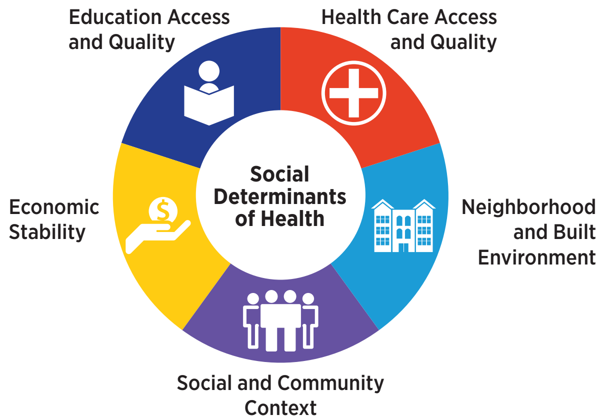
Housing as a Social Determinant of Health

Housing status is a key social determinant of health (SDoH) and one that has significant effects on other determinants, experiences, and health outcomes—including HIV.



Without stable housing, people with HIV (PWH) are more likely to face barriers to obtaining and adhering to treatment regimens and keeping up with routine care.[1,2] PWH experiencing homelessness or unstable housing have lower CD4 counts, higher viral loads, are less likely to receive and maintain antiretroviral therapy, and experience higher rates of premature death.[3] Similarly, people with substance use disorder (SUD) often face diminished outcomes and similar barriers in accessing and maintaining medication-assisted treatment, general healthcare, and wrap-around services when experiencing homelessness or housing instability.[4,5,6]

> *"Social Determinants of Health are the non-medical factors that influence health outcomes. They are conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."*[7]

Homelessness is associated with lowered life expectancy and worsened acute and chronic health condition outcomes.[8,9] Health disparities related to housing status and homelessness are especially stark for PWH who use drugs. Despite common beliefs that drug use inevitably results in homelessness, housing status is more strongly influenced by employment status and job loss, availability of affordable housing, housing program policies and eligibility (including the exclusion of people with history of criminal-legal system involvement from public housing),[10] racial disparities and discrimination, relocation, and physical health.[11,12]

Housing status has more impact on health outcomes than demographics, drug and alcohol use, mental health status or receipt of social services.

National HIV/AIDS Housing Coalition

People who use drugs (PWUD) and who also experience homelessness face intersecting and compounding barriers that prevent or limit engagement with support systems. Structural racism, criminalization, disenfranchisement, and interpersonal stigma exacerbate health disparities

KEY TERMS

ASO: AIDS service organization

CBO: Community Based Organization

CM: Case Manager

CoC: Continuum of Care

DIS: Disease Intervention Specialist

PEH: People Experiencing Homelessness/ Houslessness

PWH: People with HIV

PrEP: Pre-Exposure Prophylaxis, for HIV prevention

PSH: Permanent Supportive Housing

PWUD: People Who Use Drugs

Scattered-Site Housing: Housing programs that offer residents individual housing units at multiple properties or buildings throughout the city

SDoH: Social Determinants of Health

Sight-Based or Single-Site Housing: Residents are in housing units that are centralized within a single housing project

SUD: Substance Use Disorder

Wrap-Around Services: A comprehensive team-based collaborative approach that describes any program that is flexible, and person focused. Often provided by multiple organizations working together to provide a holistic program of supportive services

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and worsen health outcomes related to infectious disease and other health issues associated with unsafe drug markets and inequitable access to harm reduction supplies.[13,14,15,16] Programs to improve the health of PWUD experiencing homelessness should offer wrap-around services that are designed to reflect the population's needs and experiences. Safe and stable housing facilitates preventative and clinical health behaviors, including maintaining regular appointments with providers, selecting nutritious food options, securing employment, and pursuing educational attainment, among others.[17,18, 19]

Creating compassionate and effective systems of care requires learning from and about people affected by HIV, drug use, and homelessness. The narratives shared throughout this resource are drawn from interviews conducted with two men, George Elias and Jim, who are participants in a permanent supportive housing program operated by a Cincinnati-area AIDS Service Organization (ASO.) Their stories illustrate the lived reality of navigating competing priorities and multiple, complex systems of care. Their experiences, alongside the existing evidence base, provide insight into the policies and services that support or hinder individuals' goals related to getting housed and managing drug use, HIV, and other health conditions.

JIM

After his mother died, Jim moved into his uncle's house in Fort Lauderdale, FL. Upon learning of Jim's HIV-positive status, Jim's uncle kicked him out. Jim attributes this to persistent stigma against PWH among people like his uncle, who thought "things needed to be bleached" after being touched by someone with HIV. Jim experienced homelessness from 2001 to 2007 in Fort Lauderdale, where he struggled to find housing assistance: "I was grieving, I was depressed, I was fighting to get off the street. It was really difficult." Jim stated that public health budget cuts, internal issues, and high staff turnover at local social services agencies negatively affected his experience to the point that he felt he had no support. Jim believes that, "if someone can help you and you do what's needed, you'll be alright. But if someone doesn't even offer you help, you're going to stay out there forever. You're not thinking about nothing but you and getting through one day at a time." About his experience in Florida, Jim notes that he "never really depended on caseworkers. I tried it, and it didn't work. I tell people, 'Do it yourself, you'll do better. If you get stuck, use your case worker.' I do what I gotta do." Though there may be well-established systems of care for PWH, learning about and accessing these can be challenging for anyone, housed or unhoused: "It was difficult being homeless," said Jim. "Nobody to help… guide you. If you're not in a shelter or a [housing] program, you're lost." Jim describes attempts to manage his HIV medications:

> *I was homeless in Florida and trying to take care of my [HIV] status. At one point, I was on seven different medications. And I was really sick, couldn't get out of bed sometimes. Crapping all over myself. It was difficult. There were times when I got off my meds. One time I was off my meds for more than a year because I just gave up. I didn't have money for transportation to get to the doctor. At one point I had no caseworker or any kind of assistance to get my medication.*

GEORGE

George Elias was diagnosed with HIV in 2015 while living in Cincinnati. At the time of his diagnosis, George did not have an apartment of his own. To avoid street homelessness, he was doubled up at his mother's apartment, couch surfing almost daily. George recognizes the precarity of his situation at that time: "I was at risk of homelessness. My mom was being evicted. I was also addicted to heroin. I was ducking DIS [Disease Investigation Specialists]." George feels that between the stigma around HIV and the need for stable housing he wasn't in a place to prioritize HIV treatment. He notes, "I didn't want to deal with any of it—I was really scared at the time."

What is a CoC?[20]

According to the National Alliance to End Homelessness, a Continuum of Care (CoC) is a regional or local planning body that coordinates housing and services funding for homeless families and individuals. HUD identifies four necessary parts of a continuum:

1. Outreach, intake, and assessment in order to identify service and housing needs and provide a link to the appropriate level of both;
2. Emergency shelter to provide an immediate and safe alternative to sleeping on the streets, especially for homeless families with children;
3. Transitional housing with supportive services to allow for the development of skills that will be needed once permanently housed; and
4. Permanent and permanent supportive housing to provide individuals and families with an affordable place to live with services if needed.

In that same year, when George was ready to receive HIV care and services, he checked into an emergency shelter near downtown Cincinnati. The emergency shelter was part of the local Housing Continuum of Care (CoC). There, George received the homeless certification that made him eligible for the permanent supportive housing (PSH) program that Caracole offered. While awaiting housing placement, George had to check in at the shelter at least every three days or risk being evicted from the shelter and losing his forthcoming placement into PSH. George says that he felt these rules "helped to keep me in line," but he also felt that between couch surfing and chaotic drug use, checking into the shelter was not a top priority. He notes, "there were a couple of times I was down to my third day and had to get there just to scan a card (identification card linked to the local Homeless Management Information System). It made things harder. It was difficult to get around and get the card scanned. Especially when I didn't have a ride, or bus fare, or a license, and I had arrest warrants."

Additionally, during George's stay in the emergency shelter, the facility closed and reopened as two separate gender-specific facilities. Both sites were new and state-of-the-art, offering increased capacity and expanded services. The original shelter had been in a centralized and rapidly gentrifying neighborhood, which in part led to the relocation: "Now it's all white ladies in yoga pants and foofie dogs. There's a lot of change down there," says George. These changes also contributed to an increased police presence, and shelter residents began to feel unwelcome. Although the new men's shelter had more services, it was now located on the city's outskirts. Many services that residents relied on—including low-threshold health clinics and the county's social services offices—were no longer easy to access on foot. Instead, the new shelter was located further from services and across an eight-lane freeway. This made public transportation even more difficult to access and the few overpasses available for those traveling on foot easily tripled travel time. Furthermore, the men's shelter and the women's shelter were over three miles apart, creating more difficulty for heterosexual couples to see and support one another. Once the

facility moved, says George, "there were a lot of people that didn't even go over to the new shelter because it was so out of the way… A lot of people went back on the street instead."

When already marginalized people try to move into stable housing, widespread issues of housing availability and affordability create additional challenges. They can include location (including extensive issues of environmental justice for communities of color and low-income areas[21,22]), local resources and infrastructure (including medical care for HIV, viral hepatitis, and SUD), sustainability of services (including the ability to maintain service operation during natural disasters and other emergencies), and cost.[23,24,25,26] Unaffordability of housing options is associated with worsening physical and mental health.[27,28,29] Conversely, forming community attachments and social networks improves health outcomes—but housing costs, rapid redevelopment, and gentrification limit the long-term stability of these valuable connections.[30] Less than 12% of households above 150% of the federal poverty line change residences annually, while 26% of households below the poverty line move each year.[31] For many low-income households that experience involuntary moves, residents' health may be affected through added stress, exposure to harmful environments, and moving costs that divert from other expenses, in addition to disruptions to daily life like changing schools or adjusting to different transportation needs.[32,33]

What homelessness defines is a situation where everything you do of necessity is in full view.

Jeff Weinberger, housing advocate, Florida

After starting case management services at Caracole, the housing process moved rapidly for George. He says that he was surprised because, "it didn't matter that I was a felon or injecting drugs, I got housed. There weren't any barriers in the way." As George settled into his own apartment, he notes:

> *Housing helped in my HIV care because I had a base of operations, a place to keep my meds. It's hard to keep your meds when you're living out of a bag or a locker. You run the risk of getting robbed or getting things stolen. So just having a place to store my meds and a place to take them in privacy, I had more anonymity. Having that security of a room over my head allowed me to take my medication regularly. And six months later [after being stably housed], I was getting my undetectable status.*

Considerations and Recommendations

Health departments, drug user health and harm reduction programs, housing service providers, policymakers, and other stakeholders can tailor services and increase accessibility to improve health and safety outcomes in the following ways:

- Service locations should be accessible by foot and public transportation. Consider proximity to areas where unhoused people stay, other programs or locations that participants access regularly, as well as the local response to program and participant presence.[34]
- Direct service staff are essential to building relationships with participants and other community members and stakeholders. Programs should prioritize direct service and case management (CM) staffing and infrastructure, including staff mental and physical health and well-being through livable wages and generous benefits, adequate personal and medical leave, and responsive supervision.[35,36,37]
- Harm reduction and drug user health programs may have a part to play in the coordinated entry process of their local CoC.
- CoCs and participating agencies should consider partnering with drug user health and harm reduction services at health departments and Community Based Organizations (CBO) to pursue trainings and continued education, joint outreach or co-located services, and streamlined referral processes.
- Seek out resources and technical assistance from organizations like:
    - SAMHSA's Housing and Homeless Resource Center
    - J. Ronald Terwilliger Center for Housing Policy
    - National Health Care for the Homeless Council
    - National HIV/AIDS Housing Coalition
    - National Low Income Housing Coalition
    - National Alliance to End Homelessness
    - Pathways Housing First Institute
    - HOPWA National Technical Assistance
    - Pathways to Housing PA

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