Iowa's Center of Excellence for Behavioral Health

Evidence-Based Practices in Behavioral Health Summit

UNIVERSITY OF IOWA HEALTH CARE

PSH + ACT: Two Great Tastes That Taste Great Together!

Erin Sullivan & Leah Appell

September 29, 2023

Learn. Support. Advance.

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ACT Overview
The People Served

- ACT is for persons with serious mental illness
  - Schizophrenia and schizoaffective disorder
  - Bipolar and severe depressive disorders
- ACT in the Continuum of Care:

Outpatient

Supported Community Living

Assertive Community Treatment

Residential Care

Acute Hospitalization

ACT at UIHC
Key Features

- Team approach- integrated and coordinated care
- Intensive services – 24/7 availability
- Locus of care in the community
- Low patient/staff ratio (8:1) which allows visits up to twice/daily and flexibility up or down depending on how the client is doing
- Assertive outreach (no stone unturned!)
- Available long term (time-unlimited traditionally)
- Intensive + flexible + comprehensive

ACT at UIHC
The IMPACT Program – Admission Criteria

- Diagnoses - Schizophrenia, Schizoaffective, Bipolar Disorder, refractory Depressive Disorder
- High frequency/utilization of services
- Funding source
- Proximity to Iowa City (25-mile radius, or 30 minutes “windshield” time)

Permanent Supportive Housing

Evidence-based housing intervention prioritized for individuals with complex health and behavioral health issues for whom homelessness has become a chronic condition and has been proven to significantly reduce returns to jail and homelessness, reliance on emergency health services, and improve overall quality of life.

It is permanent, affordable housing combined with flexible, voluntary support services.

Approach to Care:

Focus on engagement

- Takes TIME, and a long-view mindset

Team approach

- Case managers & coordinators have strong relationships with clients

Harm reduction

- Medication management
- Support during withdrawal

Communication with other providers

- Coordinate care with hospital and other resources when possible

Shelter House Single-site

- 60 one-bedroom units
- Age Range of current tenants: 25 – 62+
- Income eligible: 0 – 30% Area Median Income (AMI)
- Meets Chronic Homeless Status as defined by HUD:
  - A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who:
    - Lives in a place not meant for human habitation, a safe-haven, or in an emergency shelter, and
    - Has been homeless and living as described 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 and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described.
  - An individual who has been residing in an institutional care facility for less, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria of this definition before entering that facility**; or
  - A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

- 36 one-bedroom units
  - Individual occupancy
- On-site staff 24/7
- On-site clinic space
- Trauma-informed design

THE 501 PROJECT

Case Example #1

JEFF

- 49-year-old Caucasian male with SPMI, EtOH abuse, SI, HI. Utilized of emergency department for care.
- Experienced homelessness in 2016. 2018 Shelter House he formally engages with case management
- Employed. Living in a place not meant for habitation.
- November '18 sees psychiatric services embedded in emergency shelter. Distrustful of psychiatrists and medications.
- Moved into housing December 1, 2018.

- IMPACT May 2019
  - "Stable" housing x 4 months (boarding house)
  - On Invega LAI
  - No financial resources, had applied for disability and was in appeal process
  - Multiple past suicide attempts
  - Daily use of methamphetamine, ETOH
- Next 2 years (2019-2021)
  - 1 week after start of IMPACT, found unresponsive by dumpster, admitted then agreed to go to residential tx
  - Multiple admissions (mostly medical related to fluid overload, complicated withdrawal, COVID/respiratory infections)
  - Continued to use meth/heroin, ETOH but frequent ER visits stopped, psych admissions declined, felt more supported
  - Maintained contact with housing case manager as they were continuing with rent support

Case Example #1 *(continued)*

- 2021
  - Several people had heroin overdoses at house, one in Jeff's room
  - Given notice of eviction
  - Re-engagement of housing case management to help finding new safe housing
  - Approved for disability
  - Sister stepped in to be his payee
  - Large sum of back-pay, sister set up a Special Needs Trust (HARM REDUCTION)
  - Vaccination for COVID
  - PSH/voucher helped move into his own apartment
- June 2021-June 2023
  - Only 2 ER visits, 3 inpatient stays in context of complicated withdrawal and COVID.
  - Periods of moderating use
  - Followed up regularly with PCP, specialists and had reconnected with his family

Case # 1 Outcomes

- Incarcerated in January 2023 (domestic assault)
- Connected with jail diversion program
- Passed away in June 2023, likely overdose

SUCCESSES:

- Jeff lived safely in the community x 4 years
- Jeff was able to live and die with dignity, under his own terms
- Reconnected with family/supports
- Engaged in medical/preventative care
- Reduced his overall risks in the community (significantly reduced hospitalizations, reduced involvement with law enforcement, use of substances in home/not in community).

CHALLENGES:

- Ongoing substance use limited ability to move forward (meaningful life activity)
- Safety (allowing others to live with him, drug use in home)
- Frequently skirted rules/guidelines (ethical concerns for case manager)

Case Example #2

CARL

- 2019 Initial Engagement and Demographics
  - 50 y.o. with schizophrenia and substance use disorder (methamphetamine)
  - Multiple hospitalizations, incarcerations and institutionalizations over lifetime
  - Guardian (brother) and payee
  - Living in boarding house, had multiple previous evictions and was peripherally involved with PATH program at local MHC.
  - Referred to IMPACT
- 2019-2020
  - Slow to engage! Avoided us like the plague!
  - On LAI (monthly), hospitalized 5 times in the first year just to get shot
  - Evicted from boarding house, tried one other boarding house situation but failed
  - Became homeless, late 2020
  - Called Shelter House and mobilized street outreach coordinator to help us find him/engage with them to find housing.
- 2021-2022
  - Homeless but still engaged with IMPACT nurse and street outreach; eventually able to gather needed documents to do PSH application with help from guardian
  - Getting injections every 3 months reluctantly
  - Changed to institutional payee per brother's request
  - Permanent Supported Housing—moved in in June 2022
  - Carl requested to end IMPACT services and agreed to get injection at outreach clinic in his building.

Case # 2 Outcomes

- SUCCESSES:
  - Engagement with providers
  - Consistent medication/treatment
  - Contact with guardian (brother), maintenance of relationship
  - Secure housing after multiple years homeless/minimally housed
  - AUTONOMY regarding preferences for care
- CHALLENGES:
  - Ongoing substance use (thwarted many a plan!)
  - Safety in the community while homeless
  - Seemingly permanent lack of insight
  - Staffing changes (engagement)

Case Example #3

Jesus

- Pre-2021
  - 40 y.o. with schizophrenia, drug use, law enforcement involvement (incarcerated many times for assaults, disruptive bx, drugs)
  - First entry in the homeless management system, in Iowa, was 2012. Primarily used shelter during the winter months every year.
    - Applied for SSI but was denied.
  - July 2018 Significant change in behavior resulting in serious harm to self. Engage with on-site psychiatric services that lead to a mental health commitment.
  - Sept 2020—was stabbed in neck, severed carotid artery and had a stroke resulting in right-sided weakness
  - Multiple psychiatric admissions/ER visits
- IMPACT Trial #1—referred by housing case manager (8/2021)
  - Homeless >10 years, recently established PSH at boarding house
  - On LAI
  - Daily visits (hard to find), tried to find adaptive equipment to help him at home, focus on meds and safety
  - March 2022—had multiple incidents of law enforcement being called to house for agitation. Started fire on the stove in his house and committal was pulled inpatient as he was a danger to self. Was eventually discharged to hab home but would not stay, left there and returned to homelessness in spring 2022.

Case Example #3 *(continued)*

- IMPACT Trial #2—re-referred when permanently housed at 501 building (6/2022-present)
  - Safety supports/risk-management strategies: 24-hour on-site staff support, multiple safety alarms in bldg., phone contact, medication management
  - Clear/safe goals (supported employment, maintain housing, take classes)
  - Daily visits, focused on ADLs/adaptive equipment recommendations from OT/PT, health maintenance
  - Initially more explosive, outbursts regularly as we re-engaged
  - Vocational rehab consulted for sheltered/supported employment—eventually decided against this and wanted to focus on school
  - Engagement varies, misses visits (forgetful), has other priorities
  - Regular meetings/consultations with housing case manager; goal planning, limit-setting

Case # 3 Outcomes

- SUCCESSES
  - Maintenance of stable housing x 1 year
  - Consistent medication use (LAI), health maintenance
  - Re-established connection with his mother/daughters
  - No law-enforcement involvement
  - Taking classes, writing novel
  - BRAIN INJURY WAIVER!
- CHALLENGES
  - Ultimately needs a higher LOC for safety. Unable to care for self adequately with physical limitations.
    - Higher LOC doesn't exist in current system
    - Putting self and others at risk
  - Intermittent substance use; he is moderating but this affects behavior

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UIHC IMPACT

SCAN ME

SESSION SURVEY

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