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Engaging Consumers Living with HIV in a Housing-First Response to a Local HIV Outbreak

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Background

Since December 2018, Hennepin and Ramsey counties have been experiencing an HIV outbreak among people using injection drugs and experiencing homelessness. As of June 20, 2024, there are a total of 259 outbreak cases. Recognizing that a lack of access to stable housing is a key contributing factor to the outbreak, Hennepin County Public Health is using a housing-first approach to respond. One part of this is the Low Barrier Housing Technical Work Group (TWG), an interdisciplinary group of government and community-based HIV and housing experts convened by the Ryan White Program in September 2021 to address housing challenges for people living with HIV (PWH) affected by the outbreak. The workgroup aims to create a model for low-barrier housing for this population, and, from February 2022 to June 2024, it sponsored the Ryan White Program to conduct the Consumer Input Project to better understand the housing experiences of PWH.

Purpose

To inform the TWG's work, the Consumer Input Project answers these questions through semi-structured interviews with people experiencing homelessness within the past year who are part of the HIV outbreak:

1. What are the barriers and facilitators to housing for PWH?
2. What does desirable housing look like for this population?

This project addresses the TWG's business need to incorporate the perspectives of people with lived experience in program planning and define desirable housing so that it can create a model that is responsive to consumers' needs.

Methods

After consulting with frontline staff, the TWG decided to conduct half-hour, semi-structured interviews on the street, at shelters, and in clinics with consumers. Participants gave informed consent and were offered a $25 gift card and housing resources after completing an interview. They were asked about their current and past housing experiences, barriers and facilitators to housing, decision-making processes around housing, elements of desirable housing, resource use, and key demographics. Participants were identified and recruited through street outreach, disease investigation services, and Ryan White data.

To allow for greater consistency and data privacy, all interviews were conducted and analyzed by Aurin Roy, who interviewed a total of 22 participants between July 2022 and March 2023. All interviews were recorded and transcribed. Established qualitative methods (descriptive coding and thematic analysis) and ATLAS.ti Web (version 7.9.0) were used to analyze and synthesize these data to identify common themes across barriers, facilitators, and desirable housing.

Key Findings

Top barriers to housing

Substance use (n=18)
Withdrawal sickness and complicated use schedules make it harder to do tasks related to housing.

Legal issues (n=15)
Losing ID documents or having a legal background makes it harder to get approved for housing.

Undesirable housing (n=14)
It is harder to accept or maintain housing options that are not desirable and do not meet needs.

Mental health (n=13)
It is harder to navigate housing processes with impacted executive functioning and motivation.

Interpersonal issues (n=13)
It is harder to access housing without social support or while in unstable interpersonal relationships.

Other barriers
Lack of motivation, transportation barriers, safety issues, financial challenges, negative provider experiences, physical health issues, discrimination, lack of knowledge about housing, no available housing, communication challenges, homelessness, and systemic issues like racism or the war on drugs.

Top facilitators to housing

Supportive services (n=22)
Both transactional and intensive services reduce barriers to housing and provide material support.

Strong relationships (n=19)
Advocates provide emotional support and help with getting connected to resources.

Availability of housing (n=11)
Open units and clear housing timelines and expectations help with getting housed.

Personal motivation (n=10)
Being motivated for housing (due to sobriety or other reasons) makes it easier to work towards it.

Desirable housing (n=9)
It is easier to accept or maintain housing options that are desirable and meet needs.

Other facilitators
HIV-specific housing, lack of legal challenges, access to communication tools, good mental health, sobriety or support around substance use, and access to transportation.

Elements of desirable housing

Location and structure
Close to community and services, at least one-bedroom, supports living alone or with family, and in a safe neighborhood (low crime, friendly, etc.).

Accessibility
Affordable, subsidized, accessible by public transit, a lower floor unit or has an elevator, flexible around legal history, and safeguards against eviction.

Amenities
Laundry, storage, private bathrooms, kitchens, community spaces, and parks or green spaces.

Flexibility
Allows visitors and pets, allows for independence but with support, and flexible and accommodating of an individual's needs.

Lifestyle
Not recognizable as HIV-specific, harm reduction-based, and culturally responsive but not exclusionary.

Support
More transitional housing, hands-on support for permanent housing, and anti-discrimination policies.

Discussion and Recommendations

These data show that there is a negative, cyclical relationship between barriers that is contrasted by a positive, synergistic relationship between facilitators. Addressing barriers will require dismantling structural barriers to care, such as the war on drugs, criminalization of homelessness, and structural racism. It is also important to improve the accessibility of facilitators by improving systemwide coordination of care and streamlining processes. Using low-barrier models, improving collaboration between agencies, and prioritizing long-term engagement with clients can improve coordination of care. Furthermore, capitalizing on the synergistic relationship between facilitators and reducing bureaucratic burdens on participants can help speed up the housing timeline.

Underscoring these recommendations is trust. Participants reiterated that their engagement in services depended on whether they trusted providers. From the data, allowing clients to be leaders in their care, providing them with the information they need to make informed decisions, meeting them where they are, and integrating harm reduction at all levels can help (re)build this trust.

Finally, it is crucial to center desirability. Participants are less likely to access or maintain housing they find undesirable and are more likely to pursue housing they find desirable. While there are general trends in what participants consider desirable, it is also important to note that participants have unique, sometimes conflicting needs that affect what they want from housing. It is thus important to not only make housing generally desirable for clients but also flexible around and tailored to their individual needs.

Conclusion

The data show that a final low-barrier housing model should address common barriers to care by simultaneously targeting barriers, disrupting the cyclical relationship between barriers, and connecting clients to multiple facilitators at once. It should also invest in and increase the accessibility of facilitators to housing by improving coordination of care, streamlining processes, and fostering trust between clients and systems. Above all, the model should center desirability; it should include elements that are generally considered desirable and adopt a flexible, client-centered approach to housing.

These findings affirm that desirable housing is not only central to the Hennepin and Ramsey counties HIV outbreak but also a human right. Incorporating the voices of PWH into a low-barrier housing model is an important step for both a housing-first response to a local HIV outbreak and the push for greater health equity for PWH.