Navigating Transitions

JIM

Approximately 30% of people experiencing homelessness experience chronic homelessness.[1] 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

CDCA: Chemical Dependency Counselor Assistant

CM: Case Management

HCV: Hepatitis C Virus

PSH: Permanent Supportive Housing

RSS: Resident Support Specialist

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

PRS: Peer Recovery Specialist

Funding for this initiative was made possible (in part) by grant no. 1H79TI085588 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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. [2,3,4]
- 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. [5,6]
- 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. [7,8,9,10,11]
- 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.[12] 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.[13,14,15,16]

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