Recovery Navigator Program Success Stories – October 2022

Success Story #1

An individual who has been involved regularly with law enforcement over a long period of Participant around substance use was incarcerated again. Through our collaboration with the co-responder at the jail, RNP case managers met with the Participant, and they agreed to enroll in treatment. A facility was found, and preparations were made for a bus ticket to the treatment facility the following day. The Participant was picked up and transported to the bus depot, but the bus was cancelled. The facility was located approximately six hours away and not able to facilitate intake for another week. RNP staff helped the Participant develop a safety plan and checked in on the them daily, providing support, essential toiletries and food items. The Participant was able to utilize local supports and staff to remain substance free for the week and was transported back to the bus depot. The Participant arrived at the treatment center, followed up with RNP personnel during their stay and was able to secure housing at a recovery house upon successful completion of treatment. This individual has a high prognosis for a successful future while the prospects for future involvement with law enforcement, including incarceration have been significantly decreased!

Success Story #2

An individual who had been chronically homeless had frequent involvement with law enforcement around substance use. This person utilized the syringe services program regularly but was not interested in treatment or assistance with housing. After suffering some medical complications, and with the trust that had been built over Participant with other county outreach personnel, treatment options were explored. RNP personnel assisted in finding a facility and facilitating an over-the-phone intake, then provided transportation to the treatment facility, where the Participant is actively engaged in treatment and is getting the medical attention they need.

Success Story #3

Participant has been in the Recovery Navigator program since March of 2022. He came to the Recovery Navigator with a unique set of circumstances and challenges that he needed help addressing. Participant is on Social Security for a disability that he recently acquired, while unhoused, due to a very bad bicycle accident. After he became disabled, he was awarded a HEN (Housing and Essential Needs) voucher, which pays for the room he rents. This HEN voucher provided him housing for the first time in many years. When Participant first came to the Recovery Navigator, he was concerned as his landlord told him he would have to pay $750 rent, as there was no HEN voucher for the month. Participant was confused and scared, afraid he was going to have to return to homelessness. The Recovery Navigator made several phone calls and helped Participant get his HEN voucher extended for one year. Had no one called to ask for this extension, Participant would have likely been exited from his programs and back into homelessness, unaware of the services available to him. Right away, Participant and his Recovery Navigator started applying for waitlists and longer-term voucher programs. Participant and the Recovery Navigator have been steadily working on finding a permanent, sustainable housing solution. In addition, Participant has needed assistance with transportation costs, as he has to ride the bus frequently due to his disability. The Recovery Navigator helped Participant apply for a reduced fare bus pass, saving a significant amount of money. Participant also had been struggling with poor vision and the Recovery Navigator helped him find an optometrist that accepts state insurance. Participant had a much needed

exam and discovered that he has severe cataracts in both eyes and will need surgery. Participant and the Recovery Navigator are now working on scheduling those appointments and surgeries. The process was daunting to Participant on his own but together they have been able to work through many challenges. This is a success story because had Participant not reached out to the Recovery Navigator Program for help, he would likely have fallen through the cracks in our systems and back out into homelessness. Because he had someone to turn to, to help advocate for his best outcome, he did not have to return to many of survival behaviors that often found him interacting negatively with law enforcement.

Success Story #4

Case managers have been working intensively with Participant. Participant was connected with APS on 8/3/22, to receive a new walker, CM assisted with the phone calls and supporting participant with following through on meeting APS case manager to obtain the walker. Participant needed medical attention in our parking lot on 9/1/22, CM called for an ambulance and followed up with hospital staff about participant's health. On 9/6/22 CL was removed from his encampment by law enforcement, RNP CM was able to store participant's belonging until 9/13/22 when Outreach team met up with him on the streets. Participant was asking for a bus pass and assistance on scheduling medical appointments. CM called APS CM and left a message about completing an intake for services. Participant was seen on 9/15/22 by Outreach and Residency Doctor, he was concerned about stomach pains that were causing diarrhea and was referred to come into a clinic. Participant did not want to be transported to urgent care. On 9/22 Outreach and RNP found Participant behind a local restaurant. Participant asked for an ambulance be called because he was feeling worse. Staff stayed with Participant until ambulance transported him to Hospital, staff held onto Participant's belongings until he was released the following day. Participant came to the office the next morning asking for help with getting his medical identification cards and a state identification card. CM transported Participant to DSHS and was able to get him a voucher for an ID card, a new EBT card, five-day bus pass, and was able to apply for Medicaid because Participant already has Medicare. CM also contact Social Worker and asked about assistance for Participant to be transferred to an out of county SUD facility and Social Worker stated she could assist with this. Participant is wanting to work on his health before entering a SUD's program and will meet with staff next week to schedule appointments.