THE ROLE OF Housing in Improving Health Outcomes and HIV Care Continuity for People Who Use Drugs

Narratives and Recommendations from Lived Experience

NASTAD

About

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Collaboration between harm reduction programs and housing providers at multiple levels can improve health and safety for unhoused people who use drugs (PWUD), including people with HIV (PWH), and address unmet needs among shared service populations.[1] Syringe services programs (SSPs) and other low-barrier health programs are well-positioned to integrate housing navigation or sheltering services, but doing so requires dedicated resources and staff support, which limit implementation. Housing services programs seeking to improve engagement with PWUD by integrating harm reduction services may require guidance on low-barrier service models and reducing barriers to care.[2,3] State and territorial health departments have important roles to play in identifying, understanding, and navigating housing needs and service infrastructure for PWUD, including those living with HIV.

To help ensure its utility and real-world application, this resource was shaped by a series of qualitative interviews with two men living with HIV who have current or former drug use and experience navigating systems of care related to homelessness, drug use, and HIV. George Elias and Jim (pseudonym) met the authors through participation in permanent supportive housing operated by a Cincinnati-area AIDS Services Organization. Their interviews anchor and inform the evidence-based recommendations shared in this resource. Subject matter experts from the harm reduction and housing fields provided additional input.

Billy Golden, Manager, Drug User Health, is the primary author of this document. Lillie Armstrong, Senior Manager, Drug User Health; Katie Evans, NASTAD Housing Consultant; Elika Upadhyay, Senior Associate, Drug User Health; Juan Tirado, Associate, Drug User Health; Meredith McCarthy, former Senior Associate, Drug User Health; Kirsten Forseth, Associate Director, Drug User Health; Kristina Santana, Associate Director, Prevention; Elana Ross, former Manager, Prevention and Erin Bascom, Director, Capacity Building Assistance (CBA) contributed additional input and guidance. NASTAD gratefully acknowledges George Elias, CDCA II, and Jim for sharing their stories and support to create this resource.

For a full list of citations, please visit: http://www.nastad.org/resources/role-housing-improving-outcomes-people-who-use-drugs

Key Terms

ASO: AIDS Service Organization

CBO: Community Based Organization

CDCA: Chemical Dependency Counselor Assistant

CM: Case Manager

CoC: Continuum of Care

DIS: Disease Intervention Specialist

HIV: Human Immunodeficiency Virus, general term for HIV and AIDS (Acquired Immunodeficiency Syndrome) diagnoses

HD: Health Department

HUD: US Department of Housing and Urban Development

LGBTQIA: Lesbian, Gay, Bisexual, Transgender, queer, Intersex, and Asexual

Master Lease: Mechanism by which property leased to one tenant can be subleased to other occupants

MOUD: Medication for Opioid Use Disorder

PEH: People Experiencing Homelessness/ Houselessness

PRS: Peer Recovery Supporter

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

SSP: Syringe Services Program

STI: Sexually Transmitted Infection (alternatively, sexually transmitted disease, or STD)

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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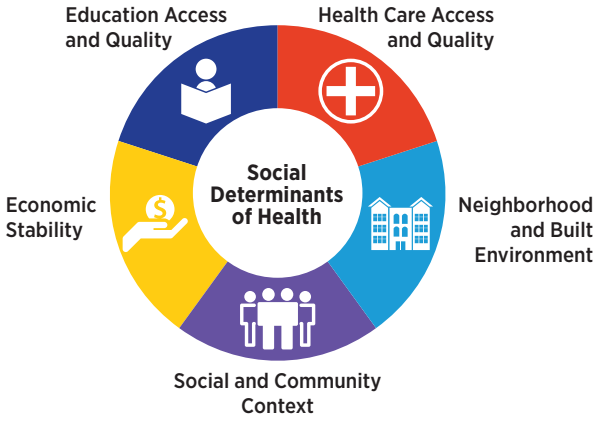
Housing as a Social Determinant of Health

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.[4,5] 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.[6] 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.[7,8,9]

> *"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."*[10]

Homelessness is associated with lowered life expectancy and worsened acute and chronic health condition outcomes.[11,12] 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),[13] racial disparities and discrimination, relocation, and physical health.[14,15]

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

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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.[16,17,18,19] 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.[20,21, 22]

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 program operated by Caracole, an AIDS service organization in Cincinnati, Ohio. 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."

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

What is a CoC?[23]

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.

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[24,25]), 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.[26,27,28,29] Unaffordability of housing options is associated with worsening physical and mental health.[30,31,32] 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.[33] 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.[34] 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.[35,36]

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.[37]
- 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.[38,39,40]
- 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

Housing First Model

At its core, Housing First is an approach that provides people experiencing homelessness (PEH) stable housing with as few barriers as possible.[41] Housing First programs offer supportive services that prioritize engagement and problem-solving instead of clinical outcomes. Access to these types of programs is not contingent on sobriety, minimum income requirements, criminal record, enrollment in or adherence to treatment programs or other services, or other standards that may be hard to reach or demonstrate. Housing First is a "proven model for addressing homelessness that prioritizes access to permanent, stable housing, linked with voluntary services as needed,"[42] including economic benefits and improved health and safety outcomes. These benefits include "societal cost savings of $1.44 for every dollar invested"[43] due to the "combined savings from healthcare, emergency housing, judicial services, welfare and disability costs, and benefits from increased employment."[44] One result is that "the average cost savings to the public ranges from $900 to $29,400 per person per year after entry into a Housing First program."[45] Stable housing provides a foundation that allows people to address other basic needs and offers the opportunity to recover from the traumas of chronic homelessness.[46] Because participation in therapeutic services is not required to obtain or maintain housing, Housing First programs provide an alternative to coercive systems and inequitable power relationships that can lead to distrust and withholding of information.

KEY TERMS

CM: Case Manager

PEH: People Experiencing Homelessness

PWH: People with HIV

PWUD: People Who Use Drugs

SUD: Substance Use Disorder

JIM

Jim briefly entered a transitional housing program in Fort Lauderdale and found abiding by the restrictions difficult. He was often in situations where he didn't feel like he could be honest about his drug use for fear of losing access to housing and other services. Jim found that the program made no allowances while residents made the complex transition from unsheltered homelessness to living inside with roommates. The program emphasized employment, and Jim was able to find work. But his largest issue with the program was the curfew. Jim's second-shift job meant he would get back to the house about 30 minutes after curfew. While at work, Jim missed mandatory group counseling. Missing curfew and mandatory counseling put his housing at risk, even though he had successfully met the expectation of getting a job. "They were hypocritical. I didn't like that structure. I followed the rules with my mom and dad, but I'm a grown man." Jim opted to leave his job to stay housed, but he soon returned to using drugs because he was "sitting around doing nothing. The rules didn't make sense." Since his first experience living in a Housing First program in Boston, Jim has found that the flexibility has worked well for him, and he appreciates the focus on individual needs: "They want to see you take care of yourself and maintain the things you need to do."

The Housing First model incorporates:[47]

- Direct or nearly direct placement of PEH into permanent housing
- No requirements for participation in supportive services or medical care
- Use of proactive outreach practices for people reluctant to enter shelters
- Continued efforts to provide case managers and hold housing for clients, even if they leave the program for a short period
- Sufficient time and support for people who have experienced chronic homelessness to transition into stable housing

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GEORGE

George feels that the solid foundation he got from Housing First programming and staff helped to make the changes he wanted in his life. George's case manager(CM) worked with CM services at other agencies to help meet various needs and goals, including substance use disorder (SUD) treatment. "I think what helped me most when I was trying to get housed was the support," says George:

> *My case managers would call me...and ask me how I was doing, how I was feeling, if there was anything they could do to support me. I had multiple support systems for my mental health. When you want to die every day, and you have somebody consistently checking on you, that says something. They didn't push recovery on me.*

His case managers became trusted sources of support and encouragement. Even when George went to jail, his case managers would visit him and ensure that he would continue to receive services once he was released. Thinking back to that time, George reflects:

> *When you're feeling that you're the smallest thing in the world and that nobody can see you and then being in jail, which is probably the worst place you can be, and then getting out and still have your housing because somebody was looking out for you, I don't have words for that.*

For George, permanent supportive housing gave him less to worry about. It allowed him "a place to clear my head. It gave me a safe place to use [drugs]." Although he relapsed a few times, he says, "having an apartment really contributed to my recovery. It gave me a foundation to start from, and it became about my choices at the end of the day." There were several times that George went to jail or rehab for more than a month, and he was relieved to have a home to which he could return. "It was a great thing—as long as I wasn't there for longer than 90 days, I wouldn't lose my apartment. I did do a couple of 60-day bids, and I would have lost my apartment anywhere else in any other situation," he notes.

Contrary to the common belief that there is a "unidirectional causal pathway between drug use and homelessness…the association between homelessness and drug use is bidirectional, and homelessness itself plays a role in drug use and overdose risk. People experiencing homelessness may use drugs for adaptive reasons."[48]

Considerations and Recommendations

Health departments, drug user health and harm reduction programs, housing service providers, policymakers, and other stakeholders can adopt and expand Housing First approaches and strengthen local service networks in the following ways:

- State and local governments and housing agencies should work collaboratively and with other stakeholders to reduce bureaucratic barriers and identify strategies to expedite approval and development processes for high-quality affordable housing and supportive housing programs.[49,50]
- Take a harm reduction-informed approach and work with participants to jointly define their goals and priorities related to health and housing. Programs should proactively identify services and connections that might be of interest.[51,52,53]
- Offer housing options that are responsive to participants' goals. Not everyone will thrive in a Housing First program – some will want or need a more rigorous structure, like transitional or sober housing. Work with participants to check in on and explore their options.[54]
- Harm reduction programs should identify the supportive services they may be able to offer to bolster Housing First programs or adapt for residents.[55,56,57,58,59]
- Housing First programs should prioritize collaborating with re-entry programs and clean-slate services for criminal-legal involved residents.[60]

Role of Housing in Drug User Health & Overdose Prevention

An unregulated drug supply, the trauma and chronic stress of homelessness, physical and mental health issues, and limited safe places to use drugs all contribute to higher risks of overdose for people experiencing homelessness (PEH).[61,62,63] Further, PEH lack access to "safe, adequate healthcare… with higher unmet needs and lower rates of access to a family doctor, resulting in significantly more hospitalizations and visits to emergency departments."[64]

Jim found that his drug use helped him cope with the day-to-day stress of homelessness because "when you're outside, all you… want is the time to go by." However, many of the shelters and housing programs Jim encountered required abstinence, presenting a high bar to entry. Once he was securely housed, Jim says that he didn't have the desire to use drugs every day, especially not to the same degree as when he was living outside.

GEORGE

George feels that having stable housing not only contributed to his overall health but was responsible for keeping him alive. "It gave me a safe place to use, and being in that safe place, I always had Narcan," George says. A supportive and non-judgmental relationship with his case manager was also crucial. "The first time I received [naloxone] was from my case manager. If I hadn't received it from him and then walked my ex-girlfriend through how to use it, I'd be dead." George explains:

> *The first time I was ever brought back with naloxone by my ex, we were in my apartment, and it was 15 minutes before I had a probation appointment in Kentucky and my case manager(CM) was taking me. He knocked on the door and I was in that bathroom because I just got back [revived with naloxone]. And my case manager was like, "if you can't go, we can call it," and I was like, 'if I don't go, they'll put a warrant out for me," and he was like, "well I'll take ya," and so I went with him. I had my head sticking out of his car window, just vomiting. And [the CM] was so cool about it and said, "do your thing man, don't worry about it. Anything can be washed."*

KEY TERMS

CM: Case Manger

HCV: Hepatitis C Virus

MOUD: Medication for Opioid Use Disorder

PEH: People Experiencing Homelessness/ Houselessness

PSH: Permanent Supportive Housing

PWUD: People Who Use Drugs

RSS: Resident Support Specialist

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

SDoH: Social Determinants of Health

SSP: Syringe Services Program

SUD: Substance Use Disorder

One study shows that PEH in Los Angeles County, CA, between 2017 and 2019 had a drug overdose rate that was 36 times higher than for the general population.[65] Among a study cohort of 60,092 PEH who received healthcare at Boston Health Care for the Homeless from 2003 to 2017, 7130 died by the end of the study period and of those that died, 1727 people had died from a drug overdose.[66]

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Considerations and Recommendations

Health departments, drug user health and harm reduction programs, housing service providers, policymakers, and other stakeholders can jointly address health and safety risks related to homelessness and drug overdose in the following ways:

- Drug user health and housing service providers can work together to assess their respective capacity to meet the needs of shared service populations.
- Housing First programs and other social and medical service providers working with PEH should offer harm reduction services and supplies relevant to community needs and experiences.[67,68]
- They should also maintain regular opportunities for internal and programmatic review, including mechanisms for participant input, to ensure that services are tailored and use best practices for the needs and cultures of communities served.[69,70]
- Increase co-located and wraparound services through partnerships between housing programs, Syringe Services Programs (SSP) and harm reduction programs, and other local service providers. Permanent supportive housing sites can work with SSPs to support secondary exchange with staff and residents. Programs and service providers can develop streamlined and bi-directional referral mechanisms to better care for participants and avoid duplication of effort.[71,72]
- The trauma of homelessness does not simply disappear once someone enters stable housing. Traumas and stresses from living outside may be exacerbated by chaotic drug use or untreated substance use disorder (SUD), mental illness, or dual diagnosis. The transition into stable housing is, in part, a transition into a new social system – and it may take several years and require specialized support. Wraparound services, like housing retention plans and intensive case management, can be helpful during the process. Incorporating aspects of the Critical Time Intervention Model and trauma-informed counseling that draws on the Transtheoretical Model/stages of change framework may be beneficial.[73,74,75]
- SSPs and other harm reduction programs can prioritize outreach to local encampments and understand how changes in the housing landscape can disrupt networks of care which could force people into unfamiliar drug markets, leading to increased overdose risk. [76,77,78]

Harm reduction supplies may include but are not limited to:

- Sterile syringes and injection supplies
- Safer smoking and snorting supplies
- Sharps containers and safe disposal
- Naloxone access
- Planning and education related to overdose prevention and response
- Education, resources, and referrals related to drug checking
- Safer use education
- Information about and connections to MOUD providers and other SUD treatment options
- Safer sex materials and information
- Safety planning and resources for people doing sex work
- iIntegrated physical and mental health services, including testing and care for HIV, viral hepatitis, sexually transmitted infections, and skin and soft-tissue infections
- Information about and access to PrEP
- Low-barrier medication storage

Navigating Transitions

JIM

Approximately 30% of people experiencing homelessness experience chronic homelessness.[79] Jim was no exception. In moving between being homeless and being housed, Jim found that offering and receiving peer support also helped him maintain housing. When living in Permanent Supportive Housing (PSH) in Boston, Jim helped run a peer support group for African-American men living with HIV that offered a safe and stabilizing space for him and other residents:

> *We had regular house meetings. One time, one of my friends, a tenant, committed suicide. We decided to open up the floor to let people talk about how they felt. For me, it really touched home because like him, I don't have no family, and to leave this world like that is really depressing and sad. I'm a peer person. When I was on the street, I didn't really hang with anyone. But sometimes it really helps to share your experience, and they share theirs. I had a caseworker when I was in Fort Lauderdale that... never experienced homelessness or addiction. We said to him, "maybe you listen to our story first, and then if you want to tell us what's in your books, you can. How can you tell us how to live and tell us what we did wrong and where we went wrong because what the book is telling you? People want to be heard.*

Jim eventually moved to Ohio and began living with his partner. When the relationship turned abusive, Jim left their home and began to couch-surf off-and-on with a friend who lived at Caracole House, a site-based PSH program. Jim's friend convinced him to connect with Caracole's case management (CM) services. While he was cautious about seeking CM services, he found the housing process to be relatively easy. At the time of the interview, Jim was still waiting on renovations at the building to wrap up so he could move into his new apartment. Even with being so close to moving into his own home, the wait for the apartment proved stressful. His previous experiences dealing with service delays and stalled referral processes contributed to anxiety and depression, and in some cases, he reverted to living unhoused. He notes:

> *You don't want to live with people all the time, you want to be in your own place. If things don't move fast enough, you get doubtful and depressed. When you get doubtful, you end up back on the streets. I am so glad I am going to have an apartment this month. I am so anxious and so excited at the same time, but I am very impatient, and that comes from my experiences. I worry something could go wrong, and I could lose my place and fall back down on the list. That is the experience I have had.*

GEORGE

In 2018, George moved into a new apartment that was close to the Caracole office. He started volunteering with the county health department-run Syringe Services Program (SSP), which Caracole hosted on Thursday evenings. After helping regularly with the SSP, George found a job as a residential support specialist (RSS) at Caracole House. As an RSS, George was able to employ his own lived experiences with homelessness, chaotic drug use, co-occurring mental health disorders, and living with HIV to connect with residents. George notes that he helped to "enhance social relationships, provide resident stability, and create

KEY TERMS

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PRS: Peer Recovery Specialist

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a sense of community. I interacted with tenants by providing supportive listening/counseling during crises or by [sharing] great news, new life skills, and harm reduction education. I proactively supported and assisted in implementation of client goals in case management plans." George left his RSS position to take a job with Caracole's prevention program. In his new role, he helps to provide HIV and hepatitis C (HCV) testing in rural counties and works with communities vulnerable to HIV and HCV infection. George says that he has used his "experience with addiction and homelessness to meet people where they're at; to test as many at-risk people as possible, reduce stigma through education on medication adherence, [undetectable equals untransmissible], [post-exposure prophylaxis], PrEP, as well as build and maintain rapport and relationships with our positive clients in community." George recalls that when he first interviewed for the RSS position, he expected that his criminal record would make him an undesirable candidate—but "[the hiring team] said, 'oh, that's just life experience,' and I was like, 'are you kidding me?'" He has since graduated from Caracole's PSH program and earned his Chemical Dependency Counselor Assistant (CDCA) and Peer Recovery Supporter (PRS) certifications. "There was value in my experience," George said. "A switch flipped, all these things that maybe you perceive as bad, at the end of it all, you can use it all to help relate to or just listen to others. Maybe that is enough to help change someone's viewpoint."

Considerations and Recommendations

Health departments, drug user health and harm reduction programs, housing service providers, policymakers, and other stakeholders can work with and learn from people with lived experience of homelessness, drug use, and HIV to improve programs and share power in the following ways:

- Programs should develop policies, procedures, and internal infrastructure to create employment opportunities for current and former participants. These should include direct service roles as well as administrative, leadership, and other programmatic opportunities. [80,81,82]
- Include lived experience alongside academic and professional experience in position descriptions and hiring requirements. Develop policies, procedures, and internal infrastructure to mitigate application and hiring barriers. [83,84]
- Investing in and adequately compensating and supporting professional development for program staff is necessary for service accessibility, sustainability, and success. Proactively identify continuing education, networking, and other career growth options for all staff. Tailor onboarding and supervision procedures to each employee. [85,86,87,88,89]
- Proactively encourage healthy boundaries and work/life balance for all staff. This may include adopting clear expectations around off-hours communication, sharing responsibility for crisis lines or other emergency response mechanisms, ensuring reasonable caseloads for CM staff, and cultivating a workplace culture where care, rest, and personal boundaries are honored and respected.[90] This is vital not only for individual health and safety, but for the health and safety of communities served and for the sustainability and efficacy of these programs.[91,92,93,94]

Next Steps in Addressing Drug User Health and Housing

Direct service outreach teams had a positive impact on Jim's life, and he believes that improving and increasing services that reach unsheltered people directly is one of the most effective interventions available to address chronic homelessness and improve health.[95] "We need more outreach caseworkers from different agencies—housing, HIV, mental healthcare, things like that—to team up and do outreach where homeless folks are," says Jim. "Some people are out there because they want to be, but most people out there are there because they don't know what else to do."

Based on his experiences, Jim also shares that data collection and screening processes could be more streamlined, deadlines should be more flexible, and programs should hire caseworkers with lived experience and compassion for the people they serve. He has found that transportation and lack of phone access are significant barriers to productively engaging with care regimens and service providers. Increasing access to transportation and enabling communication are essential to maintaining HIV care.[96,97] Policies that require a person to enter a homeless shelter before being accepted into a housing program also create unnecessary risks and delays – especially when they can mean being separated from needed medications or safer drug use supplies.

George similarly feels that his path has come full circle. Reflecting on potential barriers to receiving permanent supportive housing, he says that:

> *Having the homeless certification being a requirement is a real barrier. If you'd told me that because I was HIV-positive, I could be eligible for housing assistance, I wouldn't have believed you. I think of the people that have different issues that may contribute to their housing situation, but for them to get housing is so much harder, and their barriers are greater. Robust housing programs should be available to everyone in need of housing, even if they aren't HIV-positive.*

He also wishes that "unconditional support" were available to everyone who needed it, saying: "I saw who I wanted to be because of the support I received, and I'm grateful I had that. Not everyone does. Now I'm trying to do that with the people I work with. That's powerful. That's letting barriers down and sharing. That keeps me going."[98]

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George and Jim's stories demonstrate the value of and necessity for interdisciplinary and interagency programming that leverages experience across drug user health and harm reduction, housing, comprehensive preventative and clinical care, and other areas to co-locate services and reduce barriers to care. Successful collaboration will require that agencies develop a shared understanding of how housing infrastructure, housing policy landscape, and drug policy affect people who use drugs and people with HIV.[99,100,101] Effective responses will be informed by local community input and include bolstering networks of care, care retention and sustainability of services, co-located care, low-threshold service provision, and community reinvestment. Syringe Services Programs and other harm reduction organizations may become eligible for new and different funding sources through partnerships with housing service providers—and vice versa.[102] Health departments can support service integration by convening stakeholders and providing or facilitating funding opportunities, training, or technical assistance. Beyond service level integration, drug user health and harm reduction programs and housing service providers can work together to advance policy and advocacy for increased resources that facilitate coordination and wraparound care within the service landscape.[103,104]

Additional Resources

- Adopting a Housing First Approach, National Alliance to End Homelessness
- Bipartisan Policy Center
- By Perpetuating Substance Use Disorder Stigma, Public Housing Policy Causes Harm, Health Affairs Forefront
- Clean Slate Clearinghouse, U.S. Department of Labor
- Coordinated Entry Core Elements, HUD Exchange
- Dear Colleague Letter: HIV Outbreaks Among People Experiencing Homelessness and Housing Instability, CDC, HUD, and HRSA
- Harm Reduction Hacks
- Harm Reduction and Housing Video Series, NASTAD
- Housing Works History
- HUD Exchange HOPWA (Housing Opportunities for People With AIDS) TA Center
- Key Policy Areas that Will Affect Homelessness, National Alliance to End Homelessness
- National AIDS Housing Coalition HOME TA Center
- National Health Care for the Homeless Council
- National Low Income Housing Coalition
- Patient Navigation for People Who Use Drugs | NASTAD
- Pathways Housing First Institute
- Pathways to Housing PA Resource Page
- Public Housing History
- Preserving, Protecting, and Expanding Affordable Housing: An Overview for Local Health Departments, ChangeLab Solutions
- Report: The War on Drugs Meets Housing, Drug Policy Alliance
- SAMSHA's Homeless and Housing Resource Center
- Thinking About Starting a Supportive Housing Program? Recommendations and Considerations for the Planning Process, NASTAD
- Trauma-Informed Approaches Toolkit, NASTAD
- Trauma-Informed Housing Toolkit, Preservation of Affordable Housing

Opioid Response Network

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