CLINICAL AND ETHICAL CHALLENGES OF PERMANENT SUPPORTIVE HOUSING

Workshop Outline

1. 5 minutes – Introductions

2. 10 minutes - Overview of the Five Pillars of Medical Ethics (to help frame the discussion)
    a. Autonomy
    b. Beneficence
    c. Non-malfeasance
    d. Justice
    e. Equity

3. 30 minutes – Case discussions (see attached case descriptions) – the purpose is to develop how we think about this work, so that we can be more intentional. This approach is to allow us to learn from each other. Participants will have different levels and kinds of experiences. The appropriate frame of mind would be openness and mindfulness of assumptions. Cases are messy, with many considerations. There are often no good answers. Questions for consideration include:
    a. What kinds of ethical dilemmas do participants observe?
    b. What are the roles and responsibilities of each of the players?
    c. What is the optimal response when anyone isn't playing their role?
    d. Most people understand the work of PSH is to "keep vulnerable adults housed." How far can we take this? Are there limits? What do they look like?
    e. What are the expectations? How can they be managed?

4. Helpful Considerations for Permanent Supportive Housing Programs
    a. 12 minutes – Client education – Ways to communicate expectations creatively, managing your own expectations with respect to how quickly our clients will learn.
    b. 12 minutes – Working with Property Managers – Ways to develop partnerships, open lines of communication about issues, clarifying roles and responsibilities for all interested parties.
    c. 12 minutes – Staff Self Care – Ways to keep hope alive, when to hang in and when to let go, skill development you might not have thought of.

5. 5 minutes – Closing – What will you take back with you?

Cases for Discussion

1. AB- A 67 year-old man who has a long history of presenting to the emergency department (ED) with physical complaints while homeless and then refusing care when offered. He has also been restricted from service at many EDs across the city because of his abusive and threatening behavior. He developed partial quadriplegia secondary to cervical spinal stenosis. Following becoming wheelchair bound, he developed frequent pressure ulcers and eventually developed malnutrition and osteomyelitis in his hip. Since moving into a new supportive housing building with on-site nursing and 24/7 desk coverage, he has been calling 911 2-3 per day. He has been approved for over 150 hours per month of in home assistance but he often refuses to let the home health aide into his unit. He calls 911 for sliding out of his wheelchair and if he has lost his cell phone charging cord. He sees his primary care provider monthly to refill pain meds and often barters his pain meds for assistance from his neighbors. One recommendation of the on-site team was to ask his primary care provider to hold prescribing pain meds unless he allows his home health aide to regularly assist him. The fire department has threatened to stop responding to requests for assistance for the entire building and other tenants are fearful that they will not be able to get emergency care when needed.

2. CD - A 73 year-old man who was residing at a board and care for people with severe mental illness. When the board and care closed he moved in to independent supportive housing with on-site nursing. He regularly stopped taking his psychiatric medication and would then get quite agitated often walking around the facility naked or putting on army fatigues and stating that he is an undercover agent for the defense department. During these decompensating periods he would pry up the floor looking for listening devices. In one instance, he removed the wood around the window causing the large window to fall 6 floors to the street below. He has a supportive brother who has been able to pay for the repairs to his unit but property management feels that he is putting them at risk due to his potential harm to passersby on the street below. Other tenants have complained that they are afraid of him and asked for assistance from management. He has a strong relationship with a community psychiatrist and was able to maintain his housing at the board and care with few incidents.

3. EF - A 27 year-old man with advanced HIV/AIDS disease. He has been using amphetamines regularly for many years. During drug runs he becomes very agitated and is convinced that bugs are crawling under his skin. He is often incontinent of urine and stool and when he has been housed he has assaulted a desk clerk and other tenants resulting in jail time. He was evicted from a supportive housing program 6 months prior for nuisance and property destruction. Because he is a Veteran, he has scored high on the VI SPDAT and therefore is being prioritized into housing at a new Veteran supportive housing program.

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