making contact with other physicians to begin with and are often more effective at communicating a program's observations and concerns and at interpreting the information provided by off-site providers. Since the Supported Housing psychiatrist is familiar with the limitations of the program, they may also be able to work with an off-site provider to adjust treatment plans to take

this into account, for example, to schedule evening medications earlier in the day when staff are available to assist. The Supported Housing psychiatrist can also be quite effective at advocating for benefits. For example, a Supported Housing psychiatrist is often instrumental in securing Supplemental Security Income (SSI) or Social Security Disability (SSD). A psychiatrist can also coach housing staff about advocating for tenants and coach tenants about advocating for themselves.

Tenant and Staff Education

Offering education can be quite effective at helping both tenants and housing staff to be better able to recognize and manage psychiatric symptoms. For example, education-based programs like Wellness Self-Management (see chapter "Health Self-Management: The Emerging Importance of Trauma and Resilience") have been shown to improve a variety of outcomes. A psychiatrist has multiple options for education including staff meetings, case conferences, lectures, informal consultations for staff and groups, community meetings and individual consultations. A Supported Housing psychiatrist should also try to identify training needs in an ongoing way.

Technical Assistance

Unlike hospitals and clinics, Supported Housing programs are not primarily providers of psychiatric or medical treatment and are therefore usually not experienced at developing or maintaining systems that manage clinical processes. As mentioned previously, although many program sites can "monitor medications" (but are not allowed to "dispense medications"), the policies and procedures in place that govern this activity are not as robust as in hospitals and this can lead to errors in dosing and scheduling of medications and medication changes. A psychiatrist can be very helpful in adjusting medication monitoring policies and in trouble-shooting inconsistencies in medication monitoring procedures. A psychiatrist can also help identify staffing needs including determining how much psychiatry time a program needs.

Coordinating the Work of an On-Site Psychiatrist

The activities of the psychiatrist working for a Supported Housing program described above must be effectively coordinated with housing staff if the psychiatrist's efforts are to be optimally utilized. The usual mechanisms in place in more traditional treatment settings to ensure appropriate scheduling and effective communication between clinicians and housing staff are different or absent from these social service programs. The particular needs and characteristics of this population and the structure of Supported Housing necessitate a careful consideration and planning about how to transform the traditional practice and role of psychiatrists to function effectively in Supported Housing. A psychiatrist typically visits a housing program from a half day per week to two days per week. Attention and planning about how the psychiatrist's time will be utilized and how they will communicate with housing staff will go a long way towards creating an environment that will allow the psychiatrist to be as effective as possible in this limited time. The goal in addressing these process issues then—scheduling the psychiatrist's time and managing communication between psychiatrist and housing staff—is to optimally integrate the psychiatrist into the activity and culture of the Supported Housing program so that a psychiatrist can be as effective and productive as possible.

The Schedule

A system for scheduling is necessary to ensure optimal use of the psychiatrist's time. There are many ways to effectively create and maintain a schedule. At some programs, social service staff maintains the schedule, at others the psychiatrist maintains the schedule, and at still others both program staff and psychiatrists collaborate to maintain a schedule. Not only should tenant encounters be scheduled, but there should also be time set aside for a psychiatrist's other activities such as meeting with staff.

Even a well-conceived system of scheduling will be ineffective if there is not also a system in place to ensure that scheduled activities happen

in a timely manner—having a session scheduled is moot if the tenant does not show up. Again, there are many strategies to effectively use time. At some programs housing staff reminds tenants a day before appointments and then tries to contact tenants who have not shown for their appointments. At some programs housing staff escorts tenants to their appointments.

Although attention to the time management of the psychiatrist is essential, there is a risk of becoming too rigid about scheduling in an attempt to make optimal use of a psychiatrist's time. Some tenants cannot tolerate more than few minutes with the psychiatrist, while others may require more of a time commitment. Some tenants are unwilling or unable to cooperate with scheduled appointments but are instead quite happy to interact with the psychiatrist in a more informal, catch-as-catch-can manner. Also, psychiatrists themselves will individually be more or less comfortable and effective with systems of scheduling of varying flexibility. Part of the circumstance that resulted in consumers (and psychiatrists!) ending up participating in psychiatric treatment in nontraditional treatment settings in the first place is often an unwillingness or inability to tolerate the tightly scheduled structure of traditional treatment settings. Utilizing a psychiatrist's time requires a balance between being flexible enough to accommodate those who cannot tolerate too much structure and paying enough attention to scheduling to prevent ineffective, empty time.

Communication with the Psychiatrist

Information makes psychiatric evaluation and treatment possible. Housing staff's knowledge about a consumer is invaluable to the psychiatrist and the psychiatrist's access to this knowledge is probably the most significant advantage a Supported Housing psychiatrist has over a clinic- or office-based psychiatrist. Furthermore, a Supported Housing staff's access to the psychiatrist can be invaluable to a housing staff's understanding of a tenant and their treatment.

Psychiatrists must also effectively communicate orders and recommendations. Some communications are about *orders*, for example, about medication changes and follow-up appointments. The psychiatrist may also make *recommendations* about other issues, for example, about appropriate housing placement or about money management. Of course the expectation is that orders are executed faithfully, while recommendations may or may not be accepted. There are multiple strategies a program staff and psychiatrist can employ to ensure effective communication:

1. *Sign In and Sign Out*

A housing program should identify a liaison between housing staff and psychiatrist who meets with the psychiatrist regularly, preferably each time the psychiatrist is working for the program. This meeting might be a sign-in or sign-out meeting and preferably both happen. The sign in is most useful for the psychiatrist to learn about what has been going on with tenants since the psychiatrist's last visit. The sign in can also be a time to review the day's schedule and strategize about the day's appointments and other activities. For example, the sign in is often a good time to strategize about outreaching to a tenant who frequently misses appointments. The sign out is most useful for the program staff to understand the psychiatrist's treatment decisions. A very important aspect of this is communication about the timing of medication changes. A psychiatrist may make a decision and document this decision about a medication change early in the day while the sign out, when communication about this change happens, may not happen until the end of the day. At sign out, then, the psychiatrist and liaison should decide when the medication change should take effect taking into account the time that might be needed to obtain new medications from a pharmacy. Obviously, if the psychiatrist decides a medication change should occur immediately, they should not wait for the regularly scheduled sign out or for housing staff to read about the medication change in the sign-out note.

Sign-in and sign-out meetings need not only be with one liaison. On the contrary, especially

the sign-out meeting is probably even more effective as a staff meeting.

2. *Staff Meetings*

Periodic staff meetings with the psychiatrist can be a very valuable adjunct to the regular meeting between the program liaison and psychiatrist. Staff meetings similar to hospital clinical rounds help a housing staff and psychiatrist collaborate to formulate, understand, and plan for the execution of treatment and service plans. There is also the opportunity to assess the effectiveness of treatment plans already in place. Case conferencing allows a housing staff to collaborate more thoroughly with the psychiatrist about particularly complicated or difficult clinical situations. Housing staffs should also consider inviting the psychiatrist to give trainings or lectures about psychiatric evaluation and treatment.

3. *Phone Calls*

The Supported Housing psychiatrist should be available by phone to consult about emergent or urgent issues that arise at times when the psychiatrist is not on site. Examples of situations to call the psychiatrist include consulting about missed or improperly taken medication doses, consulting about emerging or changing side effects, requesting that the psychiatrist contact the emergency room to communicate about a tenant who has been taken there, or consulting about a tenant's suicidal, dangerous, or nuisance behavior. Calling the psychiatrist, however, is not a replacement for calling 911. Some emergent situations, for example, when a tenant is violent, require that 911 be called and housing staff should not call the site psychiatrist in lieu of this. Also, care should be taken to prevent an overwhelming number of calls to the psychiatrist. Having the liaison be the single point of contact can help streamline these communications.

4. *Clinical Charting*

A system is required to keep medical records that are complete, accessible to the psychiatrist and other staff involved in the tenant's care, and inaccessible to unauthorized staff and other consumers. Psychiatrists will document treatment and interventions that are meant to be acted upon in a timely manner and therefore appropriate staff, e.g., the liaison to the psychiatrist or the tenant's case managers should read and appreciate clinical notes the same day the psychiatrist writes them. The psychiatrist must be mindful of time-sensitive data, for example, medication changes, and should decide if they must communicate with housing staff prior to their reading of clinical notes. The psychiatrist and housing staff are often charting in different electronic records with varying levels of connectivity, including no connectivity, between these records. Therefore, the psychiatrist and housing staff should develop a system to ensure timely delivery of treatment records to housing staff (e.g., by e-mailed PDFs through a secure e-mail system, or even providing hard copies).

Making the Team Approach Work: Managing the Collaboration

Psychiatric practice in a clinic or medical center is typically a one-to-one endeavor with psychiatrist and patient making up a dyadic treatment team with little influence from others. A psychiatrist at a Supported Housing program, however, is part of a service team and the psychiatrist's treatment is one of multiple services that are offered to tenants.

A team approach to service provision is associated with multiple advantages. As mentioned above, team members have access to different information about tenants providing more data about people than any one service provider would have access to individually. For example, an employment specialist may know about symptoms a person experiences at work that the person does not express to their psychiatrist. Team members can coordinate services and ensure that these services are not at cross-purposes with each other. A psychiatrist and social worker can make sure they share a consistent psychological understanding of a person that promotes similar

psychotherapeutic interventions. Team members can support each other's practice. Social work staff monitors medications prescribed by psychiatrists. Psychiatrists liaison between social service staff and medical providers.

A hazard of the team approach, however, is the risk of blurring boundaries between professional roles. Is deciding what frequency of medication monitoring a person ought to have a clinical issue or a case management issue? If it is a little of both, who ought to decide if there is disagreement between psychiatrist, medical provider, and social service staff? Is deciding if a person ought to be on money management a clinical or case management issue? The Social Security Administration requires that a physician sign off on involuntary money management of disability benefits, but is not bill paying less of a clinical issue than medication taking? Even a role as clearly medical as medication prescribing is also partly a case management issue. A tenant in a Supported Housing program is not only a patient of a psychiatrist but is also a member of a community that is affected by the behavior of its members. Housing staff may seek pharmacologic intervention, among other interventions, to address disruptive or dangerous behavior.

In the midst of this potential blurriness, systematic, crystal-clear communication and disciplined, consistent spheres of responsibility are necessary for optimal functioning. Psychiatrists have final say on medication treatment, but also have a responsibility to ensure that other team members understand medication decisions. Housing staff faces management decisions when the psychiatrist is not working for the program, but also have a responsibility to consult with their psychiatrist if these decisions can affect tenants clinically (e.g., changes in medication monitoring). There should be an effective process for addressing disagreements between team members. For example, if a psychiatrist and social worker disagree about a medication treatment, that psychiatrist and social worker could present this disagreement as a team to a supervisor. The psychiatrist is ultimately responsible for medication decisions, but consulting a supervisor may result in alternative solutions or help either party change their opinion. Similarly, if there is a disagreement about the frequency of medication monitoring, consulting with a supervisor might yield alternative solutions.

Co-locating a psychiatrist and a social worker does not make a team. Teamwork requires clear, frank communications, mutual respect and understanding of roles, and separate, defined spheres of responsibility. Team leaders should support and nurture this kind of teamwork while at the same time keeping a clear eye on how decisions ultimately get made, executed, and communicated about.

Psychiatry in Supported Housing: Community Psychiatry in Action

What is the value of a house call versus care in a clinic, office, or medical center? Office-based settings offer access to medical technologies and procedures that cannot be replicated in a home, but the processes and structures of office-based practice can be a barrier to ongoing, productive engagement in psychiatric care. And more than other branches of medicine, psychiatric care is often suboptimal or even ineffective without effective engagement between provider and patient—the relationship is the treatment. That community psychiatry exists in the first place is due to opportunities to nurture provider-patient relationships in the community that are difficult to sustain in more traditional treatment facilities. Furthermore, practicing psychiatry in the community promotes collaboration with other service providers that also supports networks of engagement—true interdisciplinary practice is easier in community settings. Practicing psychiatry in Supported Housing offers both clinician and patient an opportunity to benefit from these possibilities of community psychiatry. The psychiatrist comes to the patient and joins their circle of care, and there is an opportunity for integration into the community. In today's health care environment, this kind of on-site care offers an accessible, effective resource to pursue meaningful recovery to an underserved and often disenfranchised population.

References

Bassuk E, Lamb R (1986). Homelessness and the implementation of deinstitutionalization. In Bassuk E (Ed.) The Mental Health Needs of the Homeless. San Francisco: Jossey-Bass.

Collins C, D'Andrea R, Dean K, Crampton D. (2016). Service providers' perspectives on permanent supportive housing for families. Families in Society: The Journal of Contemporary Social Services, 97(3), 243–252.

Cooper E, O'Hara A(2002). Priced out in 2002: Housing crisis worsens for people with psychiatric disabilities. Boston, MA: Technical Assistance Collaborative.

Department of Housing and Urban Development. (2015). Homeless Emergency Assistance and Rapid Transition to Housing: Defining "Chronically Homeless." Federal Register. 80, 75791–75806.

Dickenson-Gomez J, Quinn K, Bendixen A, Johnson A, Nowicki K, Ko Ko T, Galletly C. (2017). Identifying variability in permanent supportive housing: a comparative effectiveness approach to measuring health outcomes. The American Journal of Orthopsychiatry, 87(4), 414–424.

Fazel S, Khosla V, Doll H & Geddes J. (2008). The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS Medicine / Public Library of Science, 5, e225. https://doi.org/10.1371/journal.pmed.0050225

Fusaro, VA, Levy, HG, Shaefer, HL. Racial and Ethnic Disparities in the Lifetime Prevalence of Homelessness in the United States. Demography 55, 2119–2128 (2018). https://doi.org/10.1007/s13524-018-0717-0

Gewirtz AH. (2007). Promoting children's mental health in family supportive housing: a community-university partnership for formerly homeless children and families. J Primary Prevention. 28:359–374.

Grob GN. (1980). Abuse in American mental hospitals in historical perspective: myth and reality. International Journal of Law & Psychiatry, 3, 295–310. https://doi.org/10.1016/0160-2527(80)90009-6

Henwood BF, Cabassa LJ, Craig CM, Padgett DK. (2013). Permanent Supportive Housing: Addressing Homelessness and Health Disparities? American Journal of Public Health, 103, S188–S192. https://doi.org/10.2105/AJPH.2013.301490

Hopper, K., Jost, J., Hay, T., Welber, S., Haugland, G. (1997). Homelessness, severe mental illness, and the institutional circuit. Psychiatric Services, 48, 659–665.

Koegel P, Burnam MA & Farr RK. (1988). The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles. Archives of General Psychiatry, 45, 1085–92. https://doi.org/10.1001/archpsyc.1988.01800360033005

Kryda, A. D., & Comptom, M. T. (2009). Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. Community Ment Health J, 45, 144–150.

Kushel MB, Vittinghoff E, Haas JS. (2001). Factors Associated With the Health Care Utilization of Homeless Persons. JAMA. 285(2):200–206. https://doi.org/10.1001/jama.285.2.200

Lim S, Singh TP, Hall G, Walters S, Gould LH. (2018). Impact of a New York City supportive housing program on housing stability and preventable health care among homeless families. Health Services Research. 53:5,Part I;3437–3454. https://doi.org/10.1111/1475-6773.12849

Lipton FR, Siegel C, Hannigan A. (2000). Tenure in supportive housing for homeless persons with severe mental illness. Psychiatric Services. 51:479–486.

Padgett DK, Henwood BF, Tsemberis SJ. (2016) Housing First: Ending Homelessness, Transforming Systems, and Changing Lives. New York: Oxford University Press.

Parsell C, Petersen M, Moutou O. (2015). Single-site supportive housing: tenant perspectives. Housing Studies, 30(8), 1–21.

Piat M, Seida K & Padgett D. (2020). Choice and personal recovery for people with serious mental illness living in supported housing. Journal of Mental Health, 29, 306–313. https://doi.org/10.1080/09638237.2019.1581338

Ridgway P, Zipple, AM. (1990). The paradigm shift in residential services: From the linear continuum to supported housing approaches. Psychosocial Rehabilitation Journal, 13(4), 11–31. https://doi.org/10.1037/h0099479

Roberts, M. (1992). The prevalence of mental disorder among the homeless: A review of the empirical literature. In Janiel R. (Ed). Homelessness: A Prevention-Oriented Approach. Baltimore, MD: Johns Hopkins University Press.

Rog DJ. (2004). The evidence on supportive housing. Psychiatric Rehabilitation Journal. 27:334–344.

Rog DJ, Marshall T, Dougherty RH, George P, Daniels AS, Ghose SS, et al. (2014). Permanent supportive housing: assessing the evidence. Psychiatric Services, 65, 287–94. https://doi.org/10.1176/appi.ps.201300261

Rosenheck R, Kasprow W, Frisman L & Liu-Mares W. (2003). Cost-effectiveness of supported housing for homeless persons with mental illness. Archives of General Psychiatry, 60, 940–51. https://doi.org/10.1001/archpsyc.60.9.940

Shelton, K, Taylor, P, Bonner, A & van den Bree, M. (2009). Risk Factors for Homelessness: Evidence From a Population-Based Study. Psychiatric Services, 60(4), 465–472. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=ovftj&NEWS=N&AN=00042727-200904000-00011.

Siegel CE, Samuels J, Tang DI, Berg I, Jones K & Hopper K. (2006). Tenant outcomes in supported housing and community residences in New York City. Psychiatric Services, 57, 982–91. https://doi.org/10.1176/ps.2006.57.7.982

Susser E, Moore R & Link B. (1993). Risk factors for homelessness. Epidemiologic Reviews, 15, 546–

56. https://doi.org/10.1093/oxfordjournals.epirev.a036133

Tsemberis S & Eisenberg RF. (2000). Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatric Services, 51, 487–93. https://doi.org/10.1176/appi.ps.51.4.487

Uehara, ES (1994). Race, gender, and housing inequality: An exploration of correlates of low-quality housing among clients diagnosed with severe and persistent mental illness. J Health and Social Behavior. 35, 309–321.

Whitley R, Henwood BF. (2014). Life, liberty, and the pursuit of happiness: reframing inequities experienced by people with severe mental illness. Psychiatric Rehabilitation Journal, 37, 68–70. https://doi.org/10.1037/prj0000053

Yohanna D. (2013). Deinstitutionalization of People with Mental Illness: Causes and Consequences. Virtual Mentor, 15(10), 886–891. https://doi.org/10.1001/virtualmentor.2013.15.10.mhst1-131