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SMI Severe Mental Illness Program

Housing First

The Pathways Model to End Homelessness for People with Mental Illness and Addiction

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Chapter 4

An Interdisciplinary Approach

How the ACT and ICM Teams Serve Clients in a PHF Program

The idea, the principle, is that we're all working together toward the same goal: the person is in charge.

—Juliana Walker, training director, Pathways to Housing, Inc.

IN THE PATHWAYS HOUSING FIRST MODEL, two types of teams typically provide treatment and support services. A PHF assertive community treatment (ACT) team generally serves clients with severe psychiatric disabilities, and a PHF intensive case management (ICM) team generally serves those with more moderate disabilities. Any of these clients may also have alcohol and other substance use problems. Both of these PHF teams are community-based and interdisciplinary, and both meet clients in their own environments to flexibly provide a wide array of support and treatment services. While larger PHF programs may utilize both ACT and ICM teams, smaller programs might choose one or the other.

A Community-Based Interdisciplinary Approach

By using ACT or ICM teams, the same staff can conduct outreach and engage clients living on the streets, assist them in finding and moving into apartments, and then

continue to provide treatment and support until the client graduates from the program. This kind of continuity of care is very well suited for clients with long histories of frequent and fragmented interactions with social, mental health, addiction, and criminal justice systems. It is also an effective alternative to most continuum of care systems that use separate programs to provide this array of services.

Once the client is housed and begins to feel safe and secure, the work of these support and treatment teams begins to focus on resolving other problems. The teams are prepared to assist clients with their emerging needs; these can range from legal issues to loading a washing machine, from obtaining a physical exam to seeing a psychiatrist. These are highly individualized services that move at the client's pace, because it is the client who determines the type, sequence, and intensity of the services.

The ACT or ICM team is the client's point of entry into the PHF program, and it also provides the continuity. Team members bear the responsibility of successfully engaging clients, welcoming them to the program, and demonstrating the respect and compassion that is at the foundation of all services offered by this intervention. One of the keys to the program's success is selecting and training staff members who share the humanitarian and social justice values upon which the PHF program is based.

This chapter outlines the history, philosophy, and key activities of the PHF ACT and ICM teams, including the comprehensive assessment and treatment planning process and the all-important home visit. Chapter 5 covers some of the clinical operations of the ACT team, and chapter 6 discusses ICM teams in more detail.

Matching Clients with the Right Level of Service

As noted, PHF programs can use either ACT or ICM teams to provide the treatment and support component of the program. Assertive community treatment (ACT) services are geared toward clients with more severe mental health problems. Despite the name, intensive case management services are a step *down* in intensity from ACT services. From a diagnostic perspective, ICM clients generally do not have an Axis I diagnosis of moderately severe mental illness, which includes a range of personality disorders, PTSD, behavioral characteristics, and addiction disorders that compromise their ability to manage their lives. They are also chronically homeless and frequently go in and out of detox, emergency rooms, hospitals, or jails.

A quadrant classification system can be used to describe the mix of co-occurring diagnoses.

Psychiatric Disability	High	Psychiatric Disability	High
Substance Abuse	Low	Substance Abuse	High
Psychiatric Disability	Low	Psychiatric Disability	Low
Substance Abuse	Low	Substance Abuse	High

Clients served by ACT teams would be described by the top row: all have high severity of psychiatric disability (schizophrenia, psychotic spectrum, or major depression) and can have either high or low levels of addiction. The most vulnerable group is classified as high on both psychiatric disability (PD) and substance abuse (SA) because they often also have a host of acute and chronic health problems.

Clients served by ICM would have a moderate mental illness but are still incapacitated by it; they would be rated moderate on PD (or they once had high PD but are in remission), and they can have either low or high levels of SA.

ICM services are also made available to clients on the ACT team who are recovering and who no longer need the ACT level of intensity. Because clients' lives and their diagnoses are fluid and not static or fixed entities, it is possible that the same client may start out receiving ICM services and after a time, because of their changing needs, he or she can be moved to ACT and vice versa.

Some PHF programs use ICM services to serve clients with both severe and moderate psychiatric disabilities and addiction disorders. Clients with severe mental illness are best served by an ACT team; however, an ICM team can easily be modified to be "ACT lite" by adding a part-time psychiatrist or psychiatric nurse practitioner. This is a viable option and may be necessary because of a program's funding constraints. Other agencies may need to use ICM teams because they are small programs serving fewer than thirty or forty clients and the size of the program does not support ACT staffing levels.

ACT and ICM Teams: Differences and Similarities

Let's briefly compare the two models to see how each contributes to the overall PHF program. There are a number of structural and practice differences between the ACT

and ICM teams: different staffing patterns, client-to-staff ratios, and costs. Within the PHF program, ACT members tend to work as a team with clients; these teams are staffed with specialists that provide services directly. Because of the population it serves, the ACT team includes a nurse, addiction specialist, peer specialist, psychiatrist, social worker, and housing specialist. In contrast, ICM teams in the PHF program are staffed with generalists who broker specialty services. These teams work one on one with clients.

In the PHF context, the similarities of the two models exceed their differences, partly because both are usually modified to better meet the needs of the clients. Both provide around-the-clock on-call services. Both address housing issues: because they operate in a PHF context, significant time is devoted to addressing the housing needs of clients by providing the support necessary to promote the successful transformation from a lifestyle based on street survival to the citizenship required for successful community integration.

Finally, both PHF teams share the same recovery-focused treatment philosophy. Because of the continuity of treatment in this model, team members get to work closely with the clients and really get to know them. This allows a highly individualized treatment approach, which is at the foundation of a recovery-focused practice. In such an approach, there is an understanding and appreciation that no two clients are the same and that every client's journey in recovery is unique.

In the PHF context, both ACT and ICM teams provide the type of support that promotes community integration. Both connect clients with self-help and peer support groups as well as with more general supports that reinforce the recovery process, including spiritual, family, and community services. The teams also assist recovery by continuously providing choice, hope, and acceptance, and by helping clients develop meaningful, productive lives.

Comprehensive Assessment and Treatment Planning

In the PHF model, both types of teams—ACT and ICM—structure their operations around a comprehensive assessment and treatment plan for each client. This plan includes a number of life domains such as health, housing, employment, family and social network, and addiction. It also includes the client's Wellness Recovery Action Plan (WRAP, a very useful instrument developed by Mary Ellen Copeland), which reflects the client's strengths, needs, interests, and goals.

The WRAP is developed jointly with the client and defines a course of action for achieving immediate, near, and future goals. The plan provides an agenda and a structure that guide most interactions between the team and the client, the work of the team, and some of the life domains of the client. The plans are prepared carefully and with the full understanding that they reflect only a partial reality of the clients' lives, that clients have much more complex lives than what is written on their treatment plans.

While team members can help clients identify some areas in which they want to effect change in their lives, the client ultimately determines what, when, and how he or she wants to change. When a goal is identified, it is broken down into a number of action steps with a timeline for completion that the client determines. This timeline provides the client and the team with a useful map—an agenda that describes a course of action to realize each goal.

The following structure offers a framework for identifying and organizing clients' goals:

1. Client's goal
2. Client's role or steps to be taken
3. Team's role
4. Time frame or frequency of action

For example, a client might express the goal "I don't want to be stressed out." To achieve this goal, the client explains that exercise and meditation might be helpful. The client's role will be to

- exercise at the YMCA twice a week
- practice meditative breathing techniques for five minutes three times a week

The immediate next steps for the team's role will be to

- provide the client with a letter to buy a discounted YMCA membership
- plan a time to take the client on a tour of the YMCA to learn about using the facility

- have the wellness specialist review meditative breathing exercises with the client that week

During the initial assessment and treatment-planning interview that typically occur while the client is still homeless, almost invariably clients relate that housing and housing-related concerns are of primary importance. Since the PHF model provides housing without requiring the client to begin treatment, this first goal can be quickly met. Concerns such as small repairs, issues with the building management, neighbors, lease signing, rent payments, or other matters related to renting and maintaining an apartment are always a part of the housing-related goals conversation between the PHF team and the client.

With their housing goals achieved, it becomes possible for clients to begin to focus on other goals, most of which are broader and cover various aspects of the client's life. For example, clients have often lost contact with family members, but since they are now a part of the PHF program, they are in a position to renew past relationships with relatives. Clients' goals are as numerous and diverse as the clients themselves. Goals may include getting new dentures, obtaining a driver's license, visiting relatives, losing weight, eating healthy food, getting a job, getting off medication, getting on medication, reducing drug use, writing poetry, staying out of the hospital, getting a girlfriend or boyfriend, taking a photography or yoga class, going to the library, getting new eyeglasses, or becoming clean and sober.

One of the PHF program outcomes that providers of "treatment, sobriety, then housing" programs may find surprising is that most PHF clients list mental health treatment and substance abuse treatment as important goals *after* they are housed. *Moving into an apartment of their own creates a fundamental change in clients' motivation; it increases their investment in participating in the program and becoming an active participant in their own recovery.*

"Wow, I have my own place," reflected Stan, soon after moving in. "Now," he continued, "how do I keep it?" For Stan, "keeping it" meant taking immediate steps to reduce his drinking. For others, such as clients who still find it difficult to relax their vigilance or get a good night's sleep even after being housed, the next step might be seeing the program's psychiatrist to get medication that has helped them in the past. Other frequently reported goals include finding a job and a relationship. Addressing health concerns is also near the top of clients' lists.

Perhaps the most valuable lesson learned from the PHF program is that clients who are seemingly incapacitated and who face multiple challenges are, in fact, capable of setting and meeting their own goals for housing and treatment *if* they are provided with the right resources and support.

Treatment planning should be an active and dynamic process. As one goal is reached, another new goal emerges—often one never before considered possible. For example, Stan's initial goal was to stop drinking in order to keep his apartment. At that point he could not imagine that two years after his first AA meeting he would be invited to be a keynote speaker for his state's annual AA meeting. The successful realization of one goal creates opportunities to develop and achieve higher ones—goals that may have once been unimaginable.

The journey of recovery is an individual journey, and it is a journey of awakenings. Each client must be awakened from their hopelessness and helped to realize his or her own dreams. Many clients have had their hopes and dreams dashed by years of homelessness and negative, stigmatizing myths about mental illness and addiction. Team members can play a very useful role in the awakening and goal-setting process. Ideally, this is a synergistic process in which team members develop a trusting and collaborative relationship with clients, asking the important questions that invite and challenge clients to consider constructing a life that was once beyond their dreams.

The Art and Science of the Home Visit

> *The home visit is the heart and soul of the work we do, because I think that's ultimately where you want the change to happen, you know, in the person's environment.*
>
> **—Adam Fussaro, Pathways to Housing Philadephia**

Conducting a home visit is one the most important interventions for the clinical and support services teams. The client's home is the stage where many of the team services are performed. In this section we will define the elements of the home visit and describe how to conduct an effective one.

The home visit serves many purposes. It is both casual and focused. On any given day, PHF team members must make many home visits, so they need to be

efficient, prepared, and organized. This is not simply a social call; it is a targeted intervention. In the words of Buddy Garfinkle, MSW, a training consultant for Pathways to Housing New York:

> If you start to run the numbers and you see how much time you have for face-to-face contact with individuals—it's not that much. It's really not that much. How many people on your team's caseload? Sixty? Eighty? A hundred? You make the home visit, you better have a good idea of what it is that you're trying to accomplish.

The home visit is not like a formal therapy session, but since it is a clinician who is visiting the home of a client, there is treatment going on. The team member is not visiting to provide a prescribed treatment—the home visit is more like a visit to invite the client to participate in treatment or develop a plan for productive, meaningful activity.

The emotional tone is much like that of a visit with a relative. It begins with a warm, respectful greeting: "Good to see you." "How are you?" The conversation begins with the issues currently being addressed by the client and the team, usually the ones discussed during the treatment or WRAP plan session, and it may evolve into developing new plans or activities. The visit is warm, caring, and casual—but it is also a mandatory, targeted intervention. Balancing all of those different and somewhat orthogonal components requires a thoughtful and insightful approach, which is why we refer to the *art and science* of the home visit.

For best results in ensuring the client is home when the team visits, the visit must be scheduled in advance. It is useful to schedule all home visits for the month at the beginning of each month and at a time that is convenient for the client. In this way, the client can anticipate and prepare for the visit. Team members prepare for the home visit by reading the client's most recent progress notes and reviewing the client's goals, so there can be effective follow-up during the visit.

Often, a visit starts in the home and ends up in the community. (For an example, see ICM team leader Sarah Knight's daily log in chapter 6.) Team members often meet clients at their homes and escort them to a clinic or other appointment, or meet them at home and then go shopping with them or take a walk around the neighborhood. These outings are important because they also provide the team

member an opportunity to observe how clients interact with others in their own communities.

The primary purpose of the home visit is to ensure the client's well-being. The home visit provides a candid picture of how a client is managing in the apartment and in the building. The team can also observe the client's mood, health status, and physical condition. Above all, the purpose of a home visit is to check in and monitor a client's progress from week to week.

The second most important reason for the home visit is to ensure that clients are managing well as tenants and that their apartments are in good shape. In partnership with the client, the PHF program is also responsible for the apartment, especially in instances when the program is paying a significant portion of the rent. In some sense, the program is like a housing provider, and it assumes the risks of a housing provider. For example, if anything breaks in the apartment—not because of what the client does, but from natural wear and tear—the team member can help the client assess the damage during the next home visit and contact the landlord. If the client asks for help, the team member can call the landlord and advocate on the client's behalf.

Much can be observed during a home visit, notes Ben Henwood of Pathways to Housing Philadelphia:

> When you're doing home visits, you'll just get a lot of information. I mean some people are still in their place after a months and what you see is the furniture they moved in with, and groceries that they've bought, and there's nothing else in there. . . some people will live like that for a while. There are others who will move in right away and make it more of a home by putting pictures up and having personal effects around.

Team members can learn an enormous amount about clients by carefully observing their living spaces. They might notice half-empty wine bottles on the kitchen counter. They might wonder, who are the people in the new picture taped to the fridge? Whose shoes are those placed next to the client's by the doorway? How comfortable is the client in his or her home? Has he or she unpacked everything since moving in? What is the condition of the apartment: tidy or messy? Is there evidence that the client cooks meals? These observations and questions may be

addressed or they may also be stored as points of reference and can be returned to during a future visit. This is a long-term relationship, and engagement, trust, and disclosure travel on a long-term trajectory.

Answers to these questions and observing the client's mood and response to the visit will inform the way the team approaches the client, which could prevent a possible psychiatric or housing crisis. Adam Fussaro, MSW, of Pathways to Housing Philadelphia, put it this way:

> You get certain cues—like if the person is typically talkative and they're kind of reserved. That might be a cue that something is going on. If they're usually well groomed and if they have a less clean look, then maybe things are kind of deteriorating psychiatrically. You get clues into what's really going on in their apartment. And, on the practical side, you can support people better that way.

Another purpose of the home visit is to provide services such as counseling, medication delivery, and practical support, such as bringing medication or tools to help a client fix a leaky faucet. Treatment visits, however, can be daunting for some clients and require patience and creativity. For example, one of the team nurses needed to make daily visits to a client with severe diabetes in order to check her blood sugar level. The client was very frightened of the needle stick and initially resisted the test. To help make the visit and the procedure as comfortable as possible, the client and nurse informally developed a routine wherein the nurse enters the apartment and says hello, and the client says hello and sits down. The nurse then gets a glass of water for the client and they spend the next several minutes talking about the client's favorite sports team. Eventually, the nurse asks to check the client's blood sugar level, and the client agrees.

Yet another purpose of the home visit is to create an opportunity to connect and work on developing a deeper and more authentic relationship with the client. To do this, team members must be focused, but not hurried. Building a relationship takes time—especially when some clients are suspicious of a team's motives and are convinced that the team has the power to take the apartment away (which they do not). During the early phases of the program, clients may deny problems or troubling issues they face. To foster trust, team members must convey acceptance and concern—not judgment.

Consider the following exchange between Jen Walker and Ben Henwood, staffers at Pathways to Housing Philadelphia.

> **Ben:** *You know this is a long process and it's really getting to know people...*
>
> **Jen:** *We're in the very baby stages of these relationships that are going to be very long term, which is exciting, but progress can be slow in terms of getting to know folks and having a level of trust that enables them to tell us what's really going on. I also still feel like with most of my clients, it's like, "When is the other shoe going to drop? When are they going to catch me doing something that's going to mean I'm going to lose my apartment?" They still want to put on this front that everything's fine.*
>
> **Ben:** *And we've seen that play out. There was a couple that was living together and both were using and hiding their* IV *drug use from us. We slowly talked about that, and we talked about needle exchange and harm reduction. A week later, we got a call from one of them saying, "My partner's overdosed. I didn't know who to call and I called you." And that was the opportunity for us to go over. It was a life-and-death situation and that changed things. Since then, the conversation has looked a lot different. I think that's when they finally realized they could talk to us about what's going on. Up until then they felt like they needed to hide it. So, it takes time and it takes those sorts of occasions sometimes. There was nothing we could have done up until then that would have convinced them otherwise.*

One of the interesting things about a home visit is the way it creates a shift in power dynamics between client and staff. The home visit, after all, occurs on the client's own turf. This, coupled with the PHF program philosophy that housing is a right and not dependent on a client's participation in treatment, poses an interesting challenge for the team member. The challenge for the staff is to engage the client into treatment when treatment is not mandatory. Short, hurried visits or an absent client when the team comes to call can be indications that the team is *not* engaging well with a client. The client's degree of engagement can be one indicator of the staff's clinical skills. Another measure of the team's success is the extent to which they are warmly welcomed into their clients' apartments.

Surprise home visits should occur only if there are concerns that a client is in danger or hurt and only after all other ways to contact the client have been exhausted. It is rarely necessary for PHF team members to use their duplicate keys to enter a client's home after several warnings, but it does occasionally happen. Buddy Garfinkle, training consultant at Pathways to Housing New York, had this comment:

> There are no stinkin' rules in ACT or ICM. You better provide services to people that are in line with what they want or they're not going to open the door, or they're going to be in the house and they're going to pretend they're not there, or they're not going to be there when they know that you're coming, or when you walk in they're going to flip you off—because they can. So, the whole power dynamic changes in ACT, and that's a good thing.

The home visit, both in its form and content, provides a wealth of information about the client, the client's living conditions, the staff, and the condition of the treatment relationship. It is a microcosm of the entire program. Most of the work of the program takes place during the home visit. The teams continue to visit their clients and they bring them caring and questions: "How are you?" "How can I help you?" They try to keep the door open, and they seek to open new doors, all by asking the right questions.

Renewing Team Practice and Team Process

In the Pathways Housing First program setting, it is very useful for clinical teams to devote one meeting per month (or more during start-up) to exploring their own team process. Day-to-day life on either an ACT or an ICM team is very busy and allows little time for personal reflection, let alone reflecting on team process. The team can review its efficiencies and inefficiencies, examine incidents that were managed well and others in which there is clear room for improvement, develop team goals much like the team does for clients, and even create a Wellness Recovery Action Plan for the team.

On occasion, the PHF team is well served by a day-long team retreat. A retreat is a great time to reflect on one's own work and the work of the team, to relax and enjoy each other's company, and to replenish and recharge for the work ahead.

Chapter 4 Summary

In the Pathways to Housing program, clinical and support services are provided by **assertive community treatment (ACT) teams** and/or **intensive case management (ICM) teams.** ACT teams generally serve clients with severe psychiatric disorders and work as a team; ICM teams serve those with moderate psychiatric disorders. While an ACT team is typically composed of specialists, ICM teams are composed of generalists who work individually; they also broker services from other agencies and entities. Both types of teams manage a wide array of clinical and support services, delivered mostly in the client's own environment.

For both ACT and ICM teams, the clinical relationship to the client is based on a **comprehensive assessment and treatment plan**. This plan covers a number of life domains such as health, housing, employment, family and social network, and addiction. It also includes the client's Wellness Recovery Action Plan (WRAP), which is based on the client's strengths, needs, interests, and goals.

Both types of teams also conduct **home visits** with clients. These visits occur frequently when a new client occupies an apartment, then typically taper to once a week, then less often over time. The home visit offers the clinical team insight into the client's health, well-being, and adjustment to the apartment and the community. It also offers an opening for discussing goals and other treatment-related topics.

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