

MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

114TH ARIZONA TOWN HALL



FINAL REPORT



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MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

FINAL REPORT

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FINAL REPORT

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The 114th Statewide Arizona Town Hall took place in Tempe, AZ and online via Zoom conferencing technology from November 14-16, 2022. Over 100 attendees developed consensus recommendations on the topic of "Mental Health, Substance Use, and Homelessness." Before this capstone statewide town hall, 26 precursor community and future leaders town halls with nearly 2,000 participants provided valuable insights and ideas to the participants at the 114th statewide town hall and to the communities sponsoring the community and future leaders town halls.

The Morrison Institute for Public Policy, in partnership with community experts and the Arizona Town Hall Research Committee, lent its time and talent to create a fact-based background report integral to the understanding of the topic. The Background Report, distributed to all participants in advance of the Town Hall sessions, is an essential element to the success of these consensus-driven discussions. The Morrison Institute and all those who worked with them on the Background Report created a unique resource for a fuller understanding of the topic.

Our sincere thanks go to the report's authors for sharing their time, wealth and breadth of knowledge, and diverse professional talents.

Our deepest gratitude also goes to Kristi Eustice, Senior Research Analyst, and Benedikt Springer, Postdoctoral Scholar at the Morrison Institute for Public Policy at Arizona State University, who marshaled authors, created content and served as editors of the report.

The "Mental Health, Substance Use, and Homelessness" Town Hall sessions could not have occurred without the financial assistance of our generous Professional Partners. These Partners include general sponsors The Diane and Bruce Halle Foundation, Molina Healthcare, Arizona Public Service (APS), the Salt River Pima-Maricopa Indian Community (SRPMIC), Salt River Project (SRP), and Blue Cross Blue Shield Arizona - Health Choice, as well as the numerous sponsors of the various community and future leaders town halls around the state.

Contained in this single Final Report is the full text of the consensus recommendations developed by the participants at the 114th statewide town hall. The Final Report also includes the individual community and future leaders town halls reports as well as the Background Report.

This report will be shared with our public officials, community and business leaders around the state, Arizona Town Hall members, and many others. It is already being used as a resource, discussion guide, and action plan on how to create vibrant Arizona communities.

Sincerely,

Evelyn Casuga
Board Chair, Arizona Town Hall
www.aztownhall.org

MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Statewide Town Hall

RECOMMENDATIONS REPORT

Participants of the 114th Statewide Town Hall “Mental Health, Substance Use, and Homelessness”

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TOWN HALL PROGRAMMING

Panel presentation: **Health and Human Services and Arizona Mayors**

Presiding: **Suzanne Pfister**, President & CEO, Vitalyst Health Foundation

Sponsors Highlighted: **Salt River Project (SRP)** and **Salt River Pima–Maricopa Indian Community (SRPMIC)**

Speakers:

Paul Deasy, Mayor, City of Flagstaff

Que English, Director, Center for Faith-Based and Neighborhood Partnerships, U.S. Department of Health and Human Services

Craig McFarland, Mayor, City of Casa Grande

Corey Woods, Mayor, City of Tempe

Connecting Across Generations: Community Storytelling with **Rising Youth Theater**

Panel presentation: **Best Practices and Lessons Learned from Arizona Communities**

Presiding: **Elizabeth McNamee**, Vice Chair, Community Town Halls Committee

Sponsors Highlighted: **Molina Complete Care of Arizona** and **Arizona Public Service (APS)**

Speakers:

Don Bischoff, Captain, Special Projects, Mohave County Sheriff's Office

Shelley Mellon, Owner/Broker, RL Jones Insurance Services, Inc.

Suzanne Pfister, President & CEO, Vitalyst Health Foundation

Presentation: **The Path Forward**

Presiding: **Barry Aarons**, Owner, The Aarons Company LLC and **Holly Figueroa**, Tribal Liaison, BCBSAz – Health Choice

Sponsors Highlighted: **Blue Cross Blue Shield Arizona – Health Choice**

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Special Presentation with **HOPI-R2**

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REPORT OF THE 114TH ARIZONA TOWN HALL "Mental Health, Substance Use, and Homelessness" PERA Club, Tempe, AZ and Online via Zoom November 14-16, 2022

INTRODUCTION

"I never woke up one day and said, 'Hey I want to lead a tragic life.' My journey with mental health challenges and addiction have led me to lose everything in my life more than a couple of times — my jobs, my housing, my books and files, and my self-respect."

- Wayne Mellinger, Ph.D., "Triple Challenged Can't Grapple with Their Demons Alone"

Mental illness, substance use, and homelessness often occur together and impact people from all walks of life. They frequently exist in a vicious cycle, where one contributes to the other, making escape nearly impossible. Homelessness can lead to substance use and/or mental health issues; untreated mental illness can lead to illicit substance use; and sometimes it is substance use and/or mental illness that leads to homelessness. And once the cycle begins, it can quickly lead to a harsh and merciless downward spiral. The co-morbidities between these conditions create challenges for treatment and long-term, substantive policy development.¹

There are significant disparities that exist in the experience of homelessness, mental health and substance use disorder among people from under-represented groups. For example, people from Black, Indigenous, and People of Color (BIPOC) communities are more likely to experience homelessness in Arizona. In particular, the greatest disparity in the experience of homelessness lies among the Black and African American community. We find significant disparity among the Native American population in the experience of homelessness also, with the largest disparities in the Northern part of the state. Any action relating to solutions to address the intersection between homelessness, mental health and substance use needs to account for disparity among marginalized groups within our diverse communities. This extends to how these cycles are prevalent among the justice involved, military veterans, youth LGBTQ2+ community and the disability community.

People from all different levels of society are impacted by the cycle of mental illness, substance use, and homelessness. Many of us are only one paycheck away from facing these challenges as illustrated by a 2017 Bankrate survey. The survey found fifty-seven percent of Americans reported they do not have enough cash to cover a \$500 unexpected expense. Poverty, inequality, and discrimination also factor into the reasons for homelessness and shed light on the behaviors of people experiencing homelessness, mental illness and/or substance use. We are called on to ask the question "What happened to you?" instead of "What's wrong with you?" to understand the underlying reasons for the "Revolving Door" described in Chapter 3 of the background report. It is time to break down barriers and build bridges of understanding with one another.

¹ As noted on page 7 of the Background Report for the 114th Arizona Town Hall on Mental Health, Substance Use, and Homelessness, (the Background Report); "Someone is considered homeless if they lack a fixed nighttime residence." (Page 163 of the Final Report.) As further noted in Chapter 2, "Someone is considered to have a mental illness, mental disorder, or mental health issue...if they have been diagnosed by a licensed medical or mental health professional." Substance Use Disorder "occurs when an individual continues to use drugs (e.g., alcohol, cocaine, opiates) despite the use causing significant harm to them." (Page 166 and 167 of the Final Report.)

Those who are at the intersection of mental illness, substance use, and homelessness have to navigate a complex system of services where communication among agencies and providers is often siloed, and where a lack of a fixed residence and a reliable mode of transportation act as barriers to services. As a result, many of those who need treatment fall through cracks in the system, often cycling between the streets, emergency rooms, crisis care, jails, and prisons.

An individual's mental illness, especially a serious mental illness, can make it hard to earn a stable income and carry out daily activities, leading to difficulties maintaining housing. Self-medicating can lead to a substance use disorder putting an individual further at risk of homelessness and social isolation. Despite efforts to raise awareness and make treatment more accessible, a stigma around mental health issues persists. Many people, including healthcare and other service providers, view individuals with mental illnesses in a negative light, often attributing danger or blame to them. Sufferers can internalize these negative appraisals, leading them to eschew treatment and the support they need. This stigma is misplaced and counterproductive.

While the exact cost to end homelessness is unknown, research suggests that the costs associated with providing stabilization services, such as housing and mental health treatment, are much smaller than the public costs associated with the persistence of homelessness. These costs include police response, criminal prosecution, incarceration, emergency room visits, street clean-up, not to mention the lost opportunity costs of individuals unable to contribute to society and the like. In other words, providing support and treatment is not only a more humane approach; it is also a more cost-effective solution than having someone cycle through emergency care and legal systems.

The 114th Arizona Town Hall invited a robust, respectful policy discussion that built upon and considered the preceding community town halls that included discussions from nearly 2000 participants around the state. Participants hope their recommendations will inspire and motivate our state's leaders and stakeholders to respond to these challenges. The results of the discussions at the 114th Arizona Town Hall are included in this report. Though not all Town Hall participants agree with each of the conclusions and recommendations, this report reflects the overall consensus reached at the 114th Arizona Town Hall.

THE INTERRELATIONSHIP OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

The conditions of mental health, substance use, and homelessness are intimately tied together impacting individuals in significantly different ways. The varied and unpredictable impacts are often what make it so challenging to address the conditions holistically.

Often substance use is a coping mechanism used to self-medicate that may stem from undiagnosed and unmanaged mental health issues. Both may result in the loss of jobs and possessions, and ultimately lead to homelessness. Conversely, the difficulties, trauma and hopelessness resulting from homelessness may trigger the onset of a mental health challenge or substance use to cope with the daily challenges of homelessness. All of these conditions left untreated can lead to physical and mental debilitation and death.

The three conditions are connected in a circle, where any one of these conditions may lead to the other two, and the conditions can all cascade into one another, which is why it is important to address them together. However, it is also important to recognize that while they are often connected, that is not always the case, and a one-size fits all remedy is not the solution. For example, one can be homeless without having a mental health or substance use challenge. And one can suffer from a substance use disorder or a serious mental illness (SMI) and never experience homelessness. But, the correlation between mental health, substance use disorder and homelessness is undeniable.

Housing is a fundamental building block for addressing all of these conditions. According to Maslow's hierarchy of needs, shelter is one of the fundamental needs for human survival. It must be addressed before we can progress to addressing the need for safety, security, belonging, esteem, and self-actualization. Housing is a form of preventative health care. The longer one is without a home, the greater the sense of hopelessness, and the likelier that someone will turn to substance use or suffer mental health challenges as a result. Many people throughout Arizona are very close to becoming homeless because of economic barriers, such as low paying jobs, lack of affordable housing, increased gas prices and cost of living. Any disruption in their lives or income could result in the loss of a home, without mental illness or substance use playing a role.

Today's high-cost housing environment makes it very difficult for communities to find solutions to the problem of affordable housing. Some communities try to address homelessness by providing seasonal shelters, shelter that is made available when there are inclement weather conditions, and while these efforts are admirable, they are not sufficient.

There is strong resistance in many communities to recognize that a segment of their community is facing these problems. State and local government too often prefer to push responsibility for addressing the problem on to nonprofits and faith-based organizations. Many neighborhoods, especially those with higher property values, do not want affordable housing projects, shelters, or treatment centers in their backyards. Some people hold the view that ultimately individuals are responsible for themselves and for their life choices/circumstances, and public intervention is not warranted. We need to take individual action to change these perspectives and provide a program of public education to create broader understanding about these issues.

Some do not want people experiencing mental health, homelessness, and substance use as well as providers to become their next-door neighbors. This is a result of misperceptions about those in need of care and a lack of access to social and medical services for those experiencing these conditions. Just providing temporary shelter is not enough. For many people who are experiencing homelessness, healing takes time, and some need to be empowered and have their confidence restored. Systems need to support this. Those suffering from post-traumatic stress disorder, depression, and anxiety need ongoing therapy. Because there is a shortage of affordable mental health care providers, particularly in rural areas, there can be a significant delay in obtaining the help that is needed.

There is a dimension of the homeless population that is hidden from view. These are people who are not readily identifiable as being homeless. They may be living in their cars, or with relatives or friends. Many are working full-time jobs but cannot afford housing. Many of these "working homeless" do not know about the resources that are available to help them, in part, because they do not want anyone to know that they are homeless, for fear that it will impact their employment, child custody, or immigration status.

Treatment and prevention for substance use and mental health issues are underfunded. Navigating the red tape of public benefits can be complicated and prevent patients from seeking the treatment they need.

We are currently in a perfect storm involving the conjunction of these three conditions. The COVID-19 pandemic resulted in death or serious health conditions for some, isolation and mental health issues for others, and substance use for still others. The pandemic created financial problems that left some people just a paycheck away from becoming homeless. Also, we are facing a growing fentanyl crisis², that is made worse because of concerted misinformation and disinformation concerning the causes of the crises.

2 According to the National Institutes of Health, "fentanyl is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. It is a prescription drug that is also made and used illegally." <https://nida.nih.gov/publications/drugfacts/fentanyl>

In Arizona and nationally, there is a dire shortage of affordable housing. A partnership between the legislature, local governments, nonprofits, philanthropic organizations, and developers must look for innovative ways to assure that there is an adequate supply of housing for workers, the elderly, and low-income families. We should consider changes to zoning regulations, tax incentives, and other strategies to increase supply to meet demand.

Those who have a criminal record face yet another barrier to obtaining employment and housing. As a society, we should reconsider whether it is wise to continue punishing those who have served their time by denying them employment and housing, and ultimately consigning them to failure. Service providers such as Terros and Solari Crisis Response Network address mental health and substance use treatment needs. With the recent approval of a section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS), the Arizona Health Care Cost Containment System (AHCCCS) will implement a Housing and Health Opportunities (H2O) demonstration, a project that strives to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. Under this demonstration proposal, AHCCCS will seek to:

- Increase positive health and wellbeing outcomes for target populations including the stabilization of members' mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction,
- Reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalization, and
- Reduce homelessness and improve skills to maintain housing stability.

It is hoped that such a program will reduce gaps in support and services, meeting individuals where they are, and provide whole-person, relationship-based care to individuals.

ADDRESSING STIGMA

Many people who experience mental health, substance use, and homelessness challenges face public and private stigma and shame. Singled out, they find themselves reduced from a whole person to little more than a stereotype. Treated differently, they may feel ashamed or worthless, as if they are somehow less than other people. Stigma can also lead to discrimination, and this in turn can lead to a downward spiral especially when the impact of stigma keeps individuals from seeking, accepting, or obtaining housing, support, and services. Mental health, substance use, and homelessness can be triggered by ordinary circumstances such as job loss, change in relationship, medical conditions and other causes that can happen to any of us as we simply struggle with life circumstances, but nonetheless, people judge, blame, and stigmatize. While efforts have been made by the media and influential athletes and celebrities to lessen the stigma associated with mental illness, it still exists.

Too often, there is a perception that individuals choose to experience homelessness and substance use disorders and can simply choose to change their circumstances. The criminalization of these conditions also contributes to stigma.

Stigma affects not only the person suffering with these conditions, it also affects their communities and families. When our own families face these challenges, it can cause shame and embarrassment and our instinct is to cover it up or deny the existence of the problem. Although virtually every family has some connection to a person who has one or more of these challenges, it is easier and more comfortable to believe that it is someone

else's problem. This can lead to individuals experiencing a lack of belonging. And many living on the streets experience invisibility even when trying to be seen.

Stigma relating to stereotypes and biases can be affirmatively addressed through holistic community and provider education. Peer-run organizations can connect individuals with shared life experiences. We need to build trust, especially where there are prejudices stemming from race, ethnicity, sexual orientation, gender identity, criminal justice history, and age. Incorporating people with lived experience and listening to people's stories can help. We need to understand that rural and urban areas have their own unique circumstances including availability and access to resources. We also need to eliminate the competition between individuals and families for critical resources.

Stigma applies culturally to how individuals may or may not access care. For example, there may be cultural stigma associated with mental health that prevents an individual from accessing a diagnosis. Assessment processes are often not culturally appropriate to take these differences into consideration, and ultimately may exclude individuals from accessing services. This leads to disparity in the experience of things like homelessness, mental health, and substance use disorders and disparities in program outcomes. Our access processes need to be reviewed under an equity lens.

Working together, we can publicly reframe these issues as humanitarian issues affecting our friends, neighbors, and families instead of a law enforcement or community protection issue. We should have a trauma-informed, no-wrong-door approach to supporting Arizonans experiencing mental health, substance use disorder, or homelessness issues.

Many people are hesitant to discuss these issues in a professional setting and are concerned that their careers will be affected if they are honest about their circumstances. It is important that employers and professional licensure boards provide a welcoming environment. Not all health professionals or first responders are comfortable with these issues, so education and training for them can be helpful. A compassionate approach is key. Media needs to change the narrative of how we discuss these issues and how we present the vulnerable people who experience these challenges. Showcasing strength and stories of successful treatment is important.

The importance of effective community education cannot be overstated. People struggling with these conditions need assistance, but the services they need often are not available because neighborhoods do not want treatment facilities, such as methadone centers, in their communities. We need to get past the Not In My Back Yard ("NIMBY") mentality and understand that these facilities are needed to serve our friends, neighbors, and families.

Another way to address stigma is to treat people with kindness, dignity, and respect. We need to remember that people are not problems; people have problems and these problems are nearly always the result of what has happened to them. A simple offer of help and support can make all the difference for someone struggling with these conditions. Using "people first" language that refrains from characterizing people by the conditions that affect them has been shown to be impactful. For example, instead of "homeless people" we need to understand that these are people experiencing homelessness. Community education is needed but it is important that the message be concise and cohesive. Some examples include the Maricopa Association of Governments ("MAG") which will be using this type of messaging in reports and the Home Matters to Arizona campaign which also offers such a message and is committed to raising \$100 million in grants and loans.

To get at the root of stigma we need to reach families. Families are the source of the most help and support for people experiencing these challenges. Although family support is important in helping individuals feel connected, supported, and loved, it is essential for them to understand that they must learn to love and stand up for themselves.

Building connections with friends, neighbors and others in the community also can be a vital component of rebuilding a successful life. We need people to step up and reach out a hand to their neighbors instead of walking past them on the street or driving into the garage and closing the door. We need to speak up and push back when someone uses stigmatizing speech or demonstrates stigmatizing behavior.

DEVELOPING INTEGRATED SOLUTIONS

Housing First is an important principle that focuses on harm reduction and means that shelter is not dependent on sobriety or mental health determinants. People need a safe place to be whether or not they are sober. Many sober living environments will not accept clients who are in medication-assisted treatment, such as methadone, even though it is one of the gold standards of treatment. We should encourage harm reduction policies for some sober living locations in order to reduce homelessness for those still struggling to get sober.

Many people experiencing mental health or substance use challenges have trouble navigating a complex decentralized system. Individuals need someone who will guide them through the process of determining available services, obtaining the necessary services, and ensuring continuity of care. Ideally, the service providers should be consolidated into single locations throughout the state, providing coordinated services, which would reduce transportation and logistical challenges.³

It would also be helpful to develop a corps of navigators who could help people on an ongoing basis to maneuver through the systems and to personalize the services they receive. Collaboration and public-private partnerships are critical, but so are community education and outreach. There are many under-utilized governmental parcels throughout the state, owned by cities, school districts, and the Bureau of Land Management, that could be utilized for housing with wraparound services.

Affordable housing that integrates mental health services into its model is a key factor to its success. Programs exploring this type of approach are too few and are not available throughout the state. Most rural areas do not have such programs in their communities and have very limited access to programs in communities outside their areas.⁴

We also need more caseworkers, social workers, peer support specialists, and crisis interventionists. It would be helpful to end requirements that caseworkers be tested for marijuana, now that it is legal under state law, and we should consider creating new jobs for people with relevant life experience who may not have traditional education.

Maricopa County increased the number of shelter beds since May 2022 by 600 and is due to add an additional 800 beds in the next eighteen months. However, homeless shelters only provide temporary relief. Adding beds is therefore a “band aid” solution. Cities should consider providing permitting preferences to those developers and investors willing to construct affordable housing. We also need to include more people with lived experience at the table in discussions about the affordable housing crisis and other issues. Much of the

3 One example of an organization exploring this concept is First! Village, a 51-acre master planned community located in Austin, Texas that provides centralized affordable, permanent housing and a supportive community for men and women coming out of chronic homelessness.

4 Some examples of organizations using this approach include Save the Family and New Freedom. Save the Family is the City of Mesa’s leading provider of housing and services for more than 650 homeless and impoverished families and children each year. The organization provides eviction prevention services, housing, case management and supportive services. Families are matched with the program best suited to their individual needs and abilities and are assigned case managers who assist families with setting and achieving goals geared toward ensuring the family’s long-term housing and financial stability. These services often include securing employment, moving up in the workplace, improving financial literacy, building life-skills, and addressing substance use and mental health issues. Save the Family has an 85% success rate in bringing people from homelessness to permanent housing. The organization offers help with education, parenting, career and job placement, counseling, self-help, budgeting, and life skills, and provides transportation and other assistance. New Freedom targets the population of formerly incarcerated persons. It is a for-profit, out-patient care behavioral health facility that receives federal funding. It has a nonprofit supporting foundation that supports the other work of New Freedom, including the mentoring programs. New Freedom is peer-led and offers navigation services that help clients transition from incarceration to life outside of prison. The organization helps with vocational education, health care, transportation, housing, and employment.

affordable housing problem is caused by NIMBYism. Mixed-income and affordable housing properties have not been a priority for local leaders and developers.

The lack of affordable housing contributes to the problem of homelessness. As many as 25% of the people who occupy a bed at the downtown-Phoenix Human Services Campus (HSC) are employed, but still cannot find a place they can afford to live. There is a highly visible population of people living in tents outside the HSC campus, many of whom are there because there are no available shelter beds. City of Phoenix officials say they recognize the problem, but also do not believe that they should be required to shoulder the expense and responsibility of tending to the homelessness problem, absent involvement from other cities such as Glendale, Scottsdale, Mesa, Tempe, and Chandler.

Too often agencies involved in providing social and medical services do not communicate with each other. In fact, they may be prohibited by law from exchanging information with each other due to privacy and confidentiality laws. Because the people being helped are particularly vulnerable and subject to abuse, information about them may require special protection. As a result, people fall through the cracks.

We need more detox centers. In many cases, individuals cannot get into residential mental health or substance use disorder treatment until they have been off substances for 24 hours. We also need to change the arbitrary 28-day limit on treatment programs. Twenty-eight days is not enough time for most people to accomplish all the work they need to do in order to be in a place where they are more likely to be successful in their next step.

Further, under AHCCCS, irrespective of legal requirements, mental health care and treatment is often not on par with treatment options available for physical medical conditions. Even those with good, private insurance express frustration and struggle in obtaining mental health services. The number of mental health professionals who accept insurance or participate as AHCCCS providers are dwindling. Mental health care is becoming a cash-pay system, so only those with money can afford services.

Most services are only available during regular business hours. The nature of these conditions is that help is needed at all hours of the day or night. It is important to consider and provide for the special needs of these populations and have help available 24/7.

Also, some individuals living with a serious mental illness (SMI) require court intervention to receive necessary services. We need to ensure that Title 36 of the Arizona Revised Statutes is amended to remove unnecessary barriers to treatment and support.

We also must elevate the sense of urgency on issues surrounding mental health, substance use, and homelessness. These issues have been "talked" about for years. Now is the time for action. Nothing can be accomplished absent funding, which requires us to make a financial case to elected officials and business and community leaders that addresses the issues from prevention to rehabilitation. This will include an accounting of direct and indirect costs and demonstrating the economic benefits of ensuring that an individual is a productive member of society and earning a living wage. Many people will not support the cause unless they see a financial benefit. We currently face a problem of economics. Many people who hold the "purse strings" need data before they can commit financial resources. Quality data can raise awareness and encourage action.

There are hundreds of thousands of people in Arizona who need help with housing, mental health, and substance use. While there are many not-for-profits and social service agencies providing services, it is imperative that government be at the forefront of these issues. The Executive Branch should re-instate the Governor's Commission on Homelessness and Housing, and both the House and Senate should have standing committees dedicated to homelessness.

RECOMMENDATIONS FOR PUBLIC SECTOR ACTION

Housing is healthcare. Housing is critical to addressing mental health, substance use, and homelessness. State and local governments should provide incentives and robust funding sources plus implement zoning reforms to expand affordable housing supply. The Low-Income Housing Tax Credit (LIHTC) is a key program for incentivizing new development of low-income housing. More incentives are needed to encourage the construction of affordable housing units, especially for those who do not meet the criteria for other housing assistance. It would be good to consider providing landlord incentives for renting to people with a criminal justice history.

Public resources for people experiencing mental health, substance use, and homelessness should be further integrated and connected with the 2-1-1 Arizona and 988 Suicide & Crisis Lifeline. Interdepartmental action teams should be implemented at all levels of government to eliminate silos and put people at the center of processes to ensure they are accountable to the individual. The city of Tempe has co-located different departments of its municipal government, and this type of collaboration encourages all agencies to work together and expand their ability to help individuals.

In some communities, elected officials either do not accept that their communities have a problem involving mental health, substance use, and homelessness, or think that the problem should not be addressed by the government, either by action or funding. Some view these issues as the responsibility of faith-based and nonprofit organizations. Before they will consider acting or providing funding, elected officials and government leaders should engage in training on trauma-informed care and receive education about the full extent of mental health, substance use, and homelessness issues. They need to be aware of who the various stakeholders addressing these issues are so they can effectively combine efforts and help navigate individuals to available services. In some communities, elected officials would like to do something about these problems, but they do not know what they can effectively do. They need technical assistance to develop solutions to work for their communities.

Smaller pilot programs that allow grant recipients in both the public and private sector to try new approaches is a good idea. Seeing grant recipients as genuine partners is key to building strong relationships. Governments should coordinate and partner with businesses and non-profits. An example is the Government Property Lease Excise Tax (GPLET), a tax incentive agreement negotiated between a private party and a local government. It was established by the State of Arizona in 1996 to stimulate development in commercial districts by temporarily replacing a building's property tax with an excise tax. State and federal grant programs should eliminate spending constraints and barriers to allow for integrated care and services. Removing the constraints and barriers makes it easier for communities to use the funding where it is truly needed.

People barely making a living wage can be determined ineligible for AHCCCS and other income-based benefits programs just by receiving a small raise. Eligibility limits for government benefit programs should be reviewed more often and in light of current economic conditions. We should consider "step downs" rather than an all-or-nothing eligibility criterion.

Robust re-entry and peer support services are critical programs for sustained recovery and reduced recidivism, and it is important that the courts work with human services departments and first responders to examine how current law impacts the wellness of vulnerable individuals.

We should expand programs that divert individuals experiencing a mental health crisis from the criminal justice system to services that are more appropriate for their needs than jail or prison. Diversion programs lead to better outcomes and governments should provide more support for laws that allow individuals' behavioral

health needs to take priority over punishment and that may be better addressed outside of a jail or prison setting. We also need to ensure increased availability of specialty courts addressing mental health, substance use, and homelessness—especially in rural and underserved areas. The City of Tucson’s Homeless Court is one example of how specialty courts can better serve both the public and the individuals affected.

Mental health, substance use, and homelessness are often criminalized. The relationship between law enforcement and vulnerable populations is fraught. Law enforcement personnel may perceive substance users and persons experiencing homelessness as criminals because that is the context in which they have interacted with them. They may lack compassion and make assumptions about people based on prior experiences. Many people experiencing homelessness are terrified of the police. They respond more positively to crisis outreach teams comprised of a social worker and a healthcare provider who can address mental health crises rather than having the police as the first line of intervention. Public safety personnel should also receive training on working with individuals with mental health and substance use issues. It would be useful to consider co-response models where certified peer support specialists are funded and dispatched with law enforcement.

Providing funding for peer support is also important. Clear communication from government officials and pushback on disinformation and misinformation about these programs is critical, and the media and public should support these efforts.

We need to work with children at an early age through the schools to teach basic mental wellness skills and substance use prevention. Children must know what substances are dangerous and just how dangerous they are. As an example, fentanyl is marketed to children in appealing forms, colors, and flavors. We also should fund additional counselors and social workers in our schools.

We also need to fund programs to train people for careers in the social services and mental health fields and keep them employed in Arizona. This will require more funding to attract and retain counselors and social workers. We should provide funding and offer student loan forgiveness and tuition assistance for apprenticeship programs to increase the number of individuals entering the social services and counseling workforce. We should encourage relationship building with colleges, universities, and hospital residency programs to attract students to these fields. Rural areas face an overall shortage of resources to deal with these issues. There are fewer doctors and other professionals, as well as fewer facilities. To fund these recommendations, we could use money from the opiate settlement fund and increase reimbursement rates for mental health care and substance use prevention providers.

While recognizing tribal sovereignty, AHCCCS, the Arizona Department of Health Services (AZDHS), the Governor’s Office on Tribal Relations, and tribal liaisons should prioritize addressing off-reservation mental health, substance use, and homelessness for Arizona tribal members through cross-sector collaboration.

Everyone deserves access to housing. Laws and local codes should be reviewed to ensure that governments do not criminalize homelessness. Local zoning rules and regulations should be revised to allow for more inclusive zoning, including encouraging affordable housing – both single family homes and multi-unit residences. The Legislature should enact laws that eliminate barriers for shelters and property rental to individuals challenged by mental health, substance use, and homelessness, as well as those who have judgments against them, evictions, and criminal convictions.

We should realize that as individuals, our voices can make an impact on government. It is not always necessary to influence people at the very top. Sometimes conversing with someone can lead to life changes that make a difference. When someone makes a difference, we should let them know the significance of their impact.

ACTIONABLE RECOMMENDATIONS FOR BUSINESSES AND NON-PROFITS

The most important action that community leaders of educational institutions, businesses, nonprofits, faith-based organizations, and other groups can take is collaborate and create sustainable partnerships throughout Arizona. The next most important actions to be taken are to support or establish scattered locations with more wraparound services and resources.

Social service providers need to catalogue and inventory: (1) best practices for the services provided; (2) current collaborations and partnerships; (3) technical assistance for providers; and (4) opportunities for future multi-sector collaboration. This information should be located in a place that is easily accessible to the public. Organizations should be able to coordinate benefits and services provided to their clients. For example, centralized databases, such as the Homeless Information Management System (HMIS), may offer a viable solution.

Additionally, integrated service models must include ongoing, comprehensive services, whether or not an individual is continuing to reside in a homeless shelter, has been incarcerated, has obtained employment, or is not receiving necessary health care. Too often service organizations provide a one-time service, and once that service is provided, deem their work done, but the individual receiving the service has other needs that go unaddressed.

Both non-profit and for-profit service providers should utilize intern and extern programs in conjunction with educational institutions to expand staffing levels and provide support and services to Arizonans facing mental health, substance use and homelessness issues. Further, intern and extern programs give students real-world experience while obtaining the educational skills necessary to excel in their professions and provide better community services.

Community leaders, including elected officials, should interact on a regular basis, to strategize and communicate their plans to address mental health, substance use and homelessness. Regular communication is necessary to ensure collaborative and integrated service models that avoid duplication of efforts and to maximize resources. A "start here roadmap" should be developed and disseminated throughout the state. Similar to a public information campaign, posters can be placed in public places and in businesses, to provide information about where people can call to receive assistance.

We should encourage individuals to use 2-1-1 Arizona, a community information and referral service. Social service providers should also be strongly encouraged to affiliate with 2-1-1 Arizona to provide individuals with as many resources as possible. 2-1-1 Arizona connects people with resources to help meeting basic needs, including housing, food, transportation, and health care. 2-1-1 Arizona should be staffed with real people, not chat bots or pre-recorded messages. Human connection is important.

Social service providers should implement continuing education programs for their employees and include curriculum on trauma-informed care, Diversity, Equity and Inclusion initiatives, equity, cultural competencies, and crisis de-escalation. Burnout is a significant issue that needs to be addressed. To avoid burnout, providers should implement programs that enhance their employee's own well-being.

The Association of Recovery Community Organizations includes organizations that employ people in recovery as workers and supervisors. It would be helpful if more businesses and other organizations would hire people challenged by mental health conditions, substance use, and homelessness.

Alongside Ministries, Arouet Foundation, and New Freedom are agencies that go into the prisons to provide pre-release services. They have a buddy system that provides connections and resources for incarcerated persons who are preparing for their release from prison. These entities offer peer support and other resources that

will walk the formerly incarcerated person through the processes involved in obtaining health care, court-related documents, program applications and benefits. Hustle Prison provides housing opportunities for persons being released from prison.

Individuals should be encouraged to volunteer within their communities, with a specific emphasis on staffing crisis hotlines, learning skills necessary to de-escalate crisis situations, crisis intervention, substance overdose prevention and peer mentorship. Arizona State University funds outreach workers to address non-emergency mental health needs. It also has programs that coordinate volunteers who want to do something to help. The National Alliance on Mental Illness provides opportunities for peers and community volunteers to support those impacted by mental health issues and to facilitate classes and support groups, including programs for youth. Arizona Health Education Centers (AHEC) focus on developing integrated, sustainable, statewide health professional workforce education programs with an emphasis on primary care. AHEC increases access in Arizona's rural and underserved communities by improving the supply, quality, diversity, and distribution of health professionals in the workforce.

Individuals should also combat misinformation and disinformation regarding the reasons for homelessness, mental health issues and substance use disorders. Educating your inner circle of friends and family is a good first step into community engagement and dialogue on these issues.

PRIORITY ACTIONS

Participants prioritized the following specific actions to address mental health, substance use, and homelessness in an integrated way:

- Increase funding for low-income and affordable housing, including rental assistance, eviction protection, SMI housing, senior housing, and adolescent residential treatment facilities. While the exact cost to end homelessness is unknown, research suggests that the costs associated with providing stabilization services, such as housing and mental health treatment, are much less than the public costs associated with the persistence of homelessness. Providing housing, support and treatment is not only a more humane approach; it is also a more cost-effective solution than having someone cycle through emergency care and legal systems.
- Fund community resource navigators, peer support specialists, and social workers to guide people experiencing mental health or substance use challenges as they often have trouble navigating a complex decentralized system without help. They need a "warm handoff," someone who will guide them through the process of obtaining continuity of care and wraparound services. These navigators should also provide in-hospital services to help patients navigate state and federal healthcare and benefits' systems.
- Support and establish co-located government agencies and non-profit organizations, i.e., "one-stop shops" or shopping centers, where multiple services from different providers are offered in a single location. Save the Family is a program that offers a "one-stop shop" approach. It has an 85% success rate in bringing people from homelessness to permanent housing. They offer help with education, parenting, career and job placement, counseling, self-help, budgeting, and life skills, and provide transportation and other assistance. New Freedom is another example of a one-stop agency that targets the population of formerly incarcerated persons. It is a for-profit, out-patient care behavioral health facility with supported housing that receives federal funding. It has a nonprofit foundation that supports the other work of New Freedom, including its mentoring programs, vocational education, job placement, transportation, housing, and related benefits and eligibility documentation. New Freedom is peer-led and offers navigation services that help clients transition from incarceration to life outside of prison.

- Review laws and local codes to ensure that governments do not criminalize homelessness. Local zoning rules and regulations should be revised to allow for more inclusive zoning, including encouraging affordable housing—both single family homes and multi-unit residences. The Legislature should enact laws that eliminate barriers for shelters and property rental to individuals with mental health, substance use, and homelessness challenges, as well as those who have judgments against them, evictions, and criminal convictions.
- Implement interdepartmental action teams at all levels of government to eliminate silos and put people at the center of processes and programs. The Arizona Department of Housing, AHCCCS, and the Arizona Department of Employment Security are working toward this goal.
- Increase and expand the availability of specialty courts addressing mental health, substance use, and homelessness—especially in rural and underserved areas.
- Expand effective diversion programs and flexibility for judges to effectively support and sentence individuals facing mental health, substance use, and homelessness issues.
- Leverage lessons from the COVID-19 pandemic to continue the review and relaxation of laws and regulations related to health care and other benefits that were revised or suspended due to COVID-19. Reimbursement for telemedicine and retention of Medicaid membership are examples.
- Encourage, incentivize, and create collaborative opportunities for multiple stakeholders to seek grant funding. Increase training for staff at all levels on how to seek and utilize funding effectively. Eliminate red tape attached to funding that gets in the way of caring for the whole person.
- Bring together federal, state, tribal, county, and municipal governments, nonprofits and community organization service providers and leaders, including elected officials, in dialogue and collaboration on the issues of mental health, substance use, and homelessness for the purpose of education, sharing best practices, developing clear goals and metrics as well as coordinating planning processes. Develop initiatives for multi-sector collaboration.
- Eliminate restrictive professional licensure requirements related to mental health, substance use, and homelessness issues. Disclosure of mental illness should not be a prerequisite for licensure.
- Eliminate restrictive practices in employment applications that restrain individuals with criminal backgrounds from obtaining a job. Specific charges should be disclosed if and only if the charges relate to the individual's potential employment.
- Involve Arizonans who have shared and lived experiences with mental health, substance use, and homelessness issues at all stakeholder levels including funding, data, strategic, operational, direct service, committee, work groups, policy, etc. Ensure that involvement is done in a mindful, intentional, equitable, and informed way.
- Invest in workforce training and development to increase the supply of available staff to support Arizonans facing mental health, substance use, and homelessness issues. To avoid burnout, providers should implement programs that enhance their employees' own well-being.
- Seek new sources of revenue at the county and local levels to sustain American Rescue Plan Act (ARPA) funding beyond 2026.
- Increase and make more transparent funding, fully allocate existing funding, create additional incentives, and co-locate staff and services to better attract and compensate qualified staff, including caseworkers and healthcare providers.

- Ensure that the criteria for Title 36 court-ordered evaluation, treatment, and commitment is thoughtfully reevaluated and expanded to avoid unnecessary barriers to treatment and ensure that court-ordered services are provided in a human-centric, coordinated, and supportive way.
- Educate communities about resources including 2-1-1 Arizona and 988 to help individuals who are facing mental health, substance use, and homelessness issues. Educate 911 staff about proper diversion to these resources and screening systems to direct individuals to resources related to mental health, substance use, and homelessness.
- Create budget line-item funding for 2-1-1 Arizona and 988 in the state budget.
- Implement a statewide outreach campaign to inform citizens about alternatives to calling law enforcement. Embed mental health professionals and/or social workers with first responder units to deal with issues that may require crisis intervention, but do not require law enforcement.
- Expand the number of detox centers throughout the state. People cannot get into many residential treatment facilities until they have been off substances for 24 hours or more. Eliminate the arbitrary 28-day limit on treatment programs.
- Revise legal constraints and expand existing efforts for access to reliable data sharing between organizations serving individuals with mental health, substance use, and homelessness in order to build systems change.
- Utilize unused ARPA funding for addressing issues of mental health, substance use, and homelessness by expanding programming, shelters, affordable housing, and other related services.
- Explore the use of participatory funding models to engage citizens in the process of deciding how public money is spent to address mental health, substance use, and homelessness.
- Expand access to health care and other services to address mental health, substance use, and homelessness through a mobile delivery method especially to rural and tribal communities. Circle the City is a great example of this type of program.
- Revise restricted criteria regarding housing opportunities for individuals struggling with serious mental illness and substance abuse and those involved in the criminal justice system. Take an individualized approach when assessing housing needs for applicants.
- Implement cultural humility as a best practice in cross-sector providers.
- Braid qualitative and quantitative data utilizing the skillsets of people with mental health, substance use, and homelessness lived experience in developing executive, policy management, strategic, and direct services to decrease stigma, enhance equity, and increase trauma informed care.⁵
- Review accountability and consider an audit or review board for programs that use tax funding but fail to keep individuals from becoming frequent users of emergency systems.
- Provide universal free lunch programs for kids experiencing homelessness.
- Provide additional funding for homeless school liaisons to assist families challenged by mental health, substance use, and homelessness.
- Ensure that alternative shelters, resources, and programs are available that allow families to stay together when they find housing including those who are involved in the criminal justice system and unaccompanied teenagers.

5 As noted on page 76 of the Background Report, "Trauma-Informed Care (TIC) is an approach to human services that takes into consideration the significant impact trauma has on the individual and places emphasis on the need to acknowledge and understand how an individual's life experiences directly impact their ability to receive assistance." (Page 232 of the Final Report.)

- Provide specialized resources to address mental health, substance use, and homelessness issues that may lead people to fall into sex trafficking.
- Provide vocational assistance to help people experiencing mental health, substance use, and homelessness.
- Make employers aware that many people experiencing homelessness can be effective workers.
- Prioritize our elderly population in addressing mental health, substance use, and homelessness, particularly given our aging population.
- Eligibility limits for government benefit programs should be reviewed more often and in light of current economic conditions. We should consider "step downs" rather than an all-or-nothing eligibility criterion. People barely making a living wage can be determined ineligible for AHCCCS and other income-based benefits programs just by receiving a small raise.

WHAT ONE ACTION WILL YOU TAKE BECAUSE OF YOUR PARTICIPATION IN THIS TOWN HALL?

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the 114th statewide Arizona Town Hall. Below are individual actions that were shared and have been categorized based on impact.

Take Personal Actions That Make a Difference

- Continue to volunteer and share my experience(s) to maybe help one other person change for the "better."
- Embody compassion, tenacity, and a servant heart.
- Be uncompromising in my pursuit of positive outcomes with the issues of homelessness, substance abuse, and mental health issues!
- Say hello to homeless persons.

Collaborate and Partner for a Greater Impact

- Collaborate and partner with agencies and providers on best practices to end homelessness and address mental health and substance use.
- Help provide collaborative forum to sustain this conversation.
- Take the report, read it, and look at my action plan to see if modifications can be made.
- Look more at my role in government versus other organizations that are non-profit to establish a more collaborated way to work with them.
- Help NAMI collaborate with local coalition to end homelessness.
- Introduce Mohave Public Health with NAMI.
- Tell children's liaison about NAMI school.
- Connect further with the experts met at the town hall to build on the knowledge gained and to use this to advocate for greater cross-sector collaboration between mental health, substance use, and homeless services.
- Work to expand collaboration efforts among partner agencies.
- Get involved with the local homeless coalition team within Pinal County and see how we can try and get state involvement.

- Actively utilize the connections and contacts I have made at this town hall to implement ideas and resources in my community to address the issues of drug use, homelessness, and mental health.
- Develop partnerships.
- Work with providers to shape AHCCCS's implementation of the 1115 waiver.
- Work with stakeholders in my community to champion change.
- Continue to seek out new opportunities for partnerships to help fund communities needs for mental health, substance use, and homelessness.

Help to Raise Awareness of Mental Health, Substance Use, and Homelessness

- Convene various groups to continue educating and advocating for substantive change.
- Use my knowledge to spread awareness with my peers and colleagues regarding homelessness, substance abuse, and mental health issues.
- Share the resources I have learned about with the community organizations I am involved with.
- Work to educate community partners and private and government agencies on the issues to promote future change.
- Share more about how funding can be used.
- Educate the community.
- Share links and information to help educate the community.
- Use my voice to share what is happening and how my agency is moving forward to support the vulnerable populations, as well as learn even more to strengthen that voice.

Participate in Advocacy, Policy, and Legislative Processes

- Help with our homeless community issues that deal with mental illness and substance abuse.
- Continue to work with homeless persons, the court, and planning the homeless conference.
- Advocate for more support for mental health, substance abuse, and homelessness issues.
- Learn more about government.
- Continue to advocate for my peers.
- Perhaps write an op-ed for AZ Central.
- Work with local leaders and politicians to effect change as needed.
- Keep leaders informed of town hall results and materials.

Learn More About Mental Health, Substance Use, and Homelessness

- Educate myself on recent court and legislative changes to policy related to the topics.
- Strive to further understand the funding sources and seek out grant opportunities that foster collaboration between organizations.
- Explore how funding can be used creatively to solve problems and deliver more services to people in need.
- Learn more about community partners.
- Follow-up and review report and see how I can add value with research and evaluation to measure community change statewide.

Participate and Help Expand the Arizona Town Hall Experience and Processes

- Continue to work with Arizona Town Hall and Southwest Arizona Town Hall to promote civil discourse and collaboration.
- Initiate a town hall at South Mountain Community College on affordable housing.
- Work to intentionally and equitably involve vulnerable communities in dialogue and research.
- Join more Arizona Town Hall events.

MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Community Town Halls

FINAL REPORTS

23rd Annual Summer Institute for Behavioral Health

Wednesday, July 13, 2022
Flagstaff, AZ



23rd Annual Summer Institute for Behavioral Health

July 13, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness intersect and are indisputably interconnected. These issues are all complex and cannot be looked at individually. Homelessness is always complex with multiple factors at play. Substance use and mental health issues are often only the tip of the iceberg

A mental disorder which goes untreated can lead to substance use and substance use may lead to homelessness. Mental health is an underlying issue for many problems like substance use and homelessness.

If you give someone a home and do not address mental health or substance use, they may end up homeless again. Successful, long-term treatment and recovery is impacted by all three of these areas, so it is important to consider these three areas together to see long term success.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS AND WORKFORCE

There are a wide range of actions and approaches that can address mental health, substance use, and homelessness in a holistic and integrated way. They include partnerships between first responders and mental health providers and a person-centered approach to help individuals prioritize needs. It's important to meet people where they are and to consider the environment, social determinants of health and how systems impact or perpetuate problems.

It's important to have the right workforce to address these issues. We need a greater investment in education to fix our lack of workers, and to empower individuals so they know how and when to ask for help.

Accessibility is something that is unfair in our state, and varies depending on the zip code that an individual lives in. This is also tied to the lack of equity for already underserved populations in our community. We need greater equity in terms of access to healthcare, transportation, and even necessities like food and shelter. The level of resources varies across so many communities including LGBTQ, people of color, age, and zip code.

Our population is aging and often do not have the economic resources to effectively meet their housing needs. Systematically, we are not positioned to address this adequately. A growing aging population cannot be ignored and Arizona is not in a position to adequately address this issue. We need more support to give this population what they need, including affordable housing. We also must face the fact that as populations age, we do not have a way to replace these individuals in our workforce.

SETTING PRIORITIES

1. **Education.** People need to be educated on the resources available and we need to address bias and often incorrect stigmas surrounding the homeless population. All segments of our community need to be better educated on this issue, including law enforcement.
2. **Community.** The community needs to come together as a whole to address these issues. This is a community issue that requires a community solution. Human contact and connection are important.
3. **Focus on Prevention.** Be proactive. Prevention is key and a better more effective use of resources.

INDIVIDUAL ACTION

Individual action is important for solving these issues. Each of us can: advocate for services, promote legislation that is relevant and addresses the issues with compassion and best practices in mind, and participate in educational opportunities such as Arizona Town Hall discussions.

We can also lobby our legislators, work with local and state agencies to find solutions, help individuals get connected to resources, and create small successes. It's important for everyone to become aware of the systemic issues and support leaders who are committed to addressing the issues.

IN COLLABORATION WITH



New Freedom Community Town Hall

Tuesday, August 23, 2022

Phoenix, AZ



New Freedom Community Town Hall

August 23, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

It is important to address mental health, substance use, and homelessness together because they are branches of the same tree and are interconnected with each other at the root.

It can be a chain reaction with all of them connected to each other and with one often leading to the other. Treating one without the other is like putting a band aid over a bullet hole. Addressing the issues together is the most efficient way to optimize success and to stop the revolving door.

If you don't have stable housing, it is difficult to get a job, to feel motivated and to deal with health issues, including mental illness. Conversely, substance use may lead to mental illness and homelessness.

It is important to address these issues together so that we can create more effective, preventative, and supportive programs. Many people do not realize they have a mental health issue that can be addressed until they have an opportunity to see a therapist. For example, veterans may have PTSD and other mental health issues from their service that have never been addressed. People with mental health issues are given medication without addressing the cause of the problem or understanding its source. We should try to address these issues early, bring more awareness to those experiencing these challenges, and remove the stigma associated with mental illness so that people who face these challenges can find the resources they need.

When we support people who have mental illness, remove the stigma associated with mental illness, and educate people about why and what they are experiencing, we free people to have a chance to lead a fuller life for themselves and their family.

Transportation is also critical so that people can get to jobs and the services that help them to overcome these challenges.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

We need more places like New Freedom that cluster programs under one roof. The community and mental health support are critical to those they serve. However, we need funding and changes in policy that allow people to stay longer than 90 days.

We need to make resources more available and have outreach to people so they know where to get assistance. Using mentors who have navigated these challenges themselves can be a powerful tool because they do not come with the answers, they come with the right questions.

We can use mentors who have been there to light the path and inspire people to make change.

We need to meet people where they are, whether physically or culturally, and provide safe places for them to get the help they need, including basic needs like food and glasses.

Policy, business, and community leaders need to work better and more collaboratively to help address these challenges holistically and change policy in a way that creates better solutions.

Some of the other policy changes we need are decriminalizing mental illness, creating more programs for women and more diversion programs for substance use and mental illness. We need real changes to programs in prison, rather than just name changes, and we need to provide compassion training to prison employees to change the culture.

Educating the public about why it is important to address these issues will help with needed policy and law changes. It will also help with general outreach and provide more support for much needed funding for navigation services, therapy, one-on-one treatment, transportation, and more programs like New Freedom.

SETTING PRIORITIES

1. Funding

- a. Fund in a smart way with programs that are tried and true. Have funding accountability. Do not waste it on things that are not working
- b. Fund one stop shops
- c. Provide incentives for cooperation. A lot of people are not willing to share resources and information. Agencies and organizations should share resources and work together instead of competing with each other.
- d. We need more shelters and beds, especially for couples and families.
- e. All people who need it should receive services under AHCCCS and we need to bring more awareness to people that they have the ability to choose their access plan.

2. Educate, build awareness, and provide funding to support education

- a. Use outreach and success stories with those who are out there struggling.
- b. Start early, the younger, the better. Treat the entire family and have them address mental health and substance use as a family unit.
- c. Have community publicity that shows the benefit to the community as a whole and why it is a community problem and a human problem.
 - i. Show them the cost of not doing anything. What does it cost the health care system? What is the cost to our communities and to families if we do not do anything?
 - ii. Make it relatable with personal stories. Show how the investment of resources now will reap benefits over time to everyone.
- d. Educate to reduce the stigma of these conditions and show how we need to address it with compassion and empathy.
- e. Maximize the time people are incarcerated to provide education and support for mental illness or substance use while they are in prison.
- f. Maintain a grassroots approach to solutions, similar to New Freedom

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Walk the three blocks to CASS from the legislature and experience the area. Spend a day on the streets, in tent city, or any of the shelters without them knowing who you are to see what it's like.
- Create more shelters that are ADA accessible.
- Invest in solutions or pay the cost of the problem.
- Policy is about people not punishment.
- Have a solid commitment to a generation and let New Freedom lead the way to show people how to change their lives.
- Stop locking people up.
- Take a risk on humanity. It is worth the investment.
- Talk about the cost of the problem versus the cost of the solution. If you look at the destruction to the community versus what it costs to help, it is well worth it. Be loving, compassionate, genuine, and wage war against the things that destroy.
- Listen to the people who have experience with these issues.
- Put supports in early on and invest in the whole person with holistic nurturing and opportunities.
- Give opportunities for people to have more safe spaces.
- Demand results. How many more people have to die?
- Address what is not working. Be someone's champion and keep fighting for them when they can't fight.
- Build organizations with the clients in mind (similar to New Freedom).
- Have result based funding. What is really working? Create more vocational training and other programs that are working and reduce recidivism (like New Freedom).
- Locking people away into a cycle of incarceration doesn't work. Think about a restorative system that works.
- Stop medicating and start educating.
- Have mandatory educational guidelines instead of mandatory sentencing.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the New Freedom Community Town Hall. Below are individual actions that were shared.

I WILL...

- Never give up and keep my best self in front always.
- Continue to share my story to the next person, so I can continue to live life free of addiction and be a living example to the next person in need.
- Continue my education, so I can affect change in me and my community.

- Continue my education, so I may be of better service to the community I live in, work in, and move on to in the future.
- Be a part of New Freedom.
- Get connected with resources that will help me to provide outreach services to women who are incarcerated.
- Lobby my elected officials.
- Be the change I want to see, work for New Freedom, and come back as a VA Rep to help veterans, combat veterans with PTSD, and those with substance abuse issues.
- Give back what was so freely given to me by being of service to others.
- Continue to send hope to those who are incarcerated.
- Continue to serve "the least of these" and walk in love.
- Continue to find and provide resources for those who cannot come to New Freedom.
- Help New Freedom grow and grow to rebuild lives and families.
- Outreach with an open heart and compassion.
- Continue to be a servant for those in need and help New Freedom grown to serve the community.
- Use my voice to educate and encourage people to get active about these very important issues and continue to do what I already am, which is being of service to others like me.
- Continue to advocate to increase understanding about these topics and how they are related with legislators, funders, and leaders who have resources to give toward these solutions.
- Take the skills and mindset I have not only built for myself, but also what I have gained at New Freedom, and put them to use by building a life beyond what I ever imagined and share what I have to offer for those in need.
- Spread awareness in my journey by sharing my story with mental health, substance use, and homelessness to show there is hope in order to normalize these things and stop the stigma.
- Help others based on what my experiences were.
- Make sure people know about the different resources available to them.
- Continue to volunteer at rehabilitation and re-entry centers.
- Continue to do the next right thing and service my community.
- Learn, listen, and reflect on the impact of substance use, mental health, and homelessness by talking to more people who have experienced these issues. The more awareness I have, the more I can share with other people.
- Continue to be an example of success and show those who want to change and do better that change is possible. I will help those who want and need it.
- Help lead folks out of the hold I once found myself in. Be a navigator.
- Continue to be active in my community by helping people in addiction and homelessness to be aware of resources, offer a hand up, and treat them with dignity and respect.
- Love God and love my neighbors.

- Ask people to share their stories, so I can truly begin to see, hear, and have a better understanding of who they are, their journey, and how we can connect and support.
- Speak to policy makers about promoting human dignity for all.
- Use my voice. I will share my experience, strength, and hope to better educate and inform people that do not understand this mission or maybe don't know there even is a mission.
- Continue to promote and commit to the peer-to-peer program to impact the lives of those in need at New Freedom. Invest in the solution or pay the cost of the problem.
- Take my lived experiences, strength, and hope along with the skills I've gained at New Freedom into my community to help others and change lives. Peer support = Peer love.

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Rural Arizona (Show Low) Community Town Hall

Monday, August 29, 2022
Show Low, AZ and Online Via Zoom



Rural Arizona (Show Low) Community Town Hall

August 29, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

It is important to address mental health, substance use, and homelessness together because these issues often occur together. There is a vicious cycle with everything connected and reappearing together. For example, mental health issues can lead to substance use and homelessness. Likewise, homelessness can lead to mental health challenges and substance use. Education and job opportunities are also tied to and interconnected with these issues. To best solve these challenges, especially for our most vulnerable, we need to address these issues together and in a more coordinated way.

The stigma of experiencing issues with mental health, substance use, or homelessness is often tied to biases and misunderstandings, which keep those who need help or assistance from getting it and prevent those who can provide help from providing the best resources and approach.

We should address this stigma, provide more wrap around services, better coordination among service providers, more education of first responders and law enforcement, and more housing opportunities for those who are unhoused. We also need to better address cultural differences, trauma and other aspects that may impede services.

Finally, we should incorporate the wisdom of those with lived experiences and continue efforts to educate the community and provide opportunities for better collaboration.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

There is no cohesive response for addressing these issues and there are many gaps that create major problems.

We need to create better experiences for those seeking help. This includes addressing stigma and creating a more supportive environment that includes providing love and support to those experiencing these issues and addressing mandatory reporting requirements that may act as barriers to those seeking help. It also includes education to combat NIMBYism (not in my backyard), providing information to those who need to access resources, and working more closely with police and first responders as part of these educational efforts.

Each local community should do systems mapping to identify what is being offered, what is needed, and what their qualifiers are. We need to take another look at disqualifiers – some require sobriety, and some do not. We need to expand on the types of housing that are offered. We also need to look at the entry points – emergency department, policy, etc., and ensure that they know what other services are available, so that people are not just treated in a silo and discharged.

Turnover is often high making awareness of resources even more challenging. It is very difficult to keep resource lists current. Communication is a big issue, making people aware of what resources are available. Often, resources are there, but not used because of siloed service providers.

Peer support by people with lived experiences is critical. Yet, we lack the job opportunities for those who can provide peer support.

We also need to help families better understand these conditions and we need to address stigma that can be an obstacle to getting the resources they need. The Federal government is providing a lot of funding for opioids, but very little for other substances such as alcohol. Government funding needs to expand to all substance use.

It is often very difficult for people convicted of drug offenses to get employment and this can lead to homelessness and recidivism. Many people are losing their homes because the market is leading people to see their rental properties and the HUD fair market rents are too low in Arizona. There is no place to put people who need rental properties. Some people coming out of incarceration are sent to Maricopa County instead of receiving services in northern Arizona because of a lack of DOC approved re-entry housing.

We need to address legislative changes, such as the barriers to success for those with criminal backgrounds. We need to look at how to provide a warm hand off for those coming out of jail or prison. To ensure success, we should use more of a trauma informed approach that takes cultural and historical factors into account. We should also look at approaches that do not criminalize or "lock up" those who are experiencing homelessness.

While we have some wrap around services, we do not have enough. We need to increase the quality and the quality of wrap around services and communication efforts to those who need them. To accomplish these goals, we need more sustainable funding for much needed services and resources. One-time grants with strings attached are appreciated but are not the most beneficial for the best community response.

We need access equality to everyone, which includes transportation and access to broadband internet. We also need more prevention efforts such as diversion and education programs, as well as programs that address poverty and trauma while creating a safe space to meet people where they are.

Finally, it is important to have more gatherings like today to educate the community, breakdown barriers, and improve coordination.

SETTING PRIORITIES

The most important actions we need to take to address the conditions of mental health, substance use, and homelessness in an integrated way are as follows:

1. Education is critical, both in schools and with families. We need to reduce the stigma in education systems with programs that are interactive, trauma informed, preventative and proactive. We also need to reintroduce basic life skills into our schools.
2. Use integrated approaches including working together on health assessments, integrated family support and treatment, and decriminalization of those experiencing these issues. There should be "no wrong door" for accessing services.
3. Our system is crisis active and reactive instead of preventative and pro-active. We need to focus more on prevention and provide more funding and resources for prevention and treatment. We need to focus on root causes and address those issues.
4. We should incorporate more use of community centers for community gathering and art.

5. **Funding:** We need more funding for affordable housing, prevention, peer support, and mentorship programs. We need education that helps reduce stigma and combats the fallacy of NIMBYism (not in my backyard) because it already is in your backyard. We also need resources to improve communication and outreach about available resources. We need increase funding for mental health prevention and treatments as well as, affordable housing. We need to provide quality and equity in the provision of programs.
6. We need to have policy changes; allow recovery housing in different areas of our community.
7. We need to create facilities in this area for detoxification and for women. We also need more wrap around and transitional housing for those experience these issues.
8. There is a role for all of us to address these issues even if we are never able to completely solve them. This includes government, business, organizations, and others who can communicate resources available and provide resources.
9. There is a tremendous need to bring key stakeholders together (healthcare, businesses, first responders, police, tribal, schools, etc.) once a month at the beginning to do resource mapping and identify needs and gaps. This could be a great venue for addressing specific local ideas such as, having people cleared at the scene who need to go to a mental health facility versus a hospital or how to use more peer resources.
10. It would be good to include the Governor's office. To achieve this, we need to determine who should host and how do we get consistent participation. The RE:Center suggested that after some new hires come on board, perhaps they can be the host and facilitator. This could start small and grow larger.
11. We need more mentorship programs and more volunteers willing to help in a non-office, one-on-one basis.
12. We simply do not have enough mental health professionals in this region. We need to find ways to attract more people through virtual visits being held. Perhaps, the government could offer loan forgiveness to providers willing to commit to practice in this region.
13. Stop focusing on prevention efforts and awareness campaigns! Start focusing on treatment and recovery resources along with affordable and accessible housing inventory. We need increased access to affordable housing opportunities for felons and individuals in recovery, so they have fewer obstacles to improving their life, maintaining sobriety, and/or managing mental health. It is critical to creating an environment where families can obtain mental health support, substance use services, and housing to learn how to build a quality of life for themselves and their children. To stop the cycle and significantly reduce childhood trauma, we must create a path parents can work to obtain for themselves and their children.
14. Finally, we need to change the public consciousness so that everyone feels responsible for people suffering from these conditions.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Fund education and awareness programs.
- Connect to your local community. Come to the community and consider our input and what resources we have as you make laws. Step up to be involved in the solutions to these problems and consider the needs of rural Arizona as you do so. Apache and Navajo Counties need more detox facilities and residential programs that will accommodate families.

- Provide more funding to our schools, including programs about mental health, and SUD. Open up government funding with fewer restrictions to address these integrated needs (e.g., do not limit to just capital or just operating services).
- Consider legislation that mandates landlords to consider individual applications on a case-by-case basis and reduce regulations for sober living communities.
- Expand funding for affordable and transitional housing.
- Persuade people of all parties that this is not a partisan issue and that they need to work together as if our country were attacked by a foreign power.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Rural Arizona (Show Low) Community Town Hall. Below are individual actions that were shared.

I WILL...

- Continue to work toward improving resources and building relationships with community members to help provide the treatment necessary to get individuals back to being productive citizens in our community.
- Help more who are suffering.
- Seek out more resources, so I can address this topic.
- Provide the public with data and success stories in our community. More prevention.
- Receive brochures to disseminate to people who use my courtroom or in courthouse (public).
- Continue to reach, treat, and provide resources for and advocate for community members who are struggling with substance use disorder, mental illness, and homelessness.
- Send Melinda Navajo County substance use disorder resource cards.
- Work toward providing additional community information through social media.
- Attend future Town Hall meetings.
- Look into gathering resources and see if we could possibly create an app to share local resources with those that need it.
- Find out what we need to do to get community centers in our communities.
- Work hard to reduce stigma in my community.
- Offer support to educators in the areas of teaching student self-regulation and reducing further harm through education on adverse childhood experiences.
- Work on education in my community, starting in the elementary schools. Reach out to local groups and work on starting a community center to focus on education and family support.
- Continue the discussion with co-workers, identifying with them helpful, valuable stakeholders to include in the discussion to more recommendations to action.
- Listen to community experts and continue to work to be educated on solutions options.

- Finance more affordable housing.
- Drug prevention efforts, community awareness through brochures, media outreach, and radio. Parent prevention, adversity workshops, Narcan Training – Narcan Distribution, book clubs, Nexus Coalition.
- Take the needs discussed in this meeting to the general population.
- I will ensure that I will help where I can and share the information I have.
- Commit to becoming involved in community projects to spread support and awareness.
- Do my best to educate myself further on the topics discussed today.
- Continue to carry the message to the addict who still suffers.
- Inform the public there is help available in many forms.
- Continue to research and advocate for funding and services to address mental health, substance use, and homelessness!
- Discuss what we talked about with my peers, to open a way to help student in our school.
- Approach key stakeholders and educate them on these conditions and make it know what available resources we have in place.
- Talk to my teacher about having a peer mental health group at our school.
- I would like to help with culturally informed, trauma informed off reservation housing. Native American experience with homelessness, i.e., shelters can replicate boarding school trauma.
- Continue to go to school to work toward my degree in behavioral health and continue to help people suffering from substance abuse and mental health.
- I will communicate and share the ideas discussed today with a person of higher authority, such as city council members, school advisors, and peers.
- Help and talk about this topic, support, and educate people about this topic.
- Continue to share my experience, strength and hope while being loud about my recovery!
- Visit RE:Center.
- Build relationship with resources.
- Provide training for personnel and public.
- Review and update policies.
- Refer individuals in need to some of the services I have become aware of.
- Search out and learn about available services in the area.
- Gather data on root causes and areas of need in our communities.
- Approach county administrators and BOS to commit funding and resources as well as to advocate for policy and ordinance changes.
- Encourage others to create trauma informed workplaces.
- Take action to share resources in my community and use this information to better my role in public health.
- Do my best to reduce stigma and increase the space for voices of those with lived experience.

- Continue to reach out to people who use drugs in order to end isolation and bring them back into community by meeting them where they are at without judgment and with compassionate resources.
- Give all the information I learned today back to my community to help give ideas or any ways to improve the conditions of mental health, substance use, and homelessness in my community.
- Bring voices of this community back to our health plan leadership.
- Advocate for change.
- Through my work, show grace and empathy with all those I connect with. Always listening before judging. Connecting those to resources.
- Give information about what I have learned and give ways I can help my community.
- Say why we should address mental health, substance use, and homelessness.

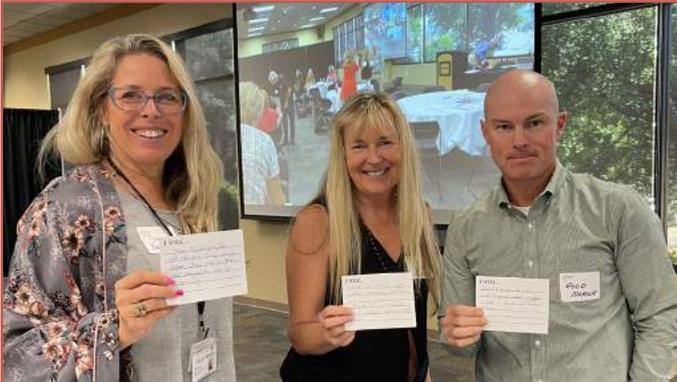
SPONSORED BY AND IN COLLABORATION WITH



Prescott Community Town Hall

Monday, September 12, 2022

Prescott, AZ and Online Via Zoom



Prescott Community Town Hall

September 12, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

While everyone who is homeless does not have mental health or substance use issues and those who have mental health and substance issues may not be homeless, these areas are interconnected and often related to each other. For example, those with lower incomes have more trouble addressing and finding treatment for mental health challenges. Finding housing is also a major challenge for many and this can lead to challenges with mental health and substance use disorders. Recovery is extremely difficult if you are homeless. Furthermore, mental health issues can lead to substance use issues and then homelessness. Although all three of these issues are interconnected, correlation does not necessarily mean causation.

It is important to address these issues together because you have much better success with outcomes. We cannot focus on any one of the issues in isolation if we want to solve all three of them. We need to look at the issues holistically, as working on one area impacts the others and these areas exacerbate each other.

To effectively address these issues, it is important to address stigma. The stigma surrounding these challenges keeps people from seeking treatment and makes everything worse. At the point people are seeking recovery, they are often at rock bottom, which makes it more difficult for them to succeed. We need to look at how we can better support people when they are in need during their most difficult times, so we can stop the revolving door and solve all of the issues collectively and effectively.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

There is a negative cultural and social stigma attached to these issues. NIMBYism (Not In My Backyard) is real and it is a challenge we must address. We can combat NIMBYism and the negative stigma attached to these conditions by letting people realize that just because you cannot see it, does not mean it is not here. It is here. To combat NIMBYism and negative stigma around these issues, we should have marketing and communication efforts, especially for children. They need to know that it is okay not to be okay.

Yavapai County has many good organizations, services, and resources available to address these issues; although, there is a shortage of health providers and affordable services for people going through these challenges.

We need to bring our resources together in a better more collaborative way to leverage the resources that are available. We also need to find ways to get people to these resources, and to help them to be ready to receive the resources that are available.

We should build comprehensive resource guides, better leverage resources that are available through collaboration and coordination, and work in a more integrated way with governments, faith-based organizations, law enforcement, service providers, and most importantly, community members.

We should consider creating a housing coalition for Yavapai County to address housing issues. The housing coalition should look at supportive housing options with wrap around services for those who need them and explore creative housing options like tiny homes.

We need to work together to better support people when they are in crisis. When people are in a crisis, having community support makes all the difference. Community case management is key, as is meeting people where they are. Accountability is also key, including individual, organizational, and community accountability. We also need resources to address these issues, whether through expansion of funds with fundraising events or better collaboration and coordination with those involved.

SETTING PRIORITIES

1. Support collaboration.
 - a. Incentivize collaboration through federal and state grant funding.
 - b. Bring all the organizations working on these issues together along with policymakers and others to have solution-based discussions for how best to take action.
 - c. Create a coalition to seek needed funding for recommended actions.
 - d. Have a centralized and coordinated intake process.
2. Make resources more centralized and available.
 - a. Provide and maintain a centralized source for resources.
 - b. Create a free one-stop shop for resources that provides access to resources and information.
 - c. Have a central information and education webpage or other source for information.
 - d. Train police and first responders about available resources.
 - e. Have a communication and marketing roll out of the information and how to access it.
3. Meet people where they are.
 - a. Send out personal caseworkers to disperse information to those who may not have access or understanding.
 - b. Provide neighborhood living and resources.
4. Housing.
 - a. Create stable affordable housing for providers and professionals.
 - b. Create stable affordable housing for those who are vulnerable and those experiencing these challenges.
 - c. Have affordable housing throughout the region and within the city limits.
 - d. Create a housing coalition to address how best to create affordable housing, including how to collaborate with builders and local leaders.
5. Transportation.
 - a. Create more public transportation.
 - b. Address the transportation challenges that prevent people from getting needed services.
6. Address workforce shortages.
 - a. Create flexible and alternate work schedules.
 - b. Create flexible payment options: sharing resources for a full-time employee who works for multiple organizations.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Prioritize affordable housing throughout the spectrum (from professionals and paraprofessionals to the unhoused).
- Everyone is just one family member or friend away from someone who is experiencing these issues.
- It makes economic sense to invest up front as it saves on the back-end. Review existing studies that show how investing up front to address the crisis of housing, mental health and substance use will save our country money going forward.
- Create a renewable state fund that allows individuals and other organizations (such as corporations) to contribute to the fund so that grant money can be made available statewide to prioritize and address these issues, perhaps looking at First Things First as a model.
- We need education and outreach tiered to the needs of the individual.
- We need your time, talent and treasure devoted to addressing homelessness, substance use, and mental health.
- Create a one stop shop and central database.
- Support more caseworkers.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Prescott Community Town Hall. Below are individual actions that were shared.

I WILL...

- Urge my peers to better understand and engage with their community by amplifying the voices of those doing the work.
- Continue to work with youth and research community resources.
- Continue to remain engaged with community resource providers in order to advocate for positive Veteran outcomes.
- Keep in contact with the community partners. Report the information to elected representatives.
- Continue to work with HUSD to provide resources, gift cards, and support to reduce the amount of homeless students.
- Continue to work with MATFORCE on educating our kids on the dangers of drugs.
- Say "yes" in my backyard.
- Continue to attempt to get community stakeholders to meet to determine joint steps to help those affected become self-sustaining once again.
- Continue to reach out within my own home and backyard. I believe healthy behaviors and coping starts in youth within the home. My vow is to ensure my child is equipped with the tools of life.
- Communicate what I have learned.

- Work on pooling resource information.
- As a leader, I will prioritize the issues of homelessness, mental health and substance use in order to create meaningful change and improvement in these areas across Yavapai County through collaboration and leveraging of resources.
- Engage in community groups, workshops, collaborations, to develop coalitions focused on housing and mental health issues.
- Make the time to consistently attend our tri-city "Community Impact Coalition", which meets monthly at the Prescott Public Library, which addresses mental health, substance abuse, and housing and is attended by community stakeholders in public service and social service organizations.
- Be more mindful about these issues.
- Leverage my position and influence to work on these issues.
- Work toward helping build consensus.
- Contribute more time in finding effective solutions to our current topics rather than just talking about it.
- Continue providing integrated care one patient at a time.
- Share AZ Community Town Hall information with organizational leaders.
- Share what was talked about today and the needs within our community.

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*Ray and Patty Newton
Family Foundation*



Cave Creek-Carefree Community Town Hall

Friday, September 16, 2022

Scottsdale, AZ and Online Via Zoom



CaveCreek-CarefreeCommunityTownHall

September 16, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

The conditions of mental health, substance use, and homelessness are all intertwined and can be seen as a Venn diagram with intersecting points. Substance use, such as alcohol and drug use, can result in homelessness, as can a general lack of resources or treatment for mental health issues. For example, veterans may self-medicate as a result of trauma relating to their service, which can lead to homelessness. Homelessness, likewise, can lead to mental health issues and substance use.

Our school systems, emergency responders, and justice systems need to come from an integrated holistic approach and address these issues together to have the best impact on all the problems.

These are big issues, and a great deal of work needs to be done, including early intervention in the schools with parents and students, which will result in a trickle up effect. We also need to address the heavy stigma that keeps those who need help from getting services, and to create networks of support systems.

Public health services, federal, state, and local governments can be a bridge to the community, acting as shepherds to guide people to needed resources and creating relationships between systems and communities.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

We need a proactive push to do outreach to communities about existing resources. Even with existing resources, there can be long wait times, involving months of waiting that discourages those who seek help. Not knowing what is available is a hindrance to those looking for assistance with substance use, mental health, and homelessness.

Having a one-stop facility available that provides housing, mental health, behavioral health, career assistance, governmental documentation needed for jobs, and follow-up with individuals, would be an integrated way to help those in need. These are lifelong challenges, and we need to address the challenges with that in mind.

We should start early with programs in schools that raise awareness of these challenges, including the fact that these issues are here in our community. Those with these challenges include our family, friends, and neighbors. We should support our overburdened teachers with ingenious programs and services that provide life skills to parents and students.

Expanding on successful models, we should provide better bridges to services, including transportation for people to get to needed services. We should work in collaboration with our faith-based organizations as part of a collaborative community wide effort.

Houston, Texas has provided an integrated tool kit that could be viewed as a best practice. St. Mary's Food Bank within our state has a great system setup.

As with any ideas, organizations, systems, individuals, and neighbors need to work together so that support can be provided. This includes financial support. Financial support should be brought together to fund opportunities and to strengthen the organizational groups already working in this space.

Follow-up care is essential, such as community navigators, mentors and others who can outreach and connect to the people who need resources.

We also need to address this issue with our elected officials by raising awareness and providing information for needed policy change.

Finally, we need to normalize mental health and get rid of the stigma associated with these challenges. People in need should not be stereotyped; empathy is crucial. Understanding why issues occur will help those who can assist to better help others and best address these challenges.

SETTING PRIORITIES

We need to address these issues collaboratively and proactively.

First, we need to raise awareness. Town halls that promote conversations about these conditions help people talk genuinely about issues and better address them. We should use the media, including social media, to raise awareness that these issues exist and are not going away. We should structure these communications in a way that helps to destigmatize these challenges and raises awareness that these conditions continue to exist and need to be addressed.

Prevention and early intervention are critical. We should increase awareness and understanding in schools with age-appropriate information about mental health issues and substance use. Adding these issues to the school curriculum can broaden the knowledge of students and their families.

Prevention also includes transitional housing and services, such as helping people to get IDs. We should get youth involved, including with social media.

Creating more partnerships with faith-based and non-profit organizations is important to have more of a holistic impact. Not knowing what other programs are offering creates silos and hinders helping people in need of resources. We need to reduce duplicative programs that compete with each other. Nonprofits and other organizations who receive funding should have more accountability and transparency. We need to continue to break down silos and encourage collaborations. We need to not only address basic needs, but also higher needs.

While addressing these issues, we should recognize mental health, substance use, and homelessness are linked, but not always.

We also need to remember that caregiver burnout and compassion fatigue are real. Raising salaries of state and service employees that provide services is crucial to be able to adequately staff resources.

Sharing success stories from other cities and towns enables communities to learn about best practices that are making a difference and enable social change.

It is important to vote. Voters can support through their vote those who can make a positive change. Public officials who promote building affordable housing and other needed services need to be actively supported.

Whether small or large, we as a community need to take whatever action we can. We need to be involved and stay involved and spread the message to others. We all can play a role in being proactive as heroes connecting resources and creating change.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Communication between leaders about resources is important. Leaders in touch with other leaders can help by learning about resources that can support these conditions in an integrated way. It is not just a quick fix that can be solved by passing one bill; it is a multi-faceted problem. Individuals should not be stereotyped. Sharing best practices is crucial.
- Take a bipartisan approach and listen to your constituents so they can make the proper changes. They also need to share best practices across systems of care utilizing elected officials.
- We can do this by measuring outcomes and from elected officials being accountable and transparent to the public.
- Provide funding for non-political bipartisan community navigators that can create urgent awareness and offer solutions from local neighbors, faith-based organizations, scientific and technical communities in a timely manner.
- Make it a priority to organize and talk about the problem, as well as the solution.
- The Human Services Campus was built as a model for the nation. Use that model to build more.
- Shore up affordable housing. We are pushing people into homelessness because they cannot afford housing.
- Support a coalition to address homelessness.
- Create an advocacy or liaison group that can help motivate and get people to the services they need.
- Stop politicizing the issue and fund all communities; let them decide how the funds should be used and how best to promote community awareness.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Cave Creek-Carefree Community Town Hall. Below are individual actions that were shared.

I WILL...

- Support and vote for candidates for local, state, and national office that support expansion of programs to alleviate the housing shortage, provide more funding for affordable housing and programs to support the mental and physical health for the indigent and unhoused population. This includes local city council candidates that support increasing housing opportunities in all neighborhoods, regardless of affluence and demographics.
- Continue to expand my knowledge around the state of mental health in Arizona, so that I can take action that is effective and impactful within my community.
- Take time to listen and speak with members of my community who are making waves in mental health movements and learn from their experiences and knowledge.
- Create partnerships in the communities I serve, learn about their resources, and share those with others.
- Work with all the chaplains, board of directors, staff, and volunteers to better the chaplaincy for the homeless.

- Foster community awareness.
- Help local non-profits and faith-based organizations that assist others.
- Distribute cards directing homeless to services.
- Work harder to fight for homeless people to be helped in our community.
- Get involved and stay involved. Continually learn and improve skills.
- Commit to being a volunteer.
- Carry water in my car to give away.
- Vote.
- Be kinder to street people. Smile more.
- Continue to vote and encourage unity.
- Be more proactive in inspiring, motivating and listening to those who are unhappy – asking if I can help.
- Continue to promote connection in our community.
- Unplug. Things work better if we unplug it for a while.
- Prayer. Meditation. The opposite of addiction is connection.
- Continue helping my son who is SMI (serious mental illness).
- Be mindful that education about the issues is never done.
- Spread awareness of this event and parts of the discussion to educate those I know of the issues our community has with homelessness, substance use, and mental health.
- Continue working with the Association for the Chronically Mentally Ill (ACMI) on legislation for secure residential treatment facilities.
- Carry the messages I have learned and always act as soon as I can.
- Continue to employ youth and advocate a sober living lifestyle.
- Take lifestyle changes group to federal prison for women.
- Maintain a sober lifestyle of my own.
- Organize education to elevate self-awareness.
- Not give up on being part of the solution.
- Identify retail outlets that sell vapes or alcohol to underage users.
- Volunteer, help organize, think tank, spread awareness, speak, and think diplomatically.
- Get in touch with community and organizational leaders.
- Become more involved and volunteer at shelters.
- Share what I've learned today with friends and family.
- Be a voice for mental health, substance use, and homeless people.
- Have empathy for those who battle mental health, substance use, and homelessness.
- Keep telling my story about disability.
- Join Arizona Town Hall.

- Continue to seek quality organizations and people to be less isolated.
- Speak with Arizona Town Hall to include chronic pain.
- Work to equip and support our neighbors, agencies, and volunteers in mental health so they have a "tool kit" to help others.
- Work to create a Community Resource Center that brings organization under one roof to help our neighbors.
- Continue to advocate as a community navigator for those who are experiencing homelessness, mental health issues, and substance use.
- Try my best to cover and report the mental health crisis for the purpose of creating awareness for people to get involved and create a conversation on this issue.
- Continue my path of presenting a new method that takes away the shame associated with a bad habit. I just published a book that gives hope to those who feel hopeless called The Plans He Has for Me.
- React and act no matter how big or small.
- Capacity build.
- Making strategic connections, awareness of existing systems of care and resources.
- Advocate for veterans and survivors of domestic and sexual violence (underserved populations)
- Seek out others within the Valley of the Sun.
- Become involved and look to connect or lead some groups – family to family or peer to peer support.

IN COLLABORATION WITH



Cochise County Community Town Hall

Tuesday, September 20, 2022

Sierra Vista, AZ



SPONSORED BY AND IN COLLABORATION WITH



Cochise County Community Town Hall

September 20, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are linked, and we need to address them together. You can have one issue without having the others, but to solve these issues, you cannot address one without addressing all of them. Putting these issues in different silos has not worked well for solving them. Experiencing one of these challenges can create a domino effect with other issues. It is like a Venn diagram with all of them intersecting with each other, whether through adverse childhood experiences, lack of knowledge, financial challenges, losing a job, poverty, the inability to find housing or other resources, or mental health issues, including undiagnosed mental health challenges.

As we address these issues we should look at where there are gaps and how we can connect schools, community, and other organizations together. We need to fill these gaps and allow those who want and need services to access them. In addressing these issues, we need to work to remove the stigma that keeps many people from seeking help for their mental health challenges and utilize people who have lived experiences as advocates and connectors.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

These issues are all around us. It is not just the people sitting on the streets. It includes our neighbors, friends, and coworkers.

Education and awareness are important, both education about resources and educating people on how to help others. We also need to educate more educators.

We need to meet people where they are. There should be “no wrong door.” Wherever someone goes for resources, they should be directed to the resources they need and not just turned away. Coming from a place of compassion and utilizing those who have shared experiences can help with connecting to those who need resources.

In addition to educating people about available resources, we need to ensure that resources are coordinated and do not overlap or compete with each other. We should explore existing resources to fill in the gaps of need and create a closed loop referral system following up on those who seek help to ensure they are traversing through the systems in a helpful way.

We need to look at how to improve “systems literacy,” the knowledge of what systems are available and how to navigate them. We need to analyze the systems we have created and ensure the people we are trying to help have the knowledge and ability to get help.

Prevention is critical. We need to start young and increase awareness and education about mental health issues and adverse childhood experiences. Many have been conditioned to keep their issues quiet and to not reach out when they have problems. We need to reduce these barriers to help eliminate the stigma attached to these challenges and do our best to create safe opportunities for people to share and seek assistance.

Community conversations are important. We should put the right people in the right room together at the right time to look at these issues in a more coordinated and collaborative way.

We could establish a task force that creates a common vision and mission for organizations and others to work together. As part of these efforts, we need to include the voices of those who have lived experiences, including our youth, and recognize one size does not fit all.

Cochise County needs a crisis center, like the one in Yavapai County. We should partner with companies to support existing efforts to build a crisis center since it will help to create the future workforce they want.

Housing is also important to address. We should visit shelters to have a greater understanding of the issues, create more affordable housing, and support programs that give purpose and value to the unhoused, such as allowing them to have earned income.

SETTING PRIORITIES

1. Education and the Media.
 - a. We should better utilize the media in an integrated way to spread the word – locally, statewide, and federally.
 - b. Increase outreach – include peer-to-peer outreach, the use of navigators and the use of those with lived experiences.
 - c. Educate family members who need assistance and provide more shelters that address the whole scope of the problem.
 - d. Survey those with lived experiences.
2. Funding.
 - a. Understanding funding opportunities would help us take better data-based positions on solutions.
 - b. Use funding for the education of first responders such as police, so they can respond more effectively to those in crisis.
 - c. Spread the word about and support the crisis center that will soon be opening in Cochise County.
3. The best approaches.
 - a. Understanding what each person is going through is important when addressing solutions.
 - b. Utilize flexible approaches to get people on the right path – including flexible work and housing options.
 - c. Increase coordination and collaboration to meet people where they are.
 - d. Create platforms that allow people to access resources and education more easily such as a county-wide behavioral dashboard that would help spread the word to the broader community.
 - e. Make it easier to get needed help including, “one stop shop” services that utilize collaborative and integrative approaches for assistance.
 - f. Utilize navigators more, the “no wrong door” approach and closed loop referral methods.
 - g. Use intervention instead of punishment for those who are experiencing challenges.
 - h. As a community, we all need to be more empathetic and compassionate to those facing challenges.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Take the time to educate yourselves. Listen to the viewpoints and conversations of those experiencing these issues and participate in the conversations.
- Have less judgment and more compassion. Spend the day in the shoes of those with low self-esteem, limited resources and who are experiencing mental health, substance use, and homelessness.
- Accept that the issue is in our backyard.
- This is not about politics or political parties; this is about people.
- Avoid generalizing and making negative assumptions. Look at people individually.
- Make more resources available for those who need access to resources.
- The funding and timelines for existing programs are not working. Reassess and re-plan these programs. Create opportunities, like the bracelets that signify someone you can talk to, to guide people to services.
- Revamp the RBHA system and award the contracts based on needs and services.
- Utilize existing resources in the community.
- Educate law enforcement on how better to respond to those experiencing these issues.
- Provide funding to educate educators.
- Revamp funding and programs to reach people where they are at.
- Instead of funding homeless shelters, fund transition facilities.
- Take a holistic approach and be proactive instead of reactive.
- Have more compassion, be more trauma informed and realize that these issues impact all of us.
- Expand the low-income housing tax credits further into rural areas, which will better allow for needed resources, such as housing programs, qualified behavioral personnel, and related programs.
- Stop prioritizing spending on private prisons and redirect that to community integration.
- Be more intentional on long lasting solutions as opposed to temporary short-term solutions and utilize all sources of communication in the same way you use those communication sources to campaign to get elected.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Cochise County Community Town Hall. Below are individual actions that were shared.

I WILL...

- Focus on connecting with the Cochise Coalition on Ending Chronic Homelessness.
- Help educate about mental health, substance abuse, and homelessness. Will take any training and opportunity to be educated to assist any individuals that need help.
- Utilize information to navigate families to mental and behavioral services. Help restoring communities and families with hope. Provide awareness to bridge the gap between addiction and recovery.

- Focus on connection. Connection with students, families, and community resources. I will ask the students for their input on presentations/programs brought to the school.
- Focus on empowering my students by providing information and awareness.
- Restart SEAGO's Housing Program, including becoming a Community Housing Development Organization (CHDO).
- Try to stay with a good group. Guide people through the dark.
- Work to connect with organizations and individuals already engaging and providing services for people in our community.
- Learn more.
- Try and stop racism and help the Black community.
- Tell more people to be more open about having mental problems or use of substance. Try to find help or if help comes to you, take it.
- Strive to always consider mental health, substance abuse, and homelessness as interconnected.
- Work on being more involved with groups in my community to support services I believe are a benefit to my community.
- Commit to empathy, not judgment.
- Be more understanding and not judge so fast. I will engage with more people.
- Have a better understanding of the existing resources available in the county to better educate and connect those in need.
- Help spread awareness. Advocate. Be a voice for victims. Support.
- Focus on engaging the issues at hand. This is a world-wide problem and I feel like it has not been dealt with to the best of our abilities.
- Focus on outreach and getting the word out on the different resources that are available. Be the voice.
- Pray for those struggling. If I see someone or anyone going through something, I will reach out to them and give the help they might need. I will give them that push that they need. I will also give them some resources I learned today. Spread the word.
- Try to help as much as I can in any way I can.
- Recognize my own issues. It is okay not to be okay.
- Advocate for reducing barriers and increasing supports and resources for community members struggling with conditions of mental health, substance use, and homelessness. Programs that promote resilience. This includes returning citizens coming out of incarceration.
- Work with community leaders and peers in healthcare to help educate on Opioid Use Disorder (OUD) and Medication Assisted Treatment (MAT). There is a need and availability in our county.
- Continue to work on working with my community for my community. This is a team effort!

Florence Community Town Hall

Wednesday, September 28, 2022

Florence, AZ



Florence Community Town Hall

September 28, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

The conditions of mental health, substance use, and homelessness are interrelated. They are circular, symbiotic, and successive. For example, if someone has a mental health disorder, they may have troubles interacting with others properly or holding down a job. This can lead to substance use and homelessness.

While not always connected, homelessness is often related to mental health issues. Similarly, homelessness can lead to substance use and mental health issues. While people can experience one of these issues without the other, they are generally connected and interrelated. Once you have one issue, it often begets the other in a circular path. Because these issues are so interrelated, to address one effectively, we need to address them together and systematically.

We are experiencing many difficult challenges in our efforts to assist the homeless. They include the lack of transportation, lack of services, insufficient counselors, and an increase in homeless seniors while at the same time there is less available housing for those who need it.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

We need to focus on education and prevention. It's better to start earlier than later, including building skills with our children so that they can better cope with stress. We also should seek to better identify and address mental health issues earlier through support for both children and their parents as well as raising awareness of how best to identify and address challenges.

Beginning early, we should teach children how to identify emotions and how to manage challenges and emotions. It's also important to provide skills for addressing and managing stress and trauma. Teaching mindfulness techniques such as yoga should be as important as physical education.

These early prevention strategies would create much greater savings later and should be considered for training curriculum.

While parent education and involvement are important, it can be very challenging to accomplish effectively, even when resources are available. Implementing these early systems is increasingly challenging for schools because of legislation that prevents schools from asking students about some of the issues.

We need to frontload prevention and education, but we also need to address the problems that currently exist. We can create and expand opportunities to address these issues through collaboration and by everyone being more compassionate, knowledgeable and understanding about how best to assist people experiencing these challenges. We should not be turning people away who are asking for assistance.

Addressing transportation challenges so that people can access needed services is critical. We also need an emergency services shelter in Pinal County.

Eighty-five percent of people in the Department of Corrections have a substance use disorder at a cost of \$35,000 per year, per person. This doesn't treat the underlying issue and it is a failure on a global scale of how best to allocate resources. The criminal justice system is the worst way to address this issue. We are simply creating a vicious cycle that impacts them for the rest of their life. Our current system is not set up for success. Instead, it creates a revolving door that hinders people from restarting their life.

SETTING PRIORITIES

Pinal County is growing at a rapid pace, and we need to proactively address these issues now.

As a state we need to better address how to support people coming out of prison so they can integrate more effectively back into the community.

Whether brick and mortar or online, we need a "one stop shop" for people to obtain the resources they need in a more effective and efficient way. 211 is great except not all agencies have their complete information in the system. A one stop shop concept should include personnel (or an informed point of contact) who have been trained to navigate people to needed resources and services.

There should be "no wrong door" for those seeking resources.

One of the greatest challenges for accomplishing these goals is effective collaboration. Instead, our systems are set up for people, organizations, and governments to compete against each other instead of working together. However, we can change this dynamic with dedication and grassroots efforts, working together in our community to create effective programs that we can then take to city and state leaders. We need a champion (or champions) from our community who will advocate on our behalf.

While there is funding available, it often comes with restrictions that prevent those who need it from getting assistance. We need more flexible funding that supports the programs we need most. A strong community that is connected and supportive is critical. Supportive community structures that include loving adults who provide positive support for all children make a big difference.

We need to take action to rebuild and strengthen our family relationships and our relationships with our neighbors so that we have a strong and supportive community that sets the example for our children of how to have strong, loving and supportive relationships.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Increase prevention and decrease discipline. The criminal justice system is ill-equipped to handle this issue. Use money currently apportioned to the criminal justice system to instead address mental health, substance use, and homelessness.

It takes a village to support the growth of a child. Create an integrated system that incentivizes cooperation and collaboration and that has a vision big enough for everyone.

We need a vision. We need to address these issues now and not wait for a better time.

Create programs that empower people to solve problems.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Florence Community Town Hall. Below are individual actions that were shared.

I WILL...

- Continue to speak the truth
- Say something positive always to anyone who is suffering with mental health, substance use, and/or homelessness.
- Make an effort to say hello to more strangers as I see them throughout my day. I may be the only positive light for them.
- Be the voice for those who need a champion to overcome mental health challenges and barriers and provide a path to healing growth and community support.
- Continue to pay attention to what is going on around me in my community.
- Continue to work with parents in the Eloy community regarding communication, prevention and other family issues through parent workshops.

IN COLLABORATION WITH



CASA GRANDE
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PINAL COUNTY
WIDE OPEN OPPORTUNITY

Public Health Services District



Banner Health
Casa Grande Medical Center



Sun Life Health
HEALTH STARTS HERE



Compilation Statement

Southwest Arizona Town Hall Forum

“Mental Health, Substance Use, and Homelessness”

PROGRAMS HOSTED

Yuma County Home Consortium Virtual Town Hall
Friday, February 25, 2022 | Online Via Zoom

Mental Health in our Community Virtual Town Hall
Friday, May 20, 2022 | Online Via Zoom

Substance Use in our Community Virtual Town Hall
Friday, June 10, 2022 | Online Via Zoom

**Designing a Community Approach to Mental Health,
Substance Use, and Homelessness**
Friday, September 30, 2022 | Yuma, AZ



Mental Health, Substance Use, and Homelessness

SEPTEMBER 30, 2022

FINAL REPORT

 **SWATH**
South West Arizona Town Hall

Southwest Arizona Town Hall Forum "Mental Health, Substance Use, and Homelessness" September 30, 2022

Mental Health, Substance Use, and Homelessness are intertwined with their impact on our population. The Southwest Arizona Town Hall (SWATH) held on September 30, 2022, at the Yuma Regional Medical Center Administration area focused on each area during breakout sessions and prioritized early action plans with leveraged partnerships.

MENTAL HEALTH

Mental health is not a situation where you can give a pill to someone, and the problem goes away. It is a continuum of care. There are many challenges that face mental health care in Yuma County:

- The stigma involved with admitting a need for these services.
- A significant lack of services for the general population, which reaches a severe level when considering certain populations, such as veterans, teenagers, the elderly, and children.
- Insurance coverage for mental health issues.
- Mental health service outreach to our region's large minority population that is culturally and linguistically appropriate.

There is a stigma with our population in admitting a need for mental health services. Intensive public outreach campaigns to stop the stigma around mental health are required. This outreach and mental health programs need to consider cultural, generational, and linguistic considerations when preparing providers and determining types of providers necessary to work with our population.

Educating the community will help our community understand what is involved and what resources exist for all ages. Removing the stigma of mental health issues and developing the skills for individuals to self-evaluate or assist those around them is needed. Funding for these services is needed. It is important for families to have the education to recognize issues and the knowledge of what to do.

In the process of public outreach, both the stigma and education on available services needs to be addressed. Individuals do not want to be labeled. The emphasis needs to be on creating a safe space to discuss the issues big or small that everyone is facing. Developing a trust in system providers is essential. Recent legislation (HB2161) has made anonymity in the school system much more difficult. Teenagers are concerned that any problems they share will be communicated to their parents, which could make their living situations more difficult.

Covering mental health services for all ages is crucial. Mental health care can be very expensive. It is difficult to find coverage for different mental health populations in Yuma County, forcing families to travel out of town to search for needed services. Teenagers receiving out-of-town services have their lives disrupted, exacerbating their mental health condition, since they are taken out of their school and community. An expansion

of Level 2 services for teenagers in Yuma County would be optimal. The current situation sees teenage mental health issues tying into other issues, including those of dropping out of school and substance use. The elderly population represents a growing segment of the population, in desperate need for services, with families that do not know how to help them. There is a lack of services for the specific needs of veterans.

Insurance coverage for mental health is a difficult path that most users do not know how to navigate. The lack of insurance can prove to be a huge obstacle to obtaining service. There is a great need for more local resources that accept all the necessary forms of insurance and ensure access to individuals. Wrap-around programs need to be available to continue progress made during treatment.

Yuma County is located on the U.S./Mexico border and includes a population that is linguistically and culturally diverse. Family is the cornerstone of our area. Policies and programs need to take into consideration the whole family/community that the individual is part of to ensure the health and support for the entirety of the family unit.

We do have programs that are in place and ongoing in our Yuma community. There is a need to prioritize outreach and deeper information to the community about the services available. Crane Elementary School District is one example of a program with social workers who hold group therapy sessions at school to help young students learn how to deal with issues throughout their lives. There are also school-based resources at the high schools that are available at no charge, but parents do not always know of these services. Yuma Union High School District supports the Yellow Ribbon groups, which provide peer support for students and are present in each high school.

Specifically, information needs to be provided to general health/support providers as to where and what the available services are to more adequately provide the necessary referrals, such as a mental health navigator. Such referrals also need to be available in Spanish and in multiple formats – online as well as by phone and in person. Hotlines for mental health assistance have been successful. Early identification of mental health issues can help with early intervention to help people. Referral systems need to have follow-through to ensure continuity of services. There should be advocacy to our elected officials for the awareness and need of funding for these services.

When building these programs, we need to ensure that we are building the bridges necessary to care for those who need assistance now. Funding programs is always an issue. To make programs effective long-term, we need to consider retaining mental health professionals through competitive salaries and leveraging the benefits of becoming part of the Yuma community. Burn-out of health care professionals is of great concern and we need to look for ways to combat professionals leaving this field.

"Growing our own" services should be a priority. A welcomed program is the Yuma Regional Medical Center psychiatry residency program. As part of the development of this system and the education of new professionals, we need to look at our existing educational opportunities. By working with the universities, Arizona Western College, Yuma Union High School District, Southwest Technical Education District of Yuma (STEDY), Yuma Regional Medical Center and local agencies, we can develop the curriculum, programs and degrees needed to support the mental health system we create. It is also important to take advantage of the talent that already exists in our community, "Growing our Own" – creating and developing pipelines to the mental health profession. Scholarship opportunities are needed to provide interested individuals assistance to follow mental health careers. Expanding partnerships in education can be accomplished through career exploration and linking with companies in this field for job creation and systematic follow-up. Stackable credentials for students can ease their career path as could highlighting what mental health professions do.

Information sharing should be streamlined for more coordination and continuation of care and the ability to track care and follow-up. This relieves the stress and pressure that might be placed on the patient or their family. It also allows providers to understand needs and evaluate services provided.

Besides working with existing university and collegiate partners, we should look outside of the State of Arizona for best practices and programs that are effective in other areas. All populations, specifically minorities and age groups, need to be brought into the decision-making process. We should do a full inventory of what parts of the system are already in place and determine where gaps exist and how those gaps can be filled. A large part of that system evaluation will be talking to those directly impacted – patients and their families. It will also require meaningful discussion and coordination between AHCCCS, court systems, law enforcement, the medical community, and schools – preschool to college.

Agency cross-training can help with coordination of referrals, services, and care. Programs need to consider ways to spread training to the wider community with those who can assist with mental health issues beyond those who are specifically health providers/social workers. Education of individuals who might make that first contact is essential: parents, caretakers, teachers, general practice physicians, pediatricians, law enforcement, religious leaders, and local agency providers. Police coordination with social workers to assess mental health problems on the street could help. By educating first contacts (parents and caretakers, teachers, law enforcement, clergy, court systems), we would be able to identify those in crisis or need, capture needed and necessary information and direct them to the best services.

In particular, coordination of care with mental health services is crucial. A one-stop center would be helpful. There needs to be quality, availability, and accessibility of services for our population. Transportation to services in Yuma County is a prevailing issue and options to reach services need to be considered. Providing virtual as well as in-person care is needed, as is expansion of services that provide local services, evaluations for mental health needs and assisting the transition from in-patient to out-patient care. Evaluation of care through patient surveys is important.

We care about the needs of our population in Yuma County. By working together, we can help those in need and provide mental health services and education to all our population.

PRIORITIZATION OF MENTAL HEALTH

VISION (ACTION: YUMA REGIONAL MEDICAL CENTER/DR. MAGU)

- Engagement of members (80%)
- Reduced duplication of resources/services
- Communication – news

ACTION PLAN

- Website – central source of information and services by December 2023
- Host first meeting by November 30, 2022
 - Inventory of services/resources
- Create a set of standard metrics/database by June 2023
- Coordination of Care
- Access and Coordination of Behavioral Health

- Form an active coalition
- Awareness Education
- Increase pipeline for healthcare professionals

MENTAL HEALTH PRIORITIES FOR YUMA COUNTY

Preventive Outreach/Insurance Coverage for families and children

Service Outreach (make services known)

Community Education – one stop shop (bring resources together)

Expansion of Systems

Education (community, development of professionals)

Reduce stigma, normalize care

Health literacy

Funding

INFRASTRUCTURE

Expansion of high-level and mid-level treatment facilities

Recruitment of properly trained mental health professionals, and support workers with lived experience

Expansion of peer support groups

EDUCATION, SCHOOLS, AND COMMUNITY

Prioritize drug prevention

Early and regular screenings for mental health concerns

Integration between current support systems

Leverage and build partnerships in Yuma County (Information into the schools and community about costs, risks and avoiding substance use)

FINANCIAL SUPPORT FOR TREATMENT

Address financial barriers

Community funding and collaboration

Social media

Grants

Partnerships

Coalitions

Local multilingual intensive outreach and education program.

Expanding system that provides local services

Coordination of care through consortium for mental health services available in Yuma County

COORDINATION OF CARE

Addressing the people's needs

Quality and availability of service

Distribution of resources available to the community

Create an active consortium for mental health (set an action plan and do a community needs assessment)

Expansion of formal education for healthcare awareness

Partner with all levels of education

Partner with agencies and employers

SUBSTANCE USE

We are experiencing a crisis; a crisis that needs to be brought to the forefront. In general society, substance use has been desensitized. However, substances – readily available on the street, at home and at school – can cause death. The presence of fentanyl, which is accessible and affordable, is growing substantially higher in Yuma County since it is being laced within other drugs. Although fentanyl is currently receiving much public attention, Yuma County has an equally large problem with methamphetamine. Vaping substances on school campuses are present during the day in the restrooms. There is denial on the individual, parent, and caretaker level that a substance use problem exists.

Challenges involved with substance use share many issues that are also present with mental health: the stigma for individuals or their family members to admit problems with substance use; education of the community about substance use; individual trust levels in existing medical and assistance systems; insurance coverage of the cost associated with substance use issues; and community outreach on resources available to address substance use.

There is significant stigma with conversations about substance use. Parents are afraid to talk about substance use. However, substance use may be considered normal at home, so children don't see its use as being wrong. Pain management is an aspect of self-medication that is readily available and seen as normal. Media entertainment and social activities may present substance use as a fun and social activity to the general population. Youth are seeking meaningful connections and when they don't find it or seek peer acceptance, they may find or rely on substances.

Sharing information about resources on substance use is important. Preventive measures will help our population to help solve problems before they escalate to a higher level. However, there is still stigma affiliated with substance use issues. Methamphetamine and fentanyl use are very prevalent in our community. Unfortunately, this substance use can reach a level where it escalates and disrupts people's lives.

One of the most important and meaningful ways to address substance use is to focus on prevention – educating children and teenagers about the risks and impacts of substance abuse and also educating parents and caretakers on the signs of substance abuse and the resources that are available. Education needs to occur on a community-wide basis, not just in schools, and at all age levels. We can capitalize on existing education programs and curriculum to develop those resources for educators. We can also utilize students that are motivated to help educate others on substance use and prevention to help promote and facilitate such education.

There needs to be more sharing of lived life experience on substance use with our community so that everyone realizes how substance use affects everyone, from all walks of life.

A media campaign about the current risks and dangers would be impactful and would help educate adults about these issues. Such a campaign would help address parent and caretaker denial. The campaign could also be used to educate the public about resources available in our community.

Providing education on substance use may not have the results desired. Being around a particular environment can strongly influence someone to use substances. While education programs are beneficial, they have to overcome the barrier of being dismissed by those who are targeted for the program. These education programs must begin with the family because often aspects within home life lead to the introduction of substances.

By developing coping skills at an early age, individuals can feel prepared to not use substances. Prioritizing substance prevention education in schools, both in English and Spanish, can help. Nevertheless, there is peer pressure, very prevalent at certain ages that can influence people to use substances. There is also the presence of substances at family members' houses that are readily available. Previous programs, such as the DARE program, have not always had successful results. Peer groups, such as Smart Recovery and Al Anon, could also help with substance use since many times family members do not know how to support others with usage issues.

Often, substance use occurs in connection or correlation with trauma, grief and loss, or other mental health issues; it may even become the catalyst. Underlying issues should be studied since substance use may be a symptom of another issue. Services can assist individuals and need to continue to support those who do get clean and need assistance in continuing their sobriety path.

Insurance coverage is difficult to navigate. Without coverage, assistance with substance use can be expensive. For those who don't have AHCCCS, there should be services readily available that do not have a high cost. There are grants available that cover the commercial insurance side. However, many of these grants require that they be referred by the school system.

There are almost no adolescent drug treatment options in Yuma County. There is a great need for more local resources that accept all the necessary forms of insurance and ensure access to individuals. To improve the situation, we need to not only consider local residential treatment, but we also need to ensure there are wrap-around programs to continue the progress made during treatment so that it can carry through. Even for adults there are limited and sporadic resources available.

Navigating the health care system is not easy. Helping individuals through a one-stop shop can integrate working with individuals who have both mental health and substance use since both issues tend to go together.

It takes a village, comprised of many organizations, to do outreach on preventive measures for substance use.

Social media has a high impact on people. Presentations that are given at school may not reach the target audience that needs to be reached about substance use. Smaller group discussions on drug prevention could have more of a relevant impact.

The crisis itself needs to be brought to the forefront. A media campaign about the current risks and dangers would be impactful and would help educate adults about these issues. Such a campaign would help address parent and caretaker denial. The campaign could also be used to educate the public about resources available in our community.

SYSTEM CHANGE

Criteria that require individuals to be clean for a period of time before they can benefit from resources need to change. People need to be helped right away.

There need to be confidential ways for individuals to reach out for assistance and help for a friend or family members. The Yellow Ribbon group is a way for high school students to help others.

We need to work on connecting medical providers to agencies that provide substance use services. Finding and training individuals to be outreach specialists would go far in helping create those connections and also educating the public about existing resources.

Our community needs detox or inpatient centers, outreach specialists that can help connect agencies and providers, and a resource communication platform. In addition, our drug court currently only assists those with felony charges – it should include a program for misdemeanor charges.

Just like mental health, we need to develop career pathways that lead to jobs in the field of substance use prevention and care. We can leverage the work that will be done in the mental health field. This will also help in addressing the impacts of staff turnover in local agencies.

Leveraging and building partnerships in Yuma County are essential. Partnerships with law enforcement and health care professionals with schools should be leveraged to get information into schools about the costs and risks of substance use.

To serve our community, it is necessary to fund and build needed infrastructure for rehabilitation and mental health that includes support for those with substance use disorders; in particular, help with navigating the health care system. There needs to be a holistic system in place instead of individuals treated on a piecemeal basis. Facilities with high-level in-patient and mid-level transitional treatment need to be expanded. There needs to be an expansion of treatment service facilities throughout the county, including pediatric support programs. Community members should meet with legislators to obtain funding for program support.

The recruitment and development of properly trained mental health professionals need to occur. Those individuals who have lived experience and have become clean and sober could be recruited to follow careers that help others with substance use disorders.

Financial barriers and insurance issues for coverage need to be addressed for substance use disorders. Communities could collaborate to obtain grants, non-traditional partnerships, and coalitions, to support work being done and the work that is still needed.

Drug prevention education in our schools and within our region needs to be prioritized, applied with cultural considerations of this area, and available in both English and Spanish.

Legislation must not prevent local school systems from educating students on substance use (HB2161). The focus should be on helping young people rather than disciplining them. Our community should instill understanding and compassion with issues and encourage community service, rather than only punitive measures.

We need integration between current support systems to serve our community, which will build rapport, and encourage services to complement each other and not duplicate efforts. Expanding coalitions within our community can assist with sharing ideas and providing resources. Town halls that are focused on substance use can provide opportunities for our community to engage in this issue and interact.

PRIORITIZATION FOR SUBSTANCE USE

VISION

ACTION: YUMA COUNTY ANTI-DRUG COALITION

- Reduced youth drug use in Yuma County (reduced school suspensions for drug use and reduced law enforcement incidences due to drug within 18 months)
- Train teachers and school staff on drug awareness
- Educate parents and caregivers
- Media campaign (all channels)
- Town hall meetings at schools and community settings

Community awareness/social media

Safe place/zone for confidential discussions

Leverage/coordinate resources and relationships

Community collaboration to gain more funding for high level treatment and long-term tradition programs

Prioritize drug prevention education in our schools and support families including funding for such programs

Continue to work on a holistic system instead of piecemeal for services provided

Fund and build necessary infrastructure for rehabilitation and mental health

Address financial barriers and insurance

Community collaboration to gain more funding for high-level treatment and long-term treatment programs

Prioritize drug prevention education in our schools and support families including funding for such programs

Continue to work on a holistic system instead of piecemeal for service provided

SWATH PERSONAL STATEMENTS OF ACTION

- Prioritize drug prevention education by informing students and parents at school campaigns, public events, and providing information.
- Prioritize drug education. Coordinate all organizations to increase community education, peer-to-peer education in work on awareness.
- Educate Yuma County on the perils of substance abuse from kindergarten through 12th grade. Community participation at school and small community grassroot teams/schools. Firsthand experience and testimonials and testimonial experience of lost loved ones.
- My goal is multi-level education programs directed at students and their parents on the hazards, identification, and consequences of drug use. Multi-level targeting of young adults and parents. Multimedia approach. Organize students against drug abuse in middle and high schools.
- Prioritized drug prevention education through young serving organizations who provide services to schools and community (CSF, YCHO, YMCA, Boys and Girls Club, coalitions, juvenile centers) to begin implementation of services with community support.

- Prioritize drug prevention education; to fund and build necessary infrastructure for rehab and mental health to address financial barriers and insurance. Create awareness presentations to parents in schools and/or public venues and provide them with statistics of drug use, overdoses, factors that contribute to substance use, and how to help their kids with resources in the community.
- Prioritize drug prevention education by using social media to spread information, having speakers go to schools, having conferences that parents can attend, and beginning to expose drug education to kids at younger ages.
- Prioritize drug prevention education by using billboards, guest speakers, using social media, and organizing a citywide rally.
- Prioritize drug prevention education by getting students involved in awareness.
- Prevent the use/misuse of substances through education to both adults and youth by collaborating with agencies that offer education.
- Educate and raise awareness on substance abuse through social media, parenting education, youth education and partnership with local agencies.
- Prioritize drug prevention education by passing information to the schools, going into agencies to promote recovery, providing information to the community, partnering with agencies, having communication meetings, and educating myself to educate others.
- My goal is prevention and education in schools and the community through social media campaigns, bridge resources into the schools, developing training for faculty, expanding billboard campaigns, getting literature posters out in the community, and developing a youth coalition.
- My goal is drug prevention education through speaking to schools and parents.
- To increase education and awareness surrounding us, stigma, treatment and resources to schools and community through partnering with schools to provide education, partnering with agencies to provide community training, and utilizing support groups and education facilities to carry out this message.
- Prioritize drug prevention education through college level prevention and strategy sessions for education students.
- Prioritize substance abuse/use prevention education through developing afterschool programs for children, integrating educational seminars and assessing the community and educating.

HOMELESSNESS

Homelessness in Yuma County affects everyone. There is no particular population nor age group that does not experience homelessness. Yuma County has initiatives to help with housing. However, housing inventory and funding is very limited. People may have vouchers for housing but cannot find housing. Housing vouchers may not cover the current cost of housing.

There are many buckets for housing for different groups: the mentally ill, substance users, etc. Difficulties arise for coordination of care and continuing to have housing provided. Keeping people housed is difficult.

Housing overall is hard to come by in Yuma County which means that those who do qualify for services or at risk for homelessness can't find the necessary housing to prevent homelessness. We are currently failing to adequately support those coming off services and transitioning them to self-sustainment.

Homelessness affects our students. Situations such as foster care can move students to another school, which is disruptive. The lack of inventory of housing also escalates this situation. These situations can also lead to issues regarding mental health and substance use. While the school system is designed to be a safe place for students, the lack of resources in their lives can disrupt their environment and lead to problems in their lives.

High school students in Yuma County may live with family members or friends, but without a permanent home address. College students may have federal financial aid, but the funds received would not cover housing as well. There may be an opportunity for students to talk with other students to help them with housing issues and do outreach with resources. It is essential to be approachable for students to feel confident and safe to speak with someone in authority. If private information is shared, it could worsen a student's life at home.

The elderly population has a big issue with affordable housing. Those on a fixed income are in shelters because they cannot afford the cost of housing at its current rate in Yuma County.

Transitional houses are utilized for the population that have transitioned from incarceration. These places are regularly full and cannot admit anyone else.

H2A workers require employers to provide housing and properties that used to be rental properties for families are no longer available since they have been acquired for these workers. During the produce season, it is very difficult to find housing. Since Yuma County is on the border, there is housing for H2A workers that may not be occupied due to federal law. This housing could be utilized for other individuals in need.

STAKEHOLDERS

Crossroads Mission is a presence in our area for those experiencing homelessness and provides help with resources. Building partnerships to create move living spaces is needed in Yuma County. Western Arizona Council of Governments (WACOG) is a possibility for partnership since they work with a population that needs housing. Transitional Living Center Recovery also provides housing. Arizona Community Foundation is present in rural areas and can partner on this topic. Yuma Regional Medical Center is another potential partner. There are elderly patients who have been dropped off by their family and the hospital is told their family can no longer care for them. There are also those who do self-harm who are housed in the hospital. Homeless in our area also are housed in prison. The Arizona Long Term Care program is another partner that helps those in need of housing.

Other partners Yuma works with to combat homelessness include shelters, rapid rehousing, and programs through the Housing Coalition of Yuma. The need is to work toward better identifying underlying issues causing homelessness for individuals, specifically mental health, and substance use. We need to include services to combat these underlying issues and support family members before these issues create homelessness. Once individuals suffering from mental illness are homeless, we need to attempt to meet them where they are. Mobile mental health services are needed.

Obtaining a list of the organizations participating in this SWATH forum and what they provide would be very helpful to move forward with knowing who provides what in Yuma County, such as a resource guide for services provided. First Things First provides a resource guide for Yuma County for needed resources for children 0-5 years old.

INITIATIVES

Tackling homelessness should be a coordinated effort led by a coalition of entities that already provide some source of housing assistance. The Yuma Coalition to End Homelessness already exists, but it may need to be supported and propped up by those local entities so that we can address overall needs of the community. In addition to strengthening or restructuring the Coalition, we can expand on existing housing assistance programs through local agencies. Depending on the Coalition's mission and/or resources, a separate coalition may need to be created to fully address the needs of the community.

We need more job training opportunities for our homeless community. Organizations such as Arizona@Work, Regional Center for Border Health, and Crossroads Mission are currently offering these services. We need to get higher education involved to offer more certifications.

Partnerships should be developed between Crossroads Mission, city government, county government, Safe House, school districts, Yuma Regional Medical Center, Yuma County Intergovernmental Public Transportation (YCAT), Western Arizona Council of Governments (WACOG), Salvation Army, Regional Center for Border Health, and churches. The business community should also be involved, possibly through the Chamber of Commerce. Yuma Coalition to End Homelessness, ACHIEVE Human Services, Yuma Community Food Bank, Amberley's Place, Catholic Charities, Transitional Living Center Recovery, Oxford House, HOPE Center, Union Pacific, Victory Outreach, and National Community Health Partners also represent potential partners. Homeowners with multiple properties could increase rental availability. Investors are needed to build properties to fill federal assistance housing programs.

The homeless population is a part of our community and should be provided the opportunities and resources that are needed to increase quality of life. Individuals and families should be able to go to one place for all of their needs - a central access point to support services. Housing assistance should use the "Housing First Model" and provide wrap around services. Supporting homeless requires a holistic support system that includes housing, case management, life skills training, and more.

We need to expand our understanding of who is classified as homeless, specifically needing to consider those who simply stay with different sets of family and friends. Limiting access to services to only those who are actually sleeping on the street, prevents services to those in need. Definitions of "homeless" are compounded by the stigma of homelessness, which prevent families and individuals from seeking services out that are available.

Our regional approach to homelessness is strained. Crossroads Mission has taken on a big role in supporting our local homeless population, but they are filling up and not able to fully support at their current capacity.

Homeless find public spaces appealing because they can just be. For example, local parks have had to close earlier, and drug use is happening in public bathrooms, while families are in close proximity. Local police have had to do more monitoring of these public spaces.

The easing of panhandling laws and restrictions has made it more lucrative for homeless residents to stay homeless and not seek local support services.

We have a real need for affordable housing throughout Yuma County. Finding a rental has become difficult. There is a lack of available affordable homes and apartments, and rent is increasing while family income (payroll, public assistance, Social Security) stays the same. This is leading families to become homeless if they do not have the resources to afford or find a rental.

PRIORITIZATION FOR HOMELESSNESS

VISION (ACTION: YUMA COALITION TO END HOMELESSNESS)

- Central Access Center – planning and development
- Grant and resource development
- Communication plan/completion of website
- Larger community meeting (SWATH to assist)

Prioritize drug prevention through community education in messaging and campaigning to assist with unblocking federal and state of Arizona restrictions through District representatives and legislators involved.

Integration of current support system

Coalition within the community to form the group to provide resources – town halls focused on the issue and action items

Role modeling concept to allow visitors to share their clean and sober

Meet with legislators to help fund and continue organization

Fund and build the NEC infrastructure and program

Collaborations with law enforcement, church, healthcare, and academics to advocate to state and federal entities

Build on Yuma's Coalition to End Homelessness (all agencies involved)

Create central access location facility under one roof

Create one place where people can go for services

Build awareness

Affordable housing

Assistance Programs (rental)

Regulate fentanyl increases

Rapid re-housing

Redefine homelessness beyond those living on the street to include those in unstable housing

Identify the population and underlying reasons including mental health issues

Provide services where the homeless are location to treat underlying issues

Yuma County is known for its collaboration. We can work together to provide solutions to these issues.

Mental Health in our Community Virtual Town Hall (SWATH)

May 20, 2022

WHAT BARRIERS DO PEOPLE FACE IN ADDRESSING MENTAL HEALTH NEEDS IN OUR COMMUNITY COMMUNITY(IES)? FOR EACH BARRIER – WHAT SOLUTIONS COME TO MIND?

There are many barriers that people face in the Yuma County area. The core barriers to those addressing mental health needs in Yuma County are a lack of local services, both direct and supporting. Services such as transportation, the cost of services and dealing with insurance/referral requirements, plus the stigma around mental illness are challenging. Key populations that face barriers in the Yuma community are young people and senior populations.

The first hurdle facing those addressing mental health needs is overcoming the stigma of mental illness and needing mental health services. Unfortunately, many individuals who are suffering are afraid to reach out since they don't have anyone to talk with about their issues and they don't want to go through this trauma alone. In particular, it is important to overcome the stigma before acute inpatient services are needed. To assist in overcoming this, programs such as the Yellow Ribbon program and other programs within our schools provide the safe space necessary to acknowledge the need for mental health services. This type of outreach should be supported by the public and could potentially help as an evaluation program, as schools are understaffed and need support in their efforts. This support and outreach should include formal educational programs on mental health, public forums and presentations attached to professional organizations. There should be more opportunity for people who are affected by mental health to tell their stories so that others in the same situation can relate and are inspired to get help.

Once the stigma is overcome, individuals and families in Yuma County then are faced with knowing where to go and how to deal with access to professionals and services. This occurs both in the realm of direct services and obtaining and working through the insurance process. For families of those dealing with mental health needs, the lack of local services greatly impacts families compounding the issues their loved ones are facing with having to take time from work to travel to Phoenix or elsewhere. This increases the difficulty since there is a lack of a standard referral system and insufficient coordination of services for individuals who are in need of services. Additionally, there exists a disparity of services for individuals depending on their type of insurance coverage. The best solutions for bringing those services back to the local community is to begin to grow our own services, and retain professionals already located in our community. For the issues of disparity, it would be helpful to have a public evaluation program that would allow individuals to determine what types of services they may need and qualify for.

Many constituents do not know where to go to address mental health needs. A designated, one stop site where people can go for information and resources on mental health and providers is needed. Individuals that need help may not know that they need help. Knowledge of how to obtain guardianship and resources for families to have voice in this situation is crucial. Some individuals do not have the resources nor insurance to help guide them to needed assistance. Providers in Yuma County are being inundated by the numbers of patients.

Family physicians are often the first place that patients go to for help; however, they may not be adequately prepared for diagnoses for mental health. There is concern that mental health issues may be misdiagnosed or discounted as “just a kid thing” for young people.

There are providers in Yuma County, but often not those who are specialized in younger ages, which limits what can be provided to that age group. There has been a recent increase in teenagers who need assistance, particularly for depression. If service cannot be provided in one location, patients are referred to other providers in other locations. There is a concern about the waiting time for patients to see providers.

The cost of services for mental health is very expensive. Some therapy may not be covered by medical insurance. The lack of pediatric mental health services is of great concern. While there are medications for various mental health issues, medications in this area were underdeveloped for many years. Many current medications for mental health issues are not generic and can be costly.

Waitlists to receive services can be very long, making the patient feel that they are forgotten. Including a bridge so that patients can obtain assistance while they are waiting and focusing on better working relationships with outside facilities would help patients transition to care.

There is a lack of specialized mental health care, particularly for young people and the elderly. The high school system has seen a definite increase in mental health issues with students. There have been issues with how to access funds to pay for services needed. The high school district has a social worker on site for each high school and has partnered with other agencies to provide services to students without students and their families needing to be concerned about how these services are paid for. It is necessary to be proactive on how services are provided to young people.

For seniors there is concern on accurate diagnosis of the patient and for elders, the additional issue of dealing with technology based or supported services as many of them lack access or knowledge on how to use those technologies.

There are challenges for individuals with mental health issues who go through the court system. The paperwork to obtain access is difficult, especially for the homeless. There is a cycle of homeless individuals not receiving timely assistance, which may cause them to walk away from help. To better understand what these individuals go through, it is recommended that residents attend a mental health court to see what happens during this process and learn more about this service to the community.

The psychiatry group has adapted to the ongoing crisis in mental health. These personnel are on call at the hospital to focus on meeting the needs of individuals who need help. Family doctors also help patients who require assistance. There are opportunities for family members to learn about the paperwork needed for patients and how to advocate for the patient. Workshops for general practice physicians would help those who first see patients with mental health issues.

This all leads to the largest barrier faced by those looking to address mental health in the Yuma Community, the lack of local services. While there are telehealth mental health services provided to students at the college, having local services would provide more coverage. This barrier encapsulates not only a lack of inpatient and outpatient services directly, but the lack of transport to such services and support for those who are trying to care for family members dealing with mental illness. The central solution to the lack of local services is to “grow our own”, that is to provide an educational program locally, that educates and creates the necessary mental health professionals and support staff that are needed to provide the level of service that is lacking in the Yuma Community.

THINK ABOUT OUR VISION TO DEVELOP EXPANDED BEHAVIORAL HEALTH IN OUR REGION FOR GENERATIONS TO COME. WHAT SPECIFIC NEEDS / SERVICES WOULD YOU LIKE TO SEE DEVELOPED/ PRIORITIZED IN THE NEXT 5 YEARS?

In the next five years, Yuma County would benefit from a local hotline that could provide services to individuals in need of assistance. Strengthening and expanding the crisis team and preparing them to work with youth would benefit our area and lessen the wait time. Coordination of care between the providers, families, and schools is crucial. It is important that the psychiatry group at the hospital grow to be able to meet the needs of the community, including more therapists and therapists who are prepared to help young people. A caseworker who helps patients navigate the system would help those who need assistance. Overall, people in the community need to know what steps are involved in providing assistance to individuals with mental health issues.

Over the next five years the Yuma Community would be best served in expanding systems that provide local services, evaluations for mental health needs and assisting the transition from inpatient to outpatient care. While the current psychiatry services provides needed assistance to our county, specifically, an expansion to the educational opportunities in mental health services locally, would allow for the growth of local services and in recruiting mental health providers and case managers. Yuma County would be greatly impacted by the institution and expansion of a formal education program in mental healthcare as it would establish the providers so desperately needed. In this expansion we need to look not just to the quantity but also the quality of those services.

A future benefit to Yuma County would be creating a psychiatry residency program so that this service could be expanded locally. A beneficial goal would be to grow current systems in place while working toward the "grow our own" idea of ensuring there exists in the Yuma community the professionals, staff, and facilities for inpatient and outpatient services. To get there we can begin with building direct services through in-person and virtual services, then move towards growing and retaining locally the professionals and staff for Inpatient and Intensive Outpatient. Once those systems are in place, we can grow the reach and quality of the services by bringing in non-profit and for-profit agencies, schools, and the public. The continued availability and funding for services in the school setting during this growing process has already been shown to be invaluable for the well-being of adolescents in the community. In particular, Yuma County needs to consider transportation options for different age groups to be able to access care.

It is crucial to provide mental health services to all age groups. There are currently only two facilities within the state who accept teens. It is necessary to augment these facilities to help families with teenagers who need these services and including one in the Yuma County area would help. Sending their children away for an unspecified amount of time is very difficult for families. The geri-psych group represents a population that is challenging to find assistance for as guardianship can take months to process in certain cases and appropriate diagnosis can be difficult.

Doing a survey for patients requiring mental health assistance would benefit our community assessing the quality of service provided. This could be a critical next step to improve the quality of care in Yuma County. A centralized database would also help provide needed care to patients.

Above all, the vision for the future needs to be centered on the concept of a "safe place" where all individuals can have somewhere or someone individuals can go to in order to talk and feel safe.

WHAT ARE THE OPPORTUNITIES TO LEVERAGE AND BUILD PARTNERSHIPS THAT WOULD ENHANCE ACCESS TO MENTAL HEALTH SERVICES AND SUPPORT?

Leverage and partnerships need to be based on trust and individuals need to be able to give that feeling of trust in return.

A consortium for mental health services could benefit Yuma County so that all could benefit from across-the-board service. The Portland, Oregon, area has created a one-stop mental health center through partnerships. The Yuma County Health Department would be a strong resource to get people to the appropriate location for mental health. This department has started to receive grants to fund this initiative.

Partnering within education is important. The education system is one that has been partnering to provide services to our county. Northern Arizona University – Yuma and Arizona State University provide social work interns who provide services within area schools. Increasing awareness through partnering with local schools is an opportunity. Schools, the college, and universities, churches and non-profits could host events and increase social engagement on this topic as well as engage in partnerships for training. Sharing resources to help our community is crucial.

It is important to advocate for Yuma County to our elected officials. Access to funding and services for mental health is essential. Building relationships with the school districts would help our community augment needed relationships. Binational collaboration would assist in helping our border area population.

A key facet of leveraging those services currently available and the experts in Yuma County is to somehow spread the information in a comprehensive manner. With this type of information partnership, individuals and organizations can discover and leverage the availability of services, programs, and funding to expand services so that best practice information to those looking to address mental health in our community is available. Some services currently present or arriving online include the 988 services for mental health emergencies which will include a texting option for adolescents and those who do not feel comfortable speaking on the phone; 741741 which is a national hotline; and First Things First, which has a Yuma Region Resource Connection Guide. Once these services have been identified looking towards expanding programs that are in existence, like the high school Yellow Ribbon program, could be expanding outreach to the Jr. High School level. A lack of resources is always a concern when considering expansion.

WHAT WILL BE MY ACTION TO IMPACT CHANGE?

- I commit to continue supporting those on the front lines who do the hard work in ways that I can.
- Sharing my story with helping those I love and myself to get services and evaluations. Working with nonprofits to build solutions.
- I plan to continue to support the leadership of YRMC and their commitment to addressing the needs in Yuma.
- We are committed to continue working with all available resources and learn from the experts. With the additional knowledge, the doors open a little more. We want to make this right and to meet our community needs.
- Continue to educate and advocate on the stigma around mental health. Talk about it! Let's get rid of the stigma.
- Form a group to hold providers accountable.

- Be the voice for the individuals who cannot speak up for themselves. Partner with the courts and the justice system.
- Connect the field of substance abuse more with the mental health agencies we have in town.
- Investigate putting up mental health education tools in the waiting room of our clinic or in the rooms; help expand our resource list.
- Educate our community about mental/social health; advocate for our youth to get more resources in Yuma County after they get referred.
- Provide a safe place for a spiritual component.
- Implement a substance abuse teaching curriculum in our residency program. Help with the development of the psychiatric residency.
- Reach out to community partners to create a community referral guide. Get that information out to student's families.
- Create internal staff mental health program, and whatever I can do.
- Continue to work towards bringing voices forward of those who have faced mental health issues.

Substance Use in our Community Virtual Town Hall (SWATH)

June 10, 2022

WHAT ARE THE UNDERLYING CAUSES OF SUBSTANCE USE DISORDER AND THE INCREASE USE OF FENTANYL IN OUR COMMUNITY? WHAT ARE THE BARRIERS OR LACK OF SUPPORT FOR TREATMENT AND SUPPORT FOR THOSE EXPERIENCING SUBSTANCE USE DISORDER IN OUR COMMUNITY(IES)?

The underlying causes of substance use disorder in the Yuma community are mental health issues, environmental factors, familial factors, and societal factors. Often drugs are being used to change the way an individual feels emotionally. Substance users may not intend or know the repercussions of the road they are following. Additionally, particularly with minors, the lack of familial and peer support causes individuals to seek the use of substances to deal with emotions and thoughts they are struggling to cope with.

Yuma County's proximity to the US/Mexico border creates more accessibility to and availability of drugs. Some young adults participate in drug trafficking because it is an enticing opportunity to make more money than in a traditional job. For those selling fentanyl, it is inexpensive to buy and then mark up.

It has also taken a long time to get the word out about the severity of fentanyl. Fentanyl is very potent, even when compared to other drugs, which makes it very dangerous. This drug is highly addictive, inexpensive, and easy to get, which is a very dangerous combination.

Drugs have long been a form of self-medication for those dealing with mental health issues, such as anxiety and depression, and fentanyl is no different. The Yuma County community is dealing with a lack of resources for mental health which deepens the problem. There are also many young children exposed to fentanyl, which means we need to begin drug education much earlier.

There are many barriers, lack of support for treatment, and missed opportunities to provide support for those experiencing substance use disorder in our community. To start, careers in treatment support and rehabilitation are not well-paid for the amount of work and stress involved. Caseloads are large, time intensive, and stressful to manage. Yuma County lacks the necessary mental health facilities and providers in our region and needs more funding and resources to make this happen.

Pathways to recovery need to be more accessible. Insurance coverage for mental health is difficult to navigate, such as understanding what is covered, what is not, or how to get access to financial support.

The Yuma community faces barriers such as the cost of treatments, access to treatments, delay of care and support to community members. These barriers often overlap through the stigma and shame that families and individuals facing substance use issues. This can be seen in requests of families seeking treatments on Sunday afternoons or other times they anticipate others not being in the facility. The judicial system can be a solution to the barrier, and local expanded treatment options making access to treatment easier and more affordable both for patients and families would help to dismantle many of the barriers to treatments.

Family issues can also be a barrier to treatment. Those who need substance abuse treatment don't always want to be helped. To support the treatment, family members need to be prepared to give a lot of time and attention to help the one in need.

Solutions to these barriers include the need to empower young people to feel better about their choices and their future. Drug prevention should not be approached from a place of fear and darkness. We need to show young people that they are in control of their future.

Parents need to be empowered to support their children through more education opportunities, offering more Spanish language resources, and by bringing all healthcare providers together – one stop where all elements of health can be addressed – physical and mental.

THINK ABOUT OUR VISION TO DEVELOP EXPANDED SUBSTANCE USE DISORDER TREATMENT AND AWARENESS IN OUR REGION FOR GENERATIONS TO COME. WHAT SPECIFIC NEEDS / SERVICES WOULD YOU LIKE TO SEE DEVELOPED/PRIORITIZED IN THE NEXT 5 YEARS?

In Yuma County the greatest need is the expansion of high-level treatment facilities in the County as patients and families struggle with having to travel to receive in-patient treatment and support those family members trying to support those individuals. Critically, the Yuma community needs a Level 1- Inpatient treatment facility. A key aspect in these expansions is to ensure that it includes availability across economic strata, specifically those not on AHCCCS or other government support. Additionally, as these services are being expanded, the expansion needs to include services for families and caregivers.

Another service that would be helpful in preventing substance use are early and regular screenings for mental health concerns before such mental health issues lead to drug use. This would be accomplished through expansion to primary care providers.

We must fund and build the necessary infrastructure for rehabilitation and mental health to include: support for those with substance use disorder navigating the healthcare system; building of more facilities; and recruitment of properly trained mental health professionals. As part of this infrastructure, we must focus on growing our own mental health and rehabilitation professionals. We could encourage those who want to get clean and sober to follow careers that support and guide others who want to get clean and sober. Peer support is beneficial and powerful.

When thinking of our vision to develop expanded substance use disorder treatment and awareness in our region today and in the next five years, we must prioritize drug prevention education in our schools (all ages) and within our region. Educational resources need to be more readily available, in both English and Spanish.

Finally, a prioritization of the integration between current support systems to ensure individuals do not fall through the cracks or repeat treatment is critical to lowering the overall substance use in the Yuma community. This could be done by a holistic system instead of piecemeal for the services that organizations provide directly to individuals. This would ensure that any service provider would have the ability to tailor treatment to an individual's specific needs.

WHAT ARE THE OPPORTUNITIES TO LEVERAGE AND BUILD PARTNERSHIPS THAT WOULD ENHANCE ACCESS TO TREATMENT, AWARENESS, AND INTERVENTION SERVICES AND SUPPORT?

There are many opportunities to enhance access to treatment, awareness, and intervention support and services by leveraging and building partnerships in Yuma County. We already do well working together and currently have many agencies working toward addressing drug prevention, mental health, and rehabilitation.

We must use this community collaboration to gain more funding, such as grants, non-traditional partnerships, and coalitions, to support the work being done and the work that is still needed. We can better utilize social media for community outreach and peer support.

The Yuma community can leverage its relationships with the University of Arizona and other higher education facilities, the hyper-local drug prevention and treatment organizations throughout the county to blanket the entire county in information and partnerships between law enforcement and health care professionals to educate the community, particularly students, on the risks of substance use, and peer support groups.

The partnerships that the community has with higher education facilities can be leveraged to encourage the expansion of mental healthcare provider education, particularly mental health providers, that can catch the co-morbidities before these issues arise and lead to substance use. While the partnerships between the hyper-local drug deterrence and treatment programs that are already doing great work within the communities of Yuma County can provide coverage across the county, providing clearer information as to the process for seeking help and the dangers of overdoses. This would also include cross border programs for those families that are living on both sides of the border.

Additionally, the partnerships between law enforcement and health care professionals with schools can be leveraged to get information into schools about the costs, risks, and avoiding substance use to begin with. The creation and expansion of peer support groups creating grassroots support for individuals, again particularly students, to reach out and discuss their issues without the stigma associated with going to professional care initially.

WHAT WILL BE MY ACTION TO IMPACT CHANGE?

- Continue to lobby for Federal and State Funding and get more involved in community actions.
- Continue to be available to my community on the front line and continue to educate all people on these crises.
- Continue to listen to the experts in the field, families and community that are impacted in order to develop strategies that are community driven.

Casa Grande Community Town Hall

Tuesday, October 4, 2022
Casa Grande, AZ



Casa Grande Community Town Hall

October 4, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are parts of a puzzle that cannot be solved without looking at all the issues collectively. It's important to address these conditions together because they typically overlap and impact each other. Addressing all three conditions together creates the best opportunities for prevention and resolution.

Mental health issues may lead to substance use, including the abuse of prescription drugs. This can lead to finding other ways to medicate and increases dependency on substance use. As an example, we have students who try to harm themselves. Without help and support this can lead to drug use. Parents may also be using substances, which leads to a lack of support at home and the inability to raise their children to be healthy and productive. Mental health issues may cause an individual to have issues that will not allow them to work or obtain any source of income, which may cause homelessness. Substance use is similar; if the issue is not addressed, it can cause homelessness. Substance use can also lead to mental health issues which can then lead to homelessness.

When someone is experiencing a mental illness, they are unable to maintain the life and coping skills needed to function properly in society and maintain housing. Very commonly, mental illness and substance use are interrelated because substances are used to self-medicate after mental illness goes without proper treatment. Homelessness results, and the person is unable to regain stability without treatment and resources.

The three areas relate to each other in many cases, but not all. It is important to address mental illnesses as they are often the beginning stages to the other two problems. Educating parents and the community on how to address these areas is critical.

Unsheltered individuals may be dealing with mental health issues or substance use. They need help to be diagnosed and assisted. Underlying trauma may also link to mental health, substance use, and homelessness. There is no wrong door, and we need to cross-train agency staff.

Because these conditions are often co-occurring, systems need to coalesce to wrap services around individuals to address multifaceted needs. In addition, these systems must be designed to address the impact of trauma.

Individuals are the only ones who know their trauma. Mental health and substance use issues do not make them less of a person and we can make a difference by working together to help them. Each condition exponentially increases the risk of becoming a victim of each of the other conditions or issues.

It is a vicious cycle. There are not enough resources for mental health. We have overworked and underpaid case managers. Drug use can induce psychosis. We have no homeless shelters, and very limited low-income housing or rent control for the disabled. We need to revamp mental hospitals and behavioral health agencies and provide more help for people who come out of prison. Without addressing all these things, we create incomplete solutions that set people up to fail.

The conditions of mental health, substance use, and homelessness can be viewed as different stages of the same social disease and people can suffer quicker and more painful stages. It is critical to attack the disease and work to relieve its symptoms.

We need greater collaboration of services, the right resources for the right need, more treatment programs strategically placed around the county with easy access to resources, a toolbox, and trauma-informed care. It's also important to remember that all it takes is one person to stop the cycle. If we stop the cause, we can prevent the problems.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

There are multiple factors contributing to the rise in substance use, mental health, and homelessness and the problem is continuing to get worse.

We need to find programs and solutions that work to take people from homelessness to self-sufficiency and implement a plan. The answer is among us – the people who care about the community. These are all community issues, and we cannot rely on the government to take care of them. It takes different groups with expertise to fill in the pieces. Non-profits, faith-based, and other organizations need to support one another and work together to train their staff and community members. The buck stops with us and we have the responsibility to help those in need.

We as a community can address these challenges by being aware of efforts within the community. We need resources to be able to talk more about these opportunities to strengthen our community. For example, the Pinal County Coalition to End Homelessness has multisystemic membership to reduce recidivism to homelessness, including strengthening the already existing groups of domestic violence and sexual violence survivors and those with lived experience. We need to generate more funding to support these efforts and other needs.

Across the board, we need to increase resources to address these issues. Resources to end homelessness need to be available, including a homeless shelter and homes for people to begin to build their lives free of drugs and to get mentally well. We also need less anti-homeless architecture, more safe dose clinics, transportation to access resources like the food pantry and additional resources to Horizon for counseling and services to people in need.

We should create one place, a "one stop shop" with many stops and hubs that care for the individual. Transitions are hard to work through and people need to be walked through each process and feel supported as they go through each step to be self-sufficient. We need to utilize methods that support people throughout the process and that do not leave them on their own to return to the same cycle.

Money is not the only answer. We need to reduce the stigma associated with receiving help. People should be able to ask for help without guilt or shame. The community needs to be more willing to help those in need and find ways to make receiving help easy and painless. We need to educate the community and work with parents and teachers on identifying and treating people in the schools as well as those families who are related to those schools. It is also important for cities to be involved and stay involved, especially the police department.

We should encourage others not to give up on people. It is important not to hand off, but to continue to work on the issues and help people receive the proper services to be able to function daily.

Systems should be better aligned. There is potential for alliance approaches that leverage interdisciplinary efforts working in sync rather than individually. These systems also include uniform approaches to the treatment planning for patients. There should be patient management software for recording and sharing for all clinicians, including social workers and doctors.

We need increased support from the government and non-profit leadership to come together to create long-term policy and solutions.

Trauma informed interventions are necessary to treat conditions that create mental illness and substance use disorders. These interventions include more resources for seriously mentally ill (SMI) housing, crisis stabilized unit shelters, and a revolving shelter system. Dialectical Behavior (DBT) groups are needed along with more incentives for people to become therapists.

We need to center and promote evidence-based and non-carceral forms of intervention and treatment. We need to educate the community better on the benefits of these programs. Courts can mandate substance use programs instead of jail time. More programs inside of jails and prisons will help those incarcerated and allow them to connect to organizations when they get out, like Celebrate Recovery.

Collaborating between multiple groups can provide deeper and more wide-ranging resources to better help people get the help they need and break cycles.

We can expand opportunities by opening more facilities, rehabs, group homes, and centers for people in need. More facilities for the community will help create positive impact. Walk-in clinics or a van that goes to people where they are would provide those experiencing homelessness with more accessible options for services. This would aid people in feeling welcomed and change their feelings about getting help.

People need housing and we need to ensure they have a place to live and are safe from outside elements. If a home is given, then drug testing can be completed, and substance use services provided along with mental health services. The iHelp model a good example.

The issues of mental health, substance use, and homelessness will get better. The issues may never go away, but they will get better.

SETTING PRIORITIES

We need to:

1. Look at what community resources we have and find what is missing.
2. Be realistic in what we can achieve to find realistic results.
3. Walk through with them, not just tell them what is available and have them go there on their own.
4. Support programs that already work (like CHIP).
5. Work with stakeholders and the police department.
6. Stop causing barriers and instead build affordable housing and family shelters.
7. Have great case management and advocacy that works with and refers to other service providers to provide whole person care and a "warm handoff."
8. Have a resource manual, programs that build trust, and culturally responsive services.
9. Provide people experiencing homelessness with food, shelter, and clothing, and opportunities to learn skills to support themselves.

10. Update youth education to teach empathy for people experiencing these conditions and teach people to not to be judgmental about these topics.
11. Make help easy to access. Release the stigma of mental health so that people are willing to receive help.
12. Align efforts, funding, and regulations.
13. Involve family and have a patient management system.
14. Work together to meet the needs.
15. Educate teachers to notice signs and symptoms in children so they will have the tools to nip problems in the bud.
16. Have diversion and treatment programs to stop over incarceration, access to resources, and treatment that takes all factors into account.
17. Eliminate legal barriers that perpetuate the system and bar people from offering aid.
18. Have more resources for mental health and substance use and safe living conditions with help, such as iHelp homeless shelter.
19. Have education, cultural humility, model-case study, peer support, housing, and safety. Intervention and education are needed to progress and grow.
20. Provide better pay for individuals who work with mental health, substance use, and homelessness because there is high turnover. Because there is high turnover, there is no trust. People have to start over when they get a new case manager, or they get lost in the cracks.
21. Have better communication between agencies. Doctors, probation officers, attorneys, case managers all need to talk and work together to find solutions to these problems.

If people are experiencing substance use and mental health issues and one is treated but not the other, they will not achieve long-term recovery. We need to share information on what programs and treatments have shown the best results and talk to the afflicted who have succeeded.

The most important action we should take in this situation is to listen. Hear people out to win their trust. Without trust and communication, we cannot establish a plan together. No matter the situation people are in, we still must give out information on what will happen and what they can do to prevent it again. The key is having the knowledge to provide what we learn to better our community and increase the knowledge in others.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- We need an increase of funding and prevention.
- Fund programs who are currently doing the work like CHIP.
- Help by providing prevention. Students need help and do not have a lot of support to receive that help.
- We cannot depend on just the leaders. We have the opportunity to lead, we just need to be realistic at what the barriers are.
- Stop looking at the issue, look at the person. Find a way to gain trust, do something, not just say something.
- We need more resources to address the problem. Support and strengthen coalitions and their activities. Recognize there are different levels of resources in rural vs urban Arizona.

- Lead by example.
- Fund, fund, fund.
- Stop arresting so many people and help them. We need more funding in programs that help with substance use, mental health, and homelessness.
- Provide better training and education on what to look for to recognize issues early on. Be accountable. Involve all agencies and organizations. Provide and gather funding. Continue to get educated on the needs of our community and then inform us about what has been learned.
- Provide more focus on trauma prevention for children and recognize its lasting effects. Provide more funding for services for the SMI population. Continue working for new solutions while collaborating with other agencies and organizations.
- Dedicate and gather resources.
- Tell the ones making the laws and providing funding to spend a week in a behavioral health facility and have them get paid what they make. We need low-income housing and shelters with peer support staff.
- HELP! We need more education and training for teachers, case managers, all staff at agencies, police, parole, and probation officers.
- Continue to pray and help. We cannot arrest and imprison our way out of this problem.
- We need to start young and get more help in the schools. We need more facilities to house mental health patients instead of incarceration and we need substance abuse recovery programs in jails and prisons.
- Housing, resources, funding, and leading by example are all great ways to help support these three issues. We need to start with prevention. Do not arrest and incarcerate. We need to find ways to help people with their problems instead of sending them to jail.
- Stop criminalizing mental health and understand its effect on homelessness and substance use. Time would be better spent looking at all three not just one issue at a time.
- One of the best ways to address all of this information is to have events in the community, schools, prisons etc.
- Create more housing options for those with low or no income and who have records that prevent them from getting into houses. We could ensure that there are rules to getting housing such as, random drug test and housing searches for those who need it, along with getting members into mental health agencies and active in their care.
- Provide easy access to help, healthcare, and resources. We spend too much on inappropriate programs that are nowhere near enough help for those who want and need it.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Casa Grande Community Town Hall. Below are individual actions that were shared.

I WILL...

- Lead by example.
- Help rural schools.
- Try to get more help for our students.
- Fund the nonprofit organizations that are there to end homelessness.
- Take on whatever is needed to end homelessness.
- Fund organizations that are doing the work.
- Continue to talk with and learn from stakeholders in Casa Grande.
- Help us by creating a homeless shelter and providing people to staff it.
- Look at Pinal County and not compare it to Maricopa.
- Support organizations that need financial assistance. Look at the service, see where it is lacking, support the cause.
- Work towards assisting my community.
- Be a volunteer to help the community.
- Continue to chair Pinal Coalition to End Homelessness and the Child Abuse Prevention Council.
- Continue to work at Against Abuse.
- Share our discussion with elected officials to help create policy that resolves this issue and promotes health and wellness.
- Continue to work to integrate and connect school-based resources.
- Commit to treatment and resources over carceral responses.
- Celebrate Recovery in all prisons. The results where Celebrate Recovery is inside are amazing!
- Fund.
- Make connections with folks in Pinal County to see in which way the organization I work for can better serve the populations we work with in Pinal County
- Amplify my voice to county and state officials.
- Work with the county to get help inside to work with the new transition home in Florence.
- Work together across county lines. Work with and listen to people on the ground and assist them with the fight they are facing.
- Create more helping programs.
- Open facilities for each topic such as mental health, homelessness, rehabs, group homes and shelters. Provide information for parents, teachers, officers, etc., that will help educate the community and prevent problems from occurring or prevent them from turning back to these problems when they just need more help.

- As a supervisor in the mental health field, I will ensure that my staff are trained and part of the solution not the problem.
- Help those who I can and put them in touch with programs I know that will help.
- Work with agencies to connect the mental health, substance use, and homeless people as they come out of prison and ensure continuity of care.
- Spread the word and keep getting knowledge out. I know I can make a change.

IN COLLABORATION WITH

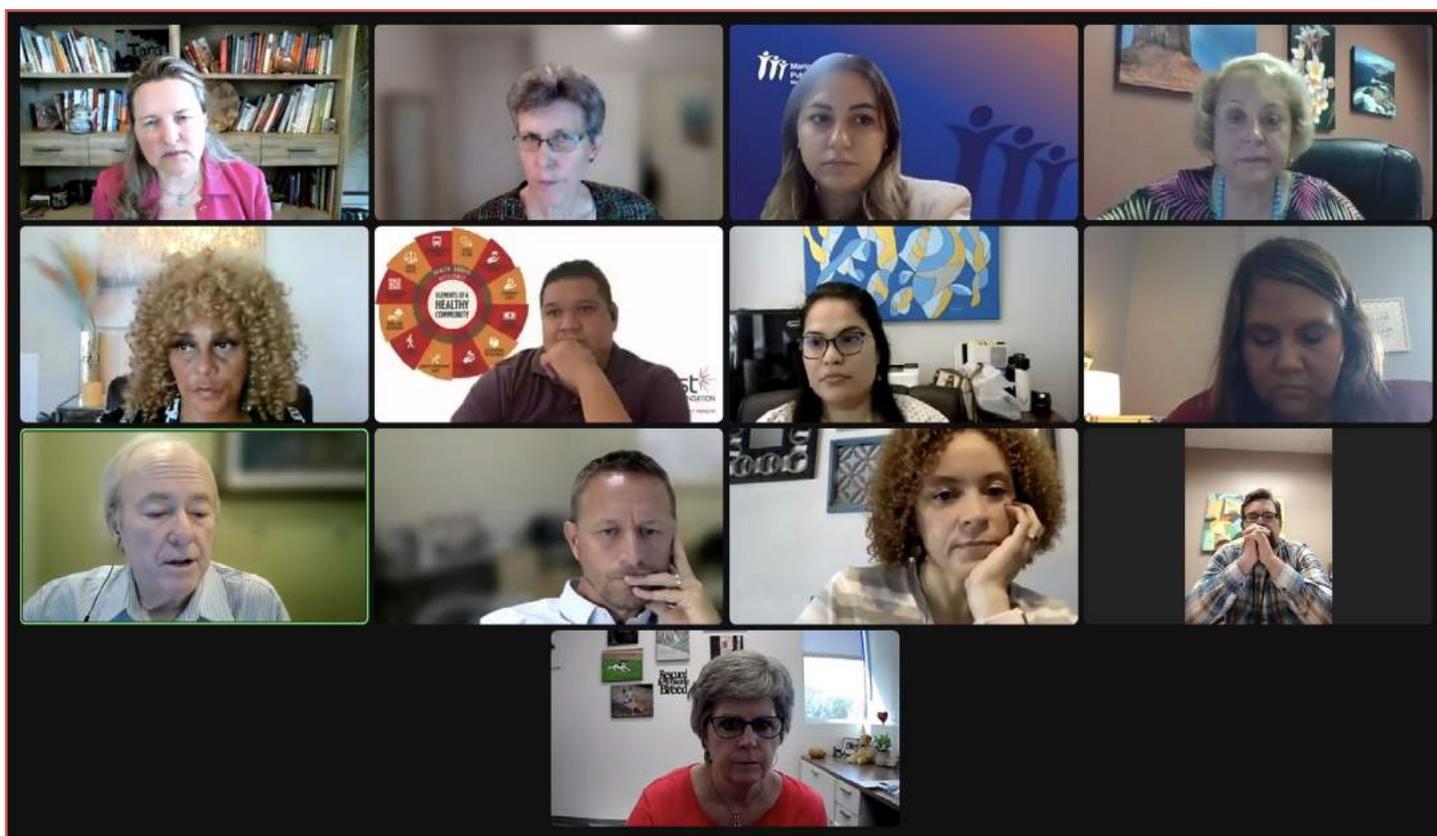


Public Health Services District



Homelessness to Housing Committee Community Town Hall

Tuesday, October 4, 2022
Online Via Zoom



Homelessness to Housing Committee Community Town Hall

October 4, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Often those who are unhoused have substance use or mental health issues and this is one reason why it is so important to address them together. While these can be connected, many are now experiencing homelessness for the first time because of the dramatic rise in housing costs. We need to keep this factor in mind as we look at how best to address homelessness. Homelessness caused by rising housing costs can lead to substance use from the depression and anxiety that come from being homeless.

While some are now homeless because of rising housing costs, we know that those experiencing homelessness have often gone through several recent traumatic events and the very act of seeking shelter can be a traumatic or triggering event. This can prevent people from seeking out shelter. It may also be traumatic to bring children into a building with lots of people versus staying in a car or a park.

Many who are homeless struggle with mental health and substance use, but not everyone. Homelessness is often a symptom of other things happening in their lives. People with any serious mental illness (SMI) can find their SMI crippling to deal with. Housing is important, but housing alone will not solve the issue. They also need assistance with their mental health issues, so they do not wind up back on the streets. They need additional resources, including transportation to services and housing.

People who have any form of SMI, such as schizophrenia, bipolar disorder, anxiety, or depression, may have a limited ability to live independently. Housing first is important, but it is not a catch-all solution. Often, when people are put into shelters, they are not able to sustain an independent living situation. Homelessness can be the result of someone who is struggling with these things. We need to look at the root cause, not just the housing.

Wraparound services are key when providing a housing first approach. It can make a substantial difference to have a housing provider that is sympathetic and a clinical team that is fluent in treating mental health to avoid further homelessness experiences and to help people achieve independence.

Homelessness can be a revolving door, or a vicious cycle. It is also important for there to be another narrative. There are many people who are experiencing homelessness for the first time because of COVID. They can no longer afford their housing under current market conditions, especially when rents are being hiked and they lack adequate financial resources or social support (e.g., family nearby). It is important to acknowledge how mental health impacts homelessness, but we cannot ignore that there is a rapidly growing population who simply cannot afford housing.

One perpetuates the other with homelessness. Stress can turn into depression and substance use can become a coping mechanism to deal with the stress. Once you become substance use dependent, you are no longer thinking about how to get out, it becomes about how to cope with these feelings.

It is an affordable housing problem at its core, but we cannot afford to wait or subsidize the solutions. Homelessness is often the effect of trauma, mental health issues, or substance use. Housing first is important but wrap around services are critical to keep them housed.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Affordable housing is an important part of the issues to address, and poverty is one of the causes of homelessness. Colocation of services, such as affordable and attainable housing on city properties, is one way to reduce NIMBYism and address housing challenges. Housing helps create stability to address other issues, but housing alone is not always the answer.

We also need to address how people can remain stable in housing. Services that address mental health and substance use are critical. There is a need for lots of support and wrap around services, including working with landlords and adding in support services for those who need it. Without these additional services, we house people and within a year they may be evicted.

We should also leverage AHCCCS changes that have happened at the federal level that allow supportive services to be combined with housing.

We need a paradigm shift in how we address these issues, and it is important that we address these topics collaborative and cooperatively, especially in a challenging political climate.

Chronically homeless individuals often have mental health issues that become a barrier to services. If there is substance use as well, it is challenging to help manage the situation. We should consider making assessments about "readiness" to change and prioritize providing services to those who have a higher readiness factor.

We may also want to consider moving to smaller regionalized shelters, creating specialized shelters for different populations.

Co-location services are key, like housing near schools, libraries etc. Cities should be looking at how we incorporate housing on their properties. What if there was workforce housing with mixed income housing near fire stations? We should leverage grant money from the federal government and use it for a combination of supportive services and housing.

COVID has exacerbated homelessness and now the increase is visible in the streets. It is impacting our communities and our businesses. We have to address affordable housing, but also how people can remain stable, so they avoid eviction, incarceration and relapses into homelessness. There are lots of people living in the community with Serious Mental Illnesses (SMIs). For example, if you take someone with schizophrenia, there are a lot of resources needed to get them set up to be housed in the first place (furniture, tools, etc.) and it is something we overlook and take for granted. It is unreasonable to expect them to have to do all of this on their own. We need to develop the capacity to house people who need support with wraparound services to avoid eviction. It is not just a behavioral health issue, but also physical health issues as well for people with health complications such as diabetes. It is going to take years to recover from the economic impacts that COVID has had on our communities. A lot of poor health outcomes are a direct result of poverty, so if we do not get our economy back on track, then we will not see rapid improvement in the homeless realm.

There is a need for a paradigm shift for the way we are managing our homeless population. With service resistant clients, there are multiple individuals that fit into that category, but that does not always mean they want to be homeless. There are chronically homeless individuals struggling with mental health who lack insight into their issues. Compounded with substance use, the question becomes, how do you manage them when you have a client who does not want to make progress and only stays the night. Some also have comorbid issues like diabetes with mental illness and it is very complex. We have had no choice but to work and collaborate with each other as COVID funding begins to fade out, and now we have more municipalities that want to remove the

problem, rather than actively work with those individuals with lived experience to mitigate these issues in their community. When we assess them for readiness to change, we have individuals who are not getting services who are ready to make those changes. Instead, we are giving more attention to people who are not. There is no “one size fits all” solution and throwing money at the problem is not going to work. We need to incorporate compassion into our work at the ground level and treat everyone with respect and dignity, so they know that we are here to help.

Partnerships are the key success for housing individuals with mental health or substance use. Let the experts do what they do best. It is just a matter of ensuring that we are working together because ultimately, we have the same goal.

Moving to small, regionalized shelters (200 beds or less) is key to meeting people where they are. Shelters may need to be specialized at some level to reach different populations. Shelter agencies and partners may have to offer constant community engagement with a 24/7 phone line that shelter neighbors can use to report concerns, which may help reduce NIMBYism as would consistent, transparent data (maybe dashboard-style) about results from the shelter. Emergency shelters are important, but we struggle with long-term engagement and follow-up.

SETTING PRIORITIES

The time is now. We need to act. Civic engagement is important from those who work in these fields and from those we serve. We need to help inform our elected leaders about the best solutions to address these issues and we need to include neighborhoods in the solution, not just providers. Single family neighborhoods have a lot of political power to help make needed changes.

Outreach and education are critical, whether it is attending neighborhood meetings or conversation like we are having today that help to dispel myths and share best practices.

Flexible funding to providers is important. We should let the experts do their jobs without having to create unnecessary and burdensome reports.

We also need to work towards engaging as many landlords as possible to support the use of vouchers and to not allow discrimination based on income source. There should be a broader choice of neighborhoods to live in with the use of vouchers as some neighborhoods can be triggering.

We should apply a racial equity lens when addressing the issues and the systems that provide services. How are we making sure to best serve populations that experience these challenges at a higher rate?

We need to care for the entire family, including cats and dogs.

Employment is low with opportunities high for employment. What is the root cause of this? We need to look at how best to work on the preventative aspect of these issues with education and other programs. We could consider approaching those who are unable to get employment with opportunities for jobs (such as in the correction institutions). We also need to create opportunities for livable wages, including in the social services sector, which has a high rate of burn-out.

Engage as many landlords as possible to increase inventory of rapid rehousing and affordable housing for voucher holders. With mental health and substance use, we want to give people a wider geographic net to choose where they want to live. We want them to live in a neighborhood that is not triggering and that supports their recovery. We need to look at this problem through a race equity lens. Black and Native populations experience

homelessness, substance use, and mental health at an increased rate. How are we making sure that we are serving these overrepresented populations?

Civic engagement is very important for everyone. Make sure that they have a voice and can exercise their right to vote in their perceived interests. People in power have plenty of information to inform decisions and as people in that position, we need to spread that knowledge. Many jobs do not provide a living wage for workers. Organizations need to pay people what they are worth. Not all pay grades should be based on degrees, but professional experience is very important, and we need to reward that financially, especially in a field that experiences high burnout.

Sometimes providers will criticize neighborhoods and use the word NIMBY as an insult. It is important to recognize that much of the political power resides in single family households. We need to include neighborhoods in the solution, not just providers. Neighborhoods supported the Cicero Bill and providers opposed it—both entities need to work together to get on the same page to resolve this issue. We need to include them in decision making so we are not just talking to ourselves. From the lens of the Cicero Bill, it was lacking the provider viewpoint, which has its own respective value. More of these conversations need to happen together, not separately.

We need to bring realities to light. Busting myths from the communities will go a long way to creating a solution for communities. In a lot of cases, direct outreach is required. At a high level, there is a perception that there are a lot of jobs available, but many are still experiencing homelessness and evictions.

We need more flexible funding. Let the expert providers do their jobs without an absurd amount of red tape and requiring huge reports that sit on a shelf.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Housing first!
- Provide flexible spending to providers.
- Require new housing developments to provide affordable housing.
- Do not be afraid of using harm reduction practices when addressing substance use. Using drugs is not a moral failing.
- The governor should release at least \$500 million from his ARPA funds to provide wraparound housing services.
- Promote an interdepartmental task force with police, fire, libraries and social services to leverage services and responses to meet people where they are.
- Keep the Housing Trust Fund funded.
- Bring people to the table with the lived experience to provide feedback and capture answers that we are missing as providers.
- System changes are needed to truly end homelessness. Livable wages, more affordable workforce housing, access to trauma-informed care, eviction reforms.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Homelessness to Housing Community Town Hall. Below are individual actions that were shared.

I WILL...

- Strive to empower the voices of those with lived experiences by bringing them to the table where decisions are being made.
- Complete the broadband whitepaper and include PPP management opportunities.
- Continue to engage our local community on this topic and join the hard discussions.
- Prioritize the issues of housing, mental health, and substance use in public health strategies at the local level.
- Stay connected to my city council rep and other elected officials (as a constituent).
- Use my knowledge to inform AHCCCS policies and contracts to make it as easy as possible to deliver high quality services.
- Do my part to help steer funding to agencies who have or want to build more collaborative care models.
- Help build leadership for social change among our younger generations.
- Continue to attend and participate in meetings like this. Collaboration is vital to ensure clients receive ALL services the community can offer. 25+ years in the field and we have not moved the bar very far. Educate the public and take a deep look into systems.
- Get connected with my city council and keep the conversation going within my network and within my community.

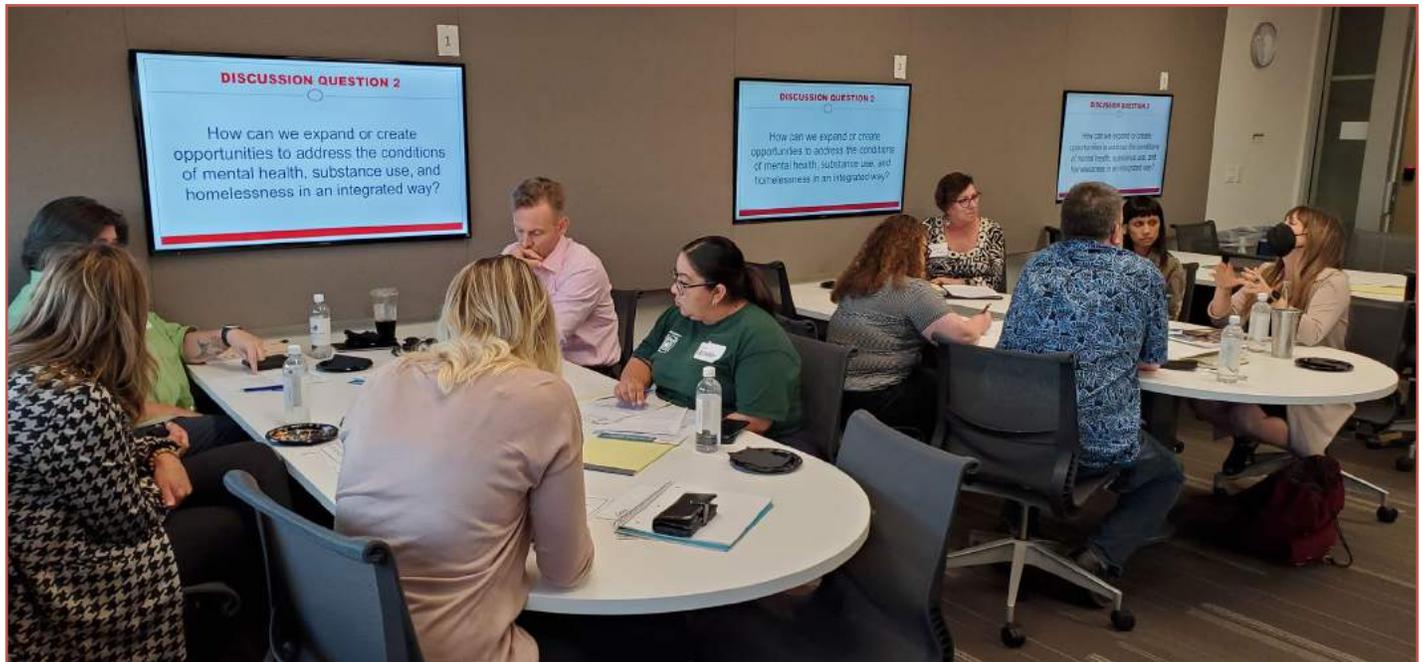
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UA Health Sciences Community Town Hall

Wednesday, October 5, 2022

Phoenix, AZ



UA Health Sciences Community Town Hall

October 5, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

The interconnected problems of mental health, substance use, and homelessness are circular, and best conceived as a Venn diagram. As we look at individuals struggling with these three conditions, we should look at the different parts of the Venn diagram to see who is in each part and treat different populations differently. Further, if each condition can be a trigger or cause for the others, they should be addressed together. Each of these conditions impacts motivation and critical thinking. They are almost always trauma related. If the conditions are not addressed simultaneously, solutions are ineffective. There should be customized care with experts in each field in the room together to bring solutions.

In addressing these issues there are several challenges. People struggling with the conditions often lack education or coping strategies for illness and treatment. Staff working in these areas are very siloed. We need to evaluate policies and funding to assure that they flow between the different silos. There is also a lack of social capital. We need more and better education about these issues, and we need to start early and repeat the message often to be sure the messaging is not lost.

Finally, housing should be integrated in diverse communities.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Effective solutions require that we address the problem of stigma associated with these three conditions through education. We should deconstruct myths and misconceptions about people who are suffering from these conditions. We need to recognize that the media often presents a sensationalized version of the story for its own purposes, and that its depictions are sometimes exaggerated or inaccurate. We need to promote compassion and empathy by finding some common ground with people in these groups and reducing the tendency to divide into “us” and “them.”

Addressing these problems is stymied to some extent by NIMBYism. Educational efforts to dispel misconceptions would be helpful to reduce NIMBYism. It might also be reduced if we reduce the physical footprint of the programs that address these problems, breaking facilities into smaller parts so that they do not seem so intrusive to neighborhoods.

There are considerable resources available in our community to address these issues, but many people, including providers, do not know about them. We should do a better job of educating providers and others about the issues and the resources that address them. Having all the resources under one roof would be very helpful. There is also a lack of providers and problems securing appropriate referrals. Because of the need for individualized solutions, a lot of hard work is required to address these conditions. Perhaps a patient broker, someone who can match the patient with the provider, and provide all relevant information upon referral, would be helpful. We need more group therapy and licensed peer support programs, and greater awareness of such programs.

We need better data to know who we are serving and how we are serving them. That should include data from the criminal justice system. Data lockers, integration of data systems, and HIE systems, are addressing the issues related to sharing of data, and such efforts should be supported and continued.

SETTING PRIORITIES

We need more inventory for people who qualify for subsidized housing. Perhaps we could establish an Air B&B or Match.com system to match tenants with landlords.

We should engage with people at a much smaller scale. For example, use HOAs to come up with solutions. In this way, we will expose more people to the issues and engage more people in developing solutions. We should also make smaller communities aware of volunteer opportunities that might be available in their neighborhood.

Medical systems should use telehealth better to address adverse childhood experiences and bring preventive health care to the schools. We should integrate the community better.

We need more and better data.

We should prioritize funding for providers. Funding should be unrestricted and from a diverse donor base, so that providers can use it where it is most needed.

We should find a convening agency to oversee all the preventative work that is ongoing in the myriad of agencies and organizations that are working in this space.

Education is key, and it should be employed effectively. Too often public education is viewed as delivery of information to consumers (students). In higher education settings, people are expected to question and challenge the status quo, to ask why and how, but in K-12 education and many other educational settings (e.g., at Department of Corrections) that kind of questioning is seen as combative or defiant behavior. To understand the root causes of these problems, we should embrace real education rather than the more passive model that prevails. For example, substance use is not just the use of illegal recreational drugs. Substances may be used for many other purposes. Smoking is a legal substance use that may have physical consequences (e.g., breathing impairment) that will interfere with the ability of people to perform certain jobs. Active education would encourage people to drill down and consider these kinds of issues.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Zoning regulations should be revised to reduce barriers to the development of affordable housing and encourage better use of empty lots.
- There should be no wrong door to access care. This concept should be emphasized across the board, particularly with legislators. People working in the separate fields should be educated about how the systems work at a macro level so that when they interact with those systems they can do so more effectively. We should look at the different systems and map them to better understand how they work. We need to understand the steps individuals must take to get care and services, to eliminate duplicate steps and integrate the systems more effectively.
- We should increase the number of trauma informed schools, government agencies, and service providers.

- We should regulate, monitor housing providers, and prioritize and incentivize permanent supportive housing over for-profit group homes and require licensed mental health services and case management to be available at all public supportive housing projects.
- Looking at income eligibility, it would be good to increase the eligibility threshold for services from 80% of Area Median Income to 100% of Area Median Income.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the UA Health Sciences Community Town Hall. Below are individual actions that were shared.

I WILL...

- Continue the conversation.
- Stay informed, listen when I can, and support where I can.
- Release an RFP or NOFO for mental health pilots in Goodyear this fiscal year (hopefully this calendar year).
- Take ideas from today's discussion and use them to better inform donors and/or spur thoughtful conversations.
- Continue to incorporate opportunities for medical trainees to gain experiences to help them understand resources and have more compassion for the people they serve.
- Engage city leadership on causes of homelessness, affordable housing, and permanent supportive housing.
- Advocate for bringing PSH and/or affordable housing to my neighborhood.
- Encourage the Phoenix Community Alliance to invite Arizona Town Hall to present on the Town Hall's findings at a PCA meeting that also include other major business groups like Greater Phoenix Leadership (GPL), Greater Phoenix Economic Council (GPEC), and the Chamber of Commerce!
- Be a vocal advocate with my family, neighbors, and co-workers for the dignity and needs of those dealing with homelessness, mental illness, and substance abuse.
- Encourage creative ideas and discussion about small and large solutions.
- Promote better understanding of the need for and level of commitment to community land trust rollout and rapid scaling.

IN COLLABORATION WITH



The University of Arizona
Health Sciences

Mohave County Community Town Hall

Thursday, October 6, 2022

Kingman, AZ



Mohave County Community Town Hall

October 6, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are interconnected and often can be a vicious circle with one leading to the other. While not always connected, mental health issues can lead to substance use and substance use can lead to mental health issues. Likewise, homelessness can lead to substance use and mental health challenges.

To address one issue, we need to address them all—treating the mind, body, and soul together and creating one stop shops that address all of these challenges and make it much easier to get services. When someone is ready to get help, we need to give them the help they need immediately.

We also should look at prevention. This includes looking at the root causes, such as childhood trauma, poverty, adverse childhood experiences, undiagnosed mental health issues, and the normalization of substance abuse or mental health issues in families. We also need to address the impact of being in the criminal justice system. Prevention also means creating personal connections and support systems; reducing barriers to housing and transportation needs; creating more transitional housing and services for those who need it; and addressing the stigma and shame that often gets in the way of people seeking needed help.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

While our county is doing great work in many areas, we still need more awareness of available resources, and more resources in general. We need more affordable housing and more sober living and residential living. As an example, in a lot of our inpatient units, we mix in those detoxing with those with mental health issues, and there are no level one inpatient services for children.

We need to stop working in silos and work together. We need to come together to apply for grants and get additional funding to obtain the services and resources we need—including a one stop shop with resources, and a resource fair for professionals that allows for connection and collaboration.

There should be no wrong door when someone is looking for assistance. We should all help them find the services they need. Community Connections is an example of an effective closed loop referral system funded by AHCCCS that will help address these issues in a more integrated way.

Integrated health care is essential—we need to address the whole person and yet we are all short staffed. We need to incentivize people to come to our community to serve in these much-needed roles, including school counselors.

We should expand our efforts with prevention and education and explore what systemic issues can be addressed. This can include raising awareness of and access to the county's resource guide and finding more ways to get people to these resources, including those who are being released from prison. It also can include having alternatives to imprisonment that open doors for detox and other services.

We need to work more collectively and collaboratively together, getting rid of the red tape and hurdles that can get in the way of organizational coordination and necessary follow up.

We also should make an effort to build more community cohesiveness with community events that connect people and have better communication to everyone about what resources are available.

We need to figure out how to get more boots on the ground to bring needed services with those who need help and to reduce the time for receiving services. Programs like this help to connect people to each other and to available resources and we should have more of them.

SETTING PRIORITIES

1. Have grant writers or other personnel to search and apply for funding for behavioral health homes.
2. Reduce the roadblocks and silos caused by competition with providers and insurance coverage.
3. Create connections between people. We're dealing with the symptoms of forgetting how to be connected as humans and as a community. Find a friend and be a friend.
4. Treat this as a problem of the entire community, not an individual problem.
5. Educate the people we serve about their conditions in a way they can understand. We need to teach just as much as we need to treat.
6. Increase mobile crisis units and response services better to meet people where they are.
7. Increase local access to mental health services after detox—build a local continuum of care in the community.
8. Find ways to increase the local talent pool for needed services.
9. Expand on existing resources with greater collaboration and teamwork. We are short staffed and can address this with greater collaboration.
10. Remember to listen and focus on the individual, not just the need.
11. Make efforts to expand knowledge about resources and create easy reference and access to these resources.
12. Provide care when someone is ready to receive it.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

1. Communicate and collaborate with those who provide resources.
2. Get informed and invest in the solution. Be open minded and listen to community concerns.
3. Create an entity like Arizona Department of Housing for Behavioral Health in order to provide direction and to obtain and distribute funding.
4. Increase release funding.
5. Provide more housing options. Create more affordable housing.
6. Invest in affordable housing with access to case managers and resources that provide the resources to heal and get stronger. Create more permanent supportive housing funds.
7. Create more mental health and substance use shelters and funding for behavioral health services and programs that address community needs.

8. Increase local talent. Expand funding for programming and pay to case managers. Incentivize and retain qualified staff.
9. Increase services all around in Mohave County.
10. We are managing the symptoms and need to address the problem which includes loneliness and soul care.
11. The need may be the same, but each individual is different.
12. Take the politics out of it and look at the person.
13. Start at an early age and make children aware of their entire being, mind body and spirit.
14. Everyone needs to work together, regardless of agency and background and whether they provide or need services.
15. Increase public/private partnerships.
16. Mandate every first responder to take a first air mental health class show understanding in action. Team up these workers with a mental health professional.
17. Instead of arresting addicts, rehabilitate them.
18. Lobby for more funding for housing, services, and qualified and passionate "fixers."
19. Educate the community about these issues and increase assistance for housing and transportation.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Mohave County Community Town Hall. Below are individual actions that were shared.

I WILL...

- Commit to being more informed about available resources in our community and share that in-formation.
- Educate myself about all of the resources available and inform others.
- Volunteer more and never create a wrong door.
- Continue working with the nonprofit I started to help medically fragile homeless and others to access resources and support.
- Continue to self-care so as not to lose my passion to help those suffering from these issues. Reach out to team members to check-in on mental health, burn out and self-care.
- Continue to be an advocate of collaboration with other organizations to help people become in-formed about resources and to help the homeless and people in need.
- Build a strong foundation for the inclusiveness we need.
- Continue to go to meetings and teach.
- Listen and meet people where they are to help them reach the services they need.
- Research successful programs to see what works.
- Be available.
- Become more available to new member of the community and collaborate with my best effort.

- Volunteer my time, knowledge, and connections to help organizations I would not normally be working with.
- Stay in the game and help my community.
- Remember why I do what I do.
- Help to make sure frontline officers are aware and willing to share available resources with potential clients during interactions, whether law enforcement related or consensual contact.
- Continue to do the best I can as an inmate re-entry coordinator at Mohave County Jail.
- Continue developing the Sheriff's re-entry program.
- Continue to work hard to overcome outstanding community issues and work harder to connect with other mental health workers and families to include the "no wrong door" policy.
- Continue to help my community.
- Attend more local government meetings to advocate for high density housing and keeping housing affordable, starting at the grassroot levels.
- Continue to partner with my community!
- Learn more.
- Show integrity.
- Work on bringing agencies together to find a way for homeless and sober living.
- Be non-judgmental, open minded, and empathetic.
- Make it less about money.
- Be the voice of those in need to be able to help those in need.
- Give more to my community.
- Advocate! Participate! Engage! Empower!
- Continue to reach out in the community to connect and find ways to better our community together.
- Ask to enforce local laws—educate early on personal responsibility, community involvement.
- Continue to work on the front lines beside individuals experiencing mental health challenges, substance abuse, mental health challenges, substance abuse, and homelessness as well as educating community members of our local issues and resources.
- Commit to work at bringing the key leaders back to the table.

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Health
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Mohave County Homeless Continuum of Care
Mohave County Community Services Department
700 W. Beale Street
Kingman, AZ
86401-7000
928-793-0723



Mohave County
Department of Public Health
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MCC Mohave
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Flagstaff Community Town Hall

Monday, October 10, 2022
Flagstaff, AZ



Flagstaff Community Town Hall

October 10, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness, while not always present together, are often correlated, intersect, and interconnected.

Housing programs can be essential for allowing the opportunity for other services. When an individual is moved out of homelessness and into housing, and then surrounded with services where the agencies come to the individuals instead of the individual having to seek out services, there is more overall success in addressing all issues.

For recovery and sustainability, we should make recovery more accessible and flexible. Reducing isolation helps with recovery success. Some people may not be ready for treatment. It is important to build relationships, destigmatize conditions, and address prevention and early trauma or genetic predispositions.

It is also important for communities to work together, to have warm handoffs, and to ensure housing is readily available for those who need it.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

We should make it easier to access mental health services. We can do this by embedding mental health services into other service programs and bringing programs and information to our schools.

We need to normalize mental health like how we discuss physical health. We should rebrand mental health issues to wellness, like physical fitness. All populations and all organizations should work together to address these issues in a coordinated and integrated manner.

It is important to tailor treatment to the individual and to create opportunities for a buffet of different options for those seeking services.

Flexible funding to meet the needs of the community and different cultures, specifically our Native American communities, is critical.

We have many good programs or programs being launched that provide inspiration for effective approaches, such as the SHIFT program and Pathways to Community.

SETTING PRIORITIES

We need a cultural shift with rebranding, reframing, and destigmatizing mental health.

We can do this by sharing stories respectfully, prioritizing the time to make these changes, and utilizing peer support as part of an integrated approach.

We need to increase funding and reduce restrictions, affording providers more flexible funding.

Taking care of those who provide services is essential. We need more workforce reinforcement, both in recruiting additional people to enter these fields and supporting those who already serve. To do this, we could use additional support, funding, and on the job training programs.

Our relationships are our connections to those we serve. We should develop plans with a team approach, providing client navigation and warm handoffs.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- We need to tell Arizona leaders the stories of crisis to better inform them on why it is important to address trauma and housing issues and why flexible funding is critical.
- We should tell Arizona's elected leaders to get out and talk to people doing this work. Listen with an open mind and believe what the community says – everything else will follow once you see what is happening firsthand.
- We need to make mental health mainstream, reframe the challenge, and invite everyone in.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Flagstaff Community Town Hall. Below are individual actions that were shared.

I WILL...

- Continue to be an advocate to our social services partners and community.
- Join into the Verde Valley Town Hall to help promote future town hall events.
- Connect with programs to have meaningful conversations and connection around these issues, and vote.
- Contact the Guidance Center to coordinate housing.
- Continue to work with the local recovery community.
- Share the knowledge I learned with my constituent group.
- Create be a part of creating a more empathetic society.
- Vote to support social safety net programs.
- Feel more empowered to talk about the issues and propose solutions when talking with Arizona's leaders.
- Become a board member to support a vital non-profit serving this critical need.
- Continue to work with OWWA to develop capacity and resources for its NEAZ chapter.
- Lobby at the local, state, and federal level for increased human services funding, spread the word about program availability, and services provided.
- Continue to be a part of this community, learning and growing from it daily.
- Continue to educate myself and others on the importance of integrative care for issues surrounding mental health, substance use, and homelessness.

- Speak up about mental health, substance use and homelessness in our community, and redirect the conversation about people in our community.
- Continue doing the badass work I, and my teams, do.
- Build better relationships with community partners.
- Continue to actively support future leaders in the Verde Valley and connect with NAU and Flagstaff area high schools to expand future leaders in the region.
- Continue to contribute financially to Arizona Town Hall and recruit others to do likewise.

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Human Services Campus Client Community Town Hall

Tuesday, October 11, 2022
Phoenix, AZ



Human Services Campus Client Community Town Hall

October 11, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are often connected. A job loss or other circumstances can cause homelessness which then leads to mental health or substance use. Likewise, substance use can lead to mental illness which can then lead to homelessness. Undiagnosed mental illness, like post-traumatic stress disorder (PTSD), can lead to substance use and then homelessness.

Whenever possible, it is important to try to prevent these crises before they occur.

All of these issues need to be addressed together with all entities working together to keep people on the right path. Relationships and respectful treatment of those experiencing homelessness are important. For those experiencing homelessness, it is important to have consistent rules and guidance on services. It is also important to have consistent housing.

It would be helpful to have life coaches and other support to help people get out of the cycle. Just knowing who to talk to and where to go can make a big difference, as can destigmatizing mental health issues.

If we do not address the homelessness, it is hard to address the other issues. They are all related and interconnected. If you are homeless for too long, it becomes even more challenging to break out of the cycle, especially if housing does not include other services that provide connections, job opportunities, or mental health services.

SETTING PRIORITIES

It is critical to have compassionate staff with proper training to serve people at the Human Services Campus. Someone who is burned out does not provide the same level of care, which creates roadblocks and can bring down the spirit of those being served.

Consistency is very important, both in rules and in the treatment of people. Consider having printed guidelines (similar to what is in the dining area), so everyone knows what to expect of staff. This would lead to greater consistency.

Work to move those with serious mental illness (SMI) to different areas to minimize the impact on others.

Consider drug testing the staff.

We need to look at how to provide training and support to staff so they can provide more training on different types of jobs to those being served (including seasonal jobs).

Create more programs that can be accessed during the down time – specifically programs that provide hope and opportunities for a way out of the cycle.

The longer someone stays on campus the more difficult it is to transition out. Create more programs that make good use of idle time and that incentivize and encourage people to get out of the cycle. As an example: create a survey asking “What are five things you have done this week to help yourself? Change programs and policies that do not incentivize making or saving money.

Create more housing that is affordable for those trying to transition out of homelessness. Minimum wage is simply not enough to cover the cost of rent for most apartments. Explore different housing solutions.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- Empathize, engage and walk in other people's shoes.
- Provide more resources for reporting abuse of power or mismanagement. Have an advocate or call line.
- Focus on prevention and prioritize resources to prevention.
- There needs to be better communication between those providing services and those being served. Provide a progress report to those being served so they have more knowledge of their own circumstances, including the status of available housing.
- Explore how to collaborate better between different services so they are more integrated.
- Come from a place of ethical values and doing what is best for people instead of how to get elected.
- Come down to the Human Services Campus and just observe so that you can better understand the challenges people are dealing with, which will allow you to make better decisions at a leadership level.

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Southeast Arizona Community Town Hall

Friday, October 14, 2022

Thatcher, AZ



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COLLEGE

Southeast Arizona Community Town Hall

October 14, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are intertwined and relate to each other. Having one of these challenges often exacerbates or leads to the others. Too often we separate these issues and do not consider them together as contributing factors to each other.

Mental health issues, including trauma or Adverse Childhood Experiences (ACEs), can lead to substance use and mental health challenges. Mental health challenges are too often stigmatized, causing people to self-medicate with substance use. These challenges can, in turn, cause homelessness, making homelessness the symptom or result of substance use or mental health issues.

Similarly, if someone does not have their basic needs met, such as housing and food, they will not be able to address mental health challenges.

Solving these issues is a marathon and not a sprint. The stigma and challenges involved require sustained effort.

In rural communities there are few resources for addressing mental health challenges. This can then cause people to use substances to cope, which leads to additional challenges.

Addressing all of these problems together will provide better outcomes in addressing each individual area. These issues do not happen in a vacuum and the entire community is impacted. It is not “their problem,” it is everyone’s problem.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

In Southeastern Arizona we have some behavioral health and mental health facilities and services such as Community Partner Integrated Healthcare (CPIH), Southeastern Arizona Behavioral Health Services (SEABHS), Easter Seals, Blake Foundation, and others. There are substance use programs for children, and some limited facilities for people working on recovery. We also have parenting, mentoring and life skills classes. Our community works hard to collaborate and work together.

There is much room for improvement. First, there is simply not enough funding. Some of the services available are based on grants which may be limited in time and scope. There are not enough residential facilities to stabilize people and we have a shortage of mental health counselors and services. To get providers to come to a rural area, we need to have salaries and housing competitive with urban areas. In addition, services that are available are often limited only to those with AHCCCS coverage, which leaves many without the ability to get needed treatment.

We simply do not have enough funding to support our community’s needs. We are spending money on probation, jails, and the court system and 97-98% of these costs are related to substance use. If we want to make a difference, we should consider focusing more on prevention and being proactive instead of reactive.

We are working hard with prevention efforts in the schools. We might have even greater success if we can figure out how to bring these prevention efforts into the home. We could improve success with greater collaboration and coordination between service providers, faith-based organization, families, and others.

To find the best solutions to these issues, we should bring in the perspectives and lived wisdom of those currently experiencing mental health, substance use, or homelessness. With their perspective and insights in mind, we should create the services and programs that best help to remove or address the barriers to success that they identify. We should also look at ways to follow up with people to encourage entering or continuing treatment.

We should consider how better to connect people with needed services. This could include more individual advocates to physically navigate people to the services they need, and a centralized place that lists all resources available or connects people to resources (such as the 211 line). We need a local Assessment and Intervention Center (AIC) and Behavioral Health Residential Facility (BHRF) so that families do not have to be separated and people are not dropped at emergency rooms where they have waited up to twelve days to get needed treatment. We desperately need these services in our county; funding and staffing are the major roadblocks for making this happen.

SETTING PRIORITIES

1. More networking with other agencies and organizations is critical so that we can share knowledge and resources.
2. We should encourage more integrated responses. As an example, medical clinics should do more whole assessments with those they serve and have resources available for mental health issues.
3. Having the people to provide services is essential. We need more support for service providers and caregivers so that they are more resilient to burnout. This can include resiliency and vicarious trauma training (some of which is already available for a reasonable cost).
4. Communication
 - a. Sit down with and inform elected leaders about these issues and the real costs to the community and invite them to spend a day "in the trenches" to get a better understanding of the issues.
 - b. Training to the community about the impact on people's mental capacity when they are using substances or if they are addicted.
 - c. Increase the visibility of services that are available, perhaps with having local businesses, government organizations, and others providing resources at their locations. Ensure that resources are available in bilingual and alternative formats to ensure a broader reach for those who may have challenges reading.
 - d. Better communication about what the true cost is to the county of these issues may help raise awareness of how best to move forward.
5. Funding: we need more to support all of these actions.
6. We should think about how we can best measure success and plan programs and services with this in mind.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Find ways to fund needed programs.

1. Provide more funding to rural communities to attract and retain mental health professionals. Consider a loan reimbursement program, salary incentives, or programs focused on "growing our own."
2. Analyze how we are spending money on the criminal justice system and consider whether this would be better spent with prevention and intervention services.
3. Find ways to create internships with university students to bring them here.
4. Work with behavioral health agencies to create training programs, including on the job training programs.
5. Use national and other resources to create programs that support peer training and peer support to augment other services. Educate leaders on why and how it can make a difference to remove barriers to employment for those with criminal backgrounds.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Southeast Arizona Community Town Hall. Below are individual actions that were shared.

I WILL...

- Educate more people in the community.
- Do more to educate our community about mental health and destigmatize mental health disorders.
- I will work to organize a resource guide for professionals in Graham County.
- I will be an advocate for resources in my community. These issues affect all aspects of our community.
- Educate my community about the importance of integrated care. Mental health care is health care.
- Continue to feed information back to leadership and company partners.
- Try and help more.
- Educate more people in the community on substance use, medically assisted treatment, and harm reduction.
- Try to get more involved with different community resources.
- Learn about all the resources, that the community has and how to get the help for those who need it.
- Continue to advocate for special populations in need and attend more Town Hall meetings.
- Incorporate what has been shared today into our health focus area for our organization.
- Continue to educate myself on needs in the community and to serve.
- Share the tremendous cost to the Graham County taxpayer as a result of substance use and the opportunities lost as a result.
- Get out and volunteer my services to organizations that are working to address these issues.
- Do my best to help join others to improve the needs of our community. Also, encourage others to speak up about ideas for helping the community.

Native American Connections Community Town Hall

Tuesday, October 18, 2022
Phoenix, AZ



Native American Connections Community Town Hall

October 18, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are connected and interrelated with one challenge often, but not always, leading to or causing the others.

For example, when someone loses a job, they and their family might then lose their home. The stress of being homeless can lead some people to self-medicate with alcohol or other substances. The stress and trauma of being homeless can also create mental health issues, especially for children. Substance abuse can also be the cause of someone losing their job and becoming homeless. Likewise, mental health challenges may lead to the use of substances and create challenges with maintaining relationships which can then cause someone to be without a home.

To solve these issues, we need to address them all together with an emphasis on programs like Native Connections that provide integrated services which address all of the issues together.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

One of the biggest barriers to addressing the conjunction of homelessness, mental health and substance use is the stigma associated with these conditions. Although these issues have been with us for a long time, we cover them up to hide our shame and embarrassment. Law enforcement personnel want to help people experiencing these conditions but are less successful because they categorize and judge them based on their behavior. Shame and embarrassment also deter people from seeking the help they need.

People in the treatment and helping professions should be welcoming and trusting, making it clear that there is nothing wrong with needing help and that healing is a good thing. Their first contact with people seeking help is very important. Clients should be welcomed, treated as adults, given information about available resources, and allowed to make their own choices. They should feel they are trusted. Staff should ask what the clients want to do with their lives, and how they can help.

Those who suffer from mental illness or substance use disorder must learn how to change their behavior, to act differently in response to difficult life situations. Clients need encouragement, and it is important for them to build self-esteem.

Some populations face additional barriers to success. Those with felony records have difficulty finding housing. It can be impossible to find needed resources when you are homeless, especially if you are also working and caring for your family. Even under the best of circumstances it is difficult to find transitional and supportive housing because demand so far outstrips supply. On the Reservation, where there are limited opportunities for well-paid supervisory positions, role-playing may be an important tool to prepare clients for success.

SETTING PRIORITIES

The population experiencing homelessness presents an overwhelming challenge. This challenge is even greater when mental health and substance use issues are also involved. In addressing the needs of this population, it is important to recognize the special conditions that must be addressed if these needs are to be met and the condition of this population improved.

Many people are reluctant to seek help. We must let them know that it is OK to ask for help, and to be vulnerable. It is useful to share what we have in common with them and help them to share how they feel.

Most people in these circumstances have experienced trauma. Sometimes there is generational trauma, with the individual coming from a family where one or both parents were homeless, mentally ill, or abusing substances. It is important to address that trauma so that they can heal and move forward.

These clients need somewhere safe to be. Sometimes shelters enable drug use, and other unsafe behaviors. Some people may feel safer on the streets.

It is also important to teach life skills. Clients need to learn to live life on life's terms. Many people experiencing homelessness, mental illness or substance use disorder do not know how to access the resources they need, or the help that would be available for them.

It can be difficult to find the motivation that is needed to change harmful behavior patterns. Those people need hope—hope that they can be successful in changing their lives, or that their circumstances will change. Hope is like a spark that ignites a fire. With hope we can see what the human spirit can accomplish.

Many persons suffering homelessness or substance use disorder are seriously mentally ill, with no reasonable prospect of that condition changing. These people will need services over the long term.

Unfortunately, all too often when members of this population finally ask for help, it is not available. Transitional housing should be in areas where it is easy to access services and jobs. We should consider doing away with the restrictions on the number of times an individual can obtain help. Sometimes people are not ready to change, or cannot find the motivation to succeed, but that does not mean they will never be ready.

Family support can be extremely helpful, but often people lack family support. In Native American communities there is a cultural value to help those in need, but there are fewer resources with which to do so. Some families have limited resources, and others must devote their resources to providing support for themselves and other family members. When families live far away from the person who is struggling it can be very challenging for them to help.

To meet the challenges presented by people suffering the conditions of homelessness, mental illness, and substance use, we as a community must open our eyes and hearts.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Vote. Elections can make a big difference in people's lives.

Adopt the Housing First model. Add wrap-around services after people are sheltered.

For some people we need to provide permanent supportive housing. The only fault in the system is that people must be required to get their lives together.

House everyone. Homelessness affects everyone, the entire society. It costs more to have people on the street than to house them. Housing is a basic right, like food and water. It is necessary to life. We could fix this problem by spending more money.

We should focus more energy on people transporting drugs. Fentanyl is killing us.

People who have overcome obstacles working in recovery are very important people, as they provide hope and encouragement to others. Sharing their stories is important. We should promote the sharing of success stories.

Funders should recognize that the three conditions (homelessness, mental illness, and substance use) go together, and provide treatment programs that address all three conditions. Often people are self-medicating because of overwhelming anxieties about life issues. They are in basic survival mode. Too many health plans do not recognize the importance of housing to health. An effective recovery plan requires housing, employment, a sponsor, and community resources.

Leaders should speak to businesses like those that have established employee transitional housing programs to help people recover from their conditions and move out as they stabilize and accumulate enough money to support themselves in permanent housing.

We should look at the number of young people who are plagued by drug use and homelessness, those who are aging out of foster care, and the impacts of the pandemic.

We should embrace harm avoidance programs, such as needle exchange programs, suboxone distribution to help revive people who have overdosed, Fentanyl test kits, and the like.

We should destigmatize and decriminalize addiction. It makes addicts turn to desperate measures and fails to address the problems of addiction. Inmates can get drugs and use in jail.

We should create awareness of these issues and of the prospect of recovery, to give addicts hope of a good life after addiction. Native American Connections is a great model of dealing with these issues in an integrated way. It has affordable and transitional housing, treats behavioral health and substance use issues, has youth and adult programs, and offers a comprehensive treatment model.

Prevention works. Give more money to harm reduction programs and entities. They need help.

We need more boots on the ground to deal with people affected by these conditions.

Fentanyl is a huge problem. Criminalization does not help. Addicts deteriorate over time, as they build up tolerance to the drugs. We need treatment facilities for Fentanyl addiction, and we need to get people into treatment as early as possible.

IN COLLABORATION WITH



NATIVE AMERICAN CONNECTIONS

Payson Community Town Hall

Wednesday, October 19, 2022

Payson, AZ



Photo Credit: Payson RoundUp

Payson Community Town Hall

October 19, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are interrelated, but they do not always occur together. Similar to a Venn diagram, there are instances when all three are involved or one can lead to the other. For example, someone can have financial challenges that cause them to become homeless. The anxiety and trauma of being homeless and losing hope can cause people to self-medicate with substance use. Similarly, alcohol or drug use can lead to homelessness. Having one of these challenges can create a vicious cycle with all three being experienced.

While one condition may lead to the other, someone can experience just one of the conditions without experiencing the other. The more proactive we can be to address these issues with programs and resources, and by reducing the stigma associated with experiencing these issues, the more we will be able to decrease the number of people who find themselves with these conditions.

There is a critical problem with the system which has so many roadblocks for needed treatment when someone is ready to seek help. This includes a lack of local resources and challenges with using the resources that are available. For example, there might be a location for treatment but no ability to transport someone to the treatment place, or a family cannot go to a shelter because children are not allowed. Reducing these roadblocks and streamlining treatment is essential to address and correct, as are prevention efforts that begin early with our children. The more we can provide a system with warm handoffs and people who are trained with local resources, the more successful we will be in addressing these challenges. While systemic issues are important to address, we can also have a positive impact simply by reaching out and connecting with those going through these challenges.

There are many doors into homelessness, but only a few narrow ones that allow people to get out. We need to create more doors out of homelessness. This includes education of professionals and of each other so that we reduce the stigma associated with those experiencing challenges, creating more affordable and transitional housing, having more peer supported programs, and raising awareness and knowledge of mental health issues.

We need to specifically address and include the perspective and needs of veterans.

We need to address stigma and the challenges that food issues (both quantity and quality) create.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

It is important to remove barriers and maximize resources. Collaborations across business and professional sectors (such as using MOUS, referral networks, or standardized forms) are impactful and should be supported. Reducing and eliminating red tape from state and federal resources would also make a big difference in creating the best programs for our community.

A team approach is best: bring teams together to provide food, housing, services for mental health and addiction challenges, and programs and support for children. We should be providing a hand up, going the

extra mile with consistency and constant encouragement. We should change systemic incentives so that they encourage providers to better help those being served instead of just having them “pass through”.

Education is critical. This includes educating our community about the scope of the problem. We need to reduce the NIMBYism (Not In My Back Yard) and show that these issues are in our community and must be addressed. We should start early with prevention and education in our schools. We should also expand programs that reduce harm and create solutions by having an intervention team that responds with or prior to law enforcement arriving. We need to empower our first responders with resources and information that allow them to best respond to those experiencing crisis. We should consider having advocates who can help those experiencing these issues navigate to needed services.

Overall, we should consider a centralized location for information and services that people can go to for information and to learn how to navigate needed services. It could also be a place where organizations experiencing success could share best practices and resources and where the community (including the tribal community) could meet regularly to continue these discussions and to keep working on solutions.

Finally, we need to keep harnessing the power for good by looking for creative solutions that reduce roadblocks to success by relying on our community’s unique strengths and resources to move forward together.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Create a consolidated, consistent team effort that is incentivized to success. It would be best if this was a state or federal level program with local offices that has consistent forms, best practices, programs, and advocates who can help navigate people to services needed. However, we do not need to wait for the state or federal government; we can begin local efforts now.

We should be sure to get the input and knowledge of those with lived experiences as we develop action plans. Peer support and resource navigators are essential to these efforts.

Building on the resources we have is a start.

We need to either find additional funding or redirect the available funding in a better way. We should explore creative and new resources for programs, housing, and integrated care. Funding should be more flexible so that we can use it in the way that works best for our community. When developing funding models for providers, we should look at how to set up incentives for providers, including outcome measures.

We should have ongoing town hall discussions to monitor current efforts, maintain community involvement, and reduce the silos that exist with providers and services.

Better communication and follow-up are essential for success. This might include a regular column or space in the Payson Roundup or attending the homeless task force meetings.

We need a more robust and impactful HMIS resource that connects all of Arizona, which may allow us to better provide services to those receiving them.

We need a Certified Community Behavioral Health Clinic (CCBHC), which includes certified peer support employees. We also need to get programs in our area to help certify peer support professionals.

If we really want to solve these issues, we should walk in the shoes of those experiencing these challenges. We should also support educators and social workers by paying them a living wage.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Payson Community Town Hall. Below are individual actions that were shared.

I WILL...

- Take my own medication every day. Do everything I can to stay on the right track and help others stay on the right track.
- Commit to continuing my commitment to helping solve the current problems associated with homelessness, mental health, and substance abuse.
- Learn more about CCBHC & the committee/taskforce that is already in place.
- Pledge to invite our legislature and ask for a commitment and legislation passed to address a protective program to reduce homelessness, starvation, substance abuse and mental health. Raise teachers' pay and social workers pay.
- Make a positive difference in my community every day.
- Discuss the topics of "mental health, substance abuse, and homelessness" with my children. Ask their thoughts and encourage discussion of solutions.
- Listen to individuals experiencing homelessness and be their voice!
- Get the word out about intercommunity meetings and the homelessness task force.
- Follow up and work with others in the community to continue to bring this issue to light.
- Start using ACES in assessment work with other agencies to support relapse prevention programs.
- Connect with the organizations that provide resources and support to those who are dealing with mental health, substance abuse, homelessness (specifically NAMI & The Warming Center).
- Communicate with town personnel to get information on the town website.
- Volunteer for veterans and reach out the homeless with resources and real help.
- Start becoming more a part of my community.
- Continue to increase integration of mental health care into primary care clinics.
- Continue to discuss the initiatives shared here and follow up with the homeless committee.
- Reach out to local contacts discussing potential options with NCHC, and personally volunteer.
- Lobby at the local, state, and federal level for increased human services funding, spread the word about program availability and services provided.
- Be more aware of the needs of the community.
- Reach out to see how we can help as my business. Come to a future follow up town hall.
- Be ready, willing, forgiving, and nonjudgmental of people experiencing homelessness.
- Continue to be a part of this community, learning and growing from it daily.
- Continue to advocate for myself and others on the importance of integrative care for issues surrounding mental health, substance use & homelessness.

- Stop and listen. Be kind—don't judge. Show that someone cares.
- Become better informed about the resources that are available within our community, so that I can better provide information to the homeless who frequent my library.
- Advocate for more resources that are greatly needed.
- Find out if we can hold meetings at HES.
- Could our team help with food?
- Crisis plan for our hospital
- Resources on our BPMC website.
- Continue to voice the need to help other interested parties come together to address the issue of substance use, mental health, and homelessness.
- Schedule another meeting in a month here.
- I will continue doing the awesome work I, and my teams do.
- Continue to plant trees that I will never sit in the shade of.
- Help veterans in crisis.
- Bring hope and connection by sharing music with people over free dinner at The Warming Center on Fridays.
- Work with the mayor to get the town council involved with solutions.
- Feel more empowered to talk about the issues and propose solutions when talking with Arizona's leaders.
- Keep moving forward.
- Try to increase my knowledge of what I can do as an individual.
- Increase the participation of my faith-based community, and all faiths in the community. Educate the community.

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Alliance of Arizona Nonprofits Community Town Hall

Monday, October 24, 2022
Online Via Zoom



Alliance of Arizona Nonprofits Community Town Hall October 24, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Housing is one of the social determinants of health, and the social determinants of health are all interrelated. The pandemic and the conditions it created has resulted in the creation of a new profile of families and family characteristics. The pandemic helped us to realize how interconnected these issues are. In this context, housing is medicine.

It is important to address mental health, substance use, and homelessness together because one may be the gateway to another. In addition, the systems relate to each other, and the systems do not work well. Instead of having people run around to find the services they need in different systems and places, there should be streaming services that work together. Instead of having people graduate to housing, they should be housed first. We need to aggressively assist them.

Although these three conditions can be related, often they are not. Not everyone who is homeless is mentally ill. Sometimes they are just without a home. Sometimes age is a factor that contributes to the status of being unhoused. In Phoenix, we have an affordable housing crisis and people may be unhoused simply because they do not make enough income to afford a place to live. When addressing these issues, we need to factor in the actual cause of the condition that is being addressed and treat the individual situation based on the specific factors at work.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

To some degree we expect law enforcement to address all social issues, even though they are not necessarily trained for this task. It would be helpful to bring in the experts and support systems that are equipped to address these issues. Phoenix Rescue Mission's workforce program launched last year in Glendale shows a lot of promise and should be scaled up to serve more people.

To be effective in addressing these conditions we should focus more on prevention services. Families need stability, a living wage, affordable childcare, and other support to prevent or address emergencies and crises. Programs should be trauma responsive. We should provide housing first and other services once the person has shelter. A great example of a supportive program is First Things First's Skycare Services for airport employees. The Skycare Services program provides childcare services so that employees can come to work. Several Arizona communities have adopted the Texas based model developed by Ernie and Joe, called Crisis Cops.

Unfortunately, our government seems to be more inclined to provide funding for criminal enforcement activities than prevention services. One reason is that results may not be immediately visible, and funders want to see results within an 18-month window. Law enforcement needs to be at the table discussing community health issues, rather than keeping law enforcement issues and funding separate from those issues. Everyone in the system should be at the table, including the persons who need services, and they all should have access to the data. We need to meet people where they are.

SETTING PRIORITIES

There is no single action or entity that will solve this problem. Collaboration does not occur naturally. Those working in these areas often end up working in silos, not by intention, but because they are working so hard to accomplish the tasks they are assigned. Opportunities for collaboration do not happen on their own; they require intentional action and hard work. Millennials seem to be very much inclined toward collaboration and as they move into the workforce may do more to promote collaborative efforts.

Community based projects such as the Blue Zone projects that are happening across the United States are an intriguing model that bear watching and may be suitable for expansion to more locations. The concept that AHCCCS money should be made available for housing is also promising, but we should avoid the temptation for health care systems to get into the business of providing housing.

There is a lot of analysis paralysis in this arena. We should pick a priority population so that we have a model that can be developed, applied, and expanded if it works.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Whatever they do, do it with urgency. In the 1-1/2 years since the Town Hall research report was written, conditions have gotten worse. The people doing the work and the people on the street know it is urgent, but the people in power do not seem to realize it. We are mired in the world of RFPs and the quest for a more perfect solution, instead of getting the money out to help save the people who need help now. We could have fixed this problem a long time ago if we had made it a priority.

In Sunnyslope, a neighborhood revitalization effort is underway that is like the one that Habitat for Humanity launched in the community adjacent to Grand Canyon University. Such efforts should be encouraged. The GCU initiative brought together state tax credit dollars, homeowners and businesses in the community, and student volunteers to revitalize the community. This public-private partnership is an example of the sort of collaborative effort that is needed to address conditions. Policymakers should look at such efforts and pay attention to the positive impact such programs can have. They should realize that no one is immune from the effects of these issues, and it will take the combined efforts of the entire community to address them successfully.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Alliance of Arizona Nonprofits Community Town Hall. Below are individual actions that were shared.

I WILL...

- Continue to draw upon the amazing experience of our Alliance members like those who participated in today's conversation.
- Continue to work to connect capacity to need, striving to fill gaps in resources and outcomes via collaboration between people, place, and policy.
- Continue to encourage those we encounter to "hold on" until systems become more compassionate and functional.

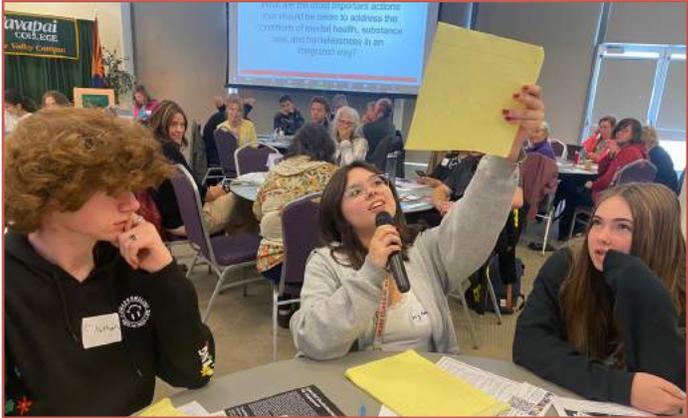
SPONSORED BY AND IN COLLABORATION WITH



Verde Valley Community Town Hall

Wednesday, October 26, 2022

Clarkdale, AZ and Online Via Zoom



Verde Valley Community Town Hall

October 26, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health substance use, and homelessness are connected and need to be addressed together. While not always cooccurring, they are often related, with one leading to the other. Many individuals may have mental health issues that may then lead to substance use and homelessness. Or, someone can experience homelessness which then leads to substance use through self-medication. These issues create many personal, family, and societal issues that impact core issues within our society and need to be addressed together.

In Yavapai County, there is a significant segment of the population that show this interconnection of all these issues. For example, public law enforcement records show an increasing number of trespassing on property due to homelessness. A number of these issues are referrals to Spectrum, due to behavioral issues. The number of issues has been increasing in recent years. Outreach collaborative programs have seen intersectionality among these three issues, creating a vicious cycle.

There is an increased level of housing insecurity in Yavapai County, due in part to a higher level of short-term rental inventory. More affordable housing needs to be addressed. The lack of affordable housing is a contributor to homelessness. Working people are homeless in our county; they live in campers or vans due to the lack of affordable housing. This particular population may not have mental health or substance use issues. Programs are trying to house families with young children to give family units some sort of stability. Housing instability affects children's learning and mental health, and it has an impact on those who already have mental health issues.

These issues should be addressed together, and they should be addressed early on before the cycle starts, using as many preventative programs as possible, especially with our children. We should come from a place of compassion in reaching out to those who need assistance. Interactions with those who are unhoused need to be sensitive to trauma they may have experienced, and with the knowledge that they are worried about meeting their most basic needs. Medications can also assist helping homeless people who have mental health issues.

We should also support programs that allow formerly incarcerated people to transition effectively into the community. A Yavapai program, Yavapai Re-entry Project, that addresses all three issues together for those individuals who have transitioned from incarceration to community, has met with increased levels of success. People looking for support have many levels of concern that should be addressed for them to live independently and regain a sense of community. The Veterans Administration also addresses all levels of care instead of one issue at a time.

We should also continue to have events like this that bring the community together and connect resources, people, and organizations.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Yavapai County shines in working together on issues and more collective work is needed. Community Health Improvement Plan (CHIP), the Mental Health Justice Coalition, MATFORCE, the Yavapai County

Substance Abuse Coalition and Collective impact partners are examples of collaboration. In addition, Manzanita Outreach focuses on resource sharing as many people do not know of the resources that exist. All of these groups are open to others joining them in working together on mental health, substance use, and homelessness.

In the Verde Valley, we have resources available, but they don't focus enough on housing or having a place to sleep. Once Maslow's basic needs are taken care of, other issues can be better addressed.

Unfortunately, funding can be siloed with a patchwork of services that are in place but not working effectively together to stop the revolving door for those who have multiple needs. A more integrated approach, perhaps led by a governmental entity, could help.

The Verde Valley is looking at a more regional approach to addressing these issues, with different organizations taking turns on providing resources and services. By collaborating with others, we learn more about difficult situations that exist, on an individual and system basis. Northern Arizona Interfaith groups have worked together to learn more about what has happened and is happening with housing inventory that affects residents. Housing option opportunities are offered with the caveat that people do not use substances. This restriction could eliminate some individuals in need. We also need to look at certain populations and their individualized needs. For example, people who are widowed or separated who need socialization as well as people who may come from different cultures or have language barriers.

NIMBYism (Not In My Backyard) is a huge challenge for solving issues with mental health, substance use, and homelessness. These issues are in our backyard. We need to address NIMBYism with more community conversations and through high level policy changes.

Various organizations have come forward with applications to provide housing for the homeless. Staffing issues have caused issues with continuity of providing affordable housing to those in need who may bring in critical problems, such as drug overdoses. It is difficult to find the answer to this complicated problem.

Bringing together people from diverse backgrounds can help in finding ways to approach these complicated challenges. We should bring everyone into this conversation and raise awareness and understanding about the underlying causes and how best to assist those in need.

We need early prevention efforts, including education in the schools that helps to reduce the stigma. We should make it easier to talk about these issues so that people know they are not alone and can be connected to available resources. We need multiple entry points that accept people where they are when they are seeking assistance. We should prioritize individuals and individual approaches that will assist with recovery and support. And we need to normalize the discussion about mental health substance use and homelessness.

The criminal justice system should be an opportunity to identify those with needs and to then connect people to available resources. To prevent people from entering the criminal justice system, we should expand co-response models with first responders and law enforcement. We should also expand and support peer support which can be very beneficial.

Finally, we need to ask the federal government for more funds for housing support. We also need to address short-term rentals, specifically we need to have the state change the laws that do not currently allow local communities to regulate short term housing, because this is creating a lack of housing affordability.

SETTING PRIORITIES

The following actions are critical to address the conditions of mental health, substance use, and homelessness in an integrated way.

Conversation and dialogue among all community-based groups and circles of influence need to acknowledge that we're in a crisis. We need to bring our resources together by collaborating among different organizations, especially those comprised of our diverse populations. All people need to be involved to consider possible solutions and they need to learn more about these three issues to make educated decisions. There needs to be more education on the complexity of this integrated challenge.

This affects people of every age group, and, in particular, new residents who have moved into our region and are not aware of available local resources.

We also need to enhance the capacity to work with individuals on an individualized or case by case basis.

Funding for additional support is always needed to support existing programs, including housing.

Education is critical as is having people who are willing and open to listening. We can use social media and other outlets to raise awareness about these issues which helps to reduce the stigma and connect those who need assistance to different programs and resources. Having a general educational program that raises understanding, such as teacher prep programs would help support students better. However, we need even more: we need a local, state, and national effort, similar to what was done with breast cancer, that raises awareness, reduces stigma, and provides a QR code or other link with resources for education and assistance. This widespread marketing campaign could include bumper stickers and other media promotions accomplished through both individual and organizational efforts.

We need to make resources more available to those who are suffering from these challenges and talk more to reduce the stigma and educate those who need help with resources, including medications.

We need a Verde Valley crisis stabilization unit.

Using our voice and the resources that already exist—including the right to vote—are important. We need to vote and share our opinions at programs like this.

We need to reevaluate high level policies that prevent communities from taking integrated actions, including educating judges, addressing issues such as zoning, and establishing a local housing authority/land trust to take advantage of federal funds.

We also need to work with the legislature on short term housing so that more affordable housing options can exist. NIMBYism has pushed back on creating or sustaining multi-family housing, further exacerbating housing issues in certain areas.

In other countries they have a mindset of working to live instead of living to work. We could take inspiration from these other countries which would help address stresses that underlie some mental health challenges.

Mental health challenges should be treated like physical or body health issues.

Finally, we need more town halls like this.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Reform the financial platform of Arizona's Governor Homeless Committee to filter this money accountably to local governments who can then implement these Town Hall recommendations at a grassroots level with oversight.

Open your eyes to the opportunities we have. These problems are happening as we speak. Change needs to happen and starting now is better than never. We as a community should be standing as one.

Remove political labels and govern for all constituencies.

Attend a town hall in a different area or with a different culture from your own.

Create an Arizona interagency council on homelessness to establish and support community-based teams made of a mix of psychiatrists, social workers, and law enforcement to address these issues on a case-by-case basis.

Increase education with younger generations and schools to educate them before these problems begin to give the next generations resources at a young age which would help with the bad stigma that follows it and so that they are more comfortable talking about their problems when they need help. The kids can go home and talk to their parents about it. That would most likely be an eye opener for the parents.

Show up, actively listen, and represent the people to remove the obstacles for solving these issues.

One size does not fit all. Each community is unique. It is important for us to collaborate on all different levels of government and come together with public and private partnerships. Sufficient resources need to be gathered to address this integrated challenge. The state legislature places its will on local governments. State level bills have a tendency to re-appear; one proposed bill, in particular, would override local zoning ordinances, in which case, the state legislature would decide on local density. Communities know their local situation, what resources are needed and what works best for them. The current state budget surplus should be distributed for needed local services determined by local governments.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Valley Verde Community Town Hall. Below are individual actions that were shared.

I WILL...

- Work together with Northern Arizona Interfaith Council to build awareness about local and state government issues, especially with housing, mental health, and substance use. The faith-based organizations are aware of these issues and could address them through legislative actions. Currently, these situations are being addressed downstream with temporary solutions to major problems that need to be addressed more comprehensively through systemic legislative actions.
- Continue to work with my colleagues within the Verde Valley and through our state lobbyists to educate legislators and to testify before committees.
- Arrange a field trip to Yavapai (VV) College for my Rotary Club.
- Arrange a town hall for our Senior High Interact kids with our Senior Rotary Club.
- Not just pass by an individual, but I will stop and reach out for their specific need and advocate for the homeless, mentally ill, and drug addicted.
- Advocate for the mental health of my students through compassionate, open education on social and emotional supports and lessons.
- Be an advocate for all of this, I am a peer and have started a grassroots program that addresses all of these issues. I will connect, collaborate, and stand for what I believe in! There is hope.
- Collaborate with cities across the Verde Valley to help solve homelessness, mental health, and drug use.

- Share about non-profit organizations and share about mental health and substance use, especially among my classes and schoolmates.
- Help people who need it. I would like to be able to show them the way before the consequences are too important for their future life, especially amongst young people.
- Help in my community, talk about it, and make other people be inspired by our ideas and us.
- Continue to reach out to young participants in future leaders to explore ways to improve and sustain their engagement with AZ Town Hall, as well as with community-based organizations addressing these issues.
- Continue to participate in my community, but not be afraid to say "no" and feel good about take care of myself.
- Continue to support Resident Council Hope House.
- Vote.
- Stay informed.
- Read town hall reports in library and actions.
- Connect with local homeless at St. Andrew dinners.
- Be socially active and contact legislators.
- Use my voice to make a difference and publicize resources available.



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LEADERSHIP LEARNING SYSTEMS, INC.



Pima County Community Town Hall

Thursday, October 27, 2022

Tucson, AZ



Pima County Community Town Hall

October 27, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health substance use, and homelessness all go together. They are interrelated, correlated, and exacerbate each other. Substance use and mental health can be the drivers or triggers for homelessness. Similarly, homelessness can be the driver or trigger for mental health issues and substance use. None of these issues occurs in a vacuum—experiencing one can lead to the other which may perpetuate the revolving door for those experiencing these challenges. Accessing the help to get out of this cycle can be extremely challenging, especially when people are in survival mode.

We need to have a comprehensive way to address these issues together in order to remove barriers for success and we need to engage people where they are. As part of addressing these challenges, stable housing is foundational as is reducing stigma, education, and early intervention and prevention (which includes reducing access to street drugs). We also need to take into account historical trauma for specific groups (e.g., LGBTQ+, Tribal, and people of color) and other individualized issues that best match needs with support.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

The system is very complex. We need to work together to see how we can better contribute together to a more integrated system.

There are still many gaps between systems. We need more integration with organizations who provide services. Specifically, we need to improve “warm handoffs,” closed loop systems, transportation to and between services, and more opportunities for services outside of standard work hours,

We need a top down, bottom-up approach that creates integrated care (perhaps we should consider having this required by the government).

We need a better mechanism for coordination, and we need to make receiving services easier, more accessible, and convenient—perhaps with an integrated facility and trained staff.

The workforce in behavioral health has dwindled with lots of staff turnover. Many agencies are without the workers they had pre-COVID. We need more people on the ground doing more outreach and connecting more with those experiences these systems. We should consider using more peer support systems and those with lived experiences. Having a highly trained peer workforce will create more of a community feel and allow people to leave the revolving door of experiencing these conditions more easily.

It’s also important to bring those experiencing these issues into the conversation; we need to involve them in creating the solutions. We should increase outreach services to the populations experiencing these challenges while taking into account the need for those doing outreach to feel safe.

Funding is simply insufficient, can be conditional or restricted, and is not always equal for these three interrelated areas.

We need more unrestricted funding for housing. Housing first is important. We need a plethora of low barrier housing with intensive wrap around services specific to individual needs. It would be good to leverage public and private resources to create needed housing.

Early intervention is key, and literacy has a big impact. Education in schools is important, with emphasis on special populations who have experienced historical trauma or discrimination. Stigma and lack of education or knowledge in the community prevents people from getting needed services and prevents services providers from maximizing effectiveness.

We should focus on social determinants of health in an upstream effort, perhaps using primary care doctors to assist with education and screening of potential issues. It's also important for systems that have been historically punitive (such as the criminal justice system) to be more restorative through education and other resources.

Along those lines, we need to look at older policies that may have created negative impacts on certain populations and create harm reduction services and safe spaces for those impacted.

We should assist communities historically marginalized or discriminated against, so they can more easily break out of cycles of service.

Having an alternative response team is a better way to address those who are experiencing mental health issues than sending the police.

Finally, we need to increase community awareness of how people find themselves in these situations, and what resources are available. We need to train all members of the community, including teachers, organizational leaders, and others on how to best deal with those experiencing these challenges.

SETTING PRIORITIES

The most important actions that need to be taken to address mental health substance use and in an integrated way include:

1. Interaction and listening for understanding is critical. We should create more town halls like this where we can have these conversations, share ideas, and create new connections solutions. We need to advocate to elected authorities to create more gatherings like this to build coalitions and understanding. We also need to advocate for unrestricted funding that can better and more effectively reached those experiencing these conditions.
2. We need to have judgment free advocacy on behalf of individuals experiencing these challenges.
3. Bring the office to the people. It's much more challenging for people to get to providers for services.
4. Prioritize funding for low barrier housing with wraparound support.
5. Strengthen connections and collaborations with agencies. We need to increase delivery of care without creating silos and work to unify services for marginalized communities.
6. We need to enhance programs in jail and prison and incorporate the justice system into these...Do not turn off AHCCCS while they are in jail.
7. Have a mandate to create a community strategic mission with funding tied to measurable outcomes.
8. Create a public information campaign to educate the public on the issues and reduce NIMBYism, this should include stories humanizing those experiencing these challenges and it should be sensitive to cultural differences and language. As part of this campaign, we need to acknowledge systemic harm and make efforts

to reduce negative stigmas. We also need more education on available resources and the need for the private sector to be a part of the solution, whether through volunteering or sponsoring specific families experiencing homelessness.

9. Have more peer support systems. Bring in people with lived experiences and pay them what they are worth.
10. We need stronger trauma informed responses.
11. Have a resource hub that includes support with how to navigate and connect to needed resources and consistent follow-up with those served.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

1. Pass laws to support state or federally funded transitional housing as a part of mental health substance use with wrap around services that are medication and family friendly.
2. Housing is a basic human right. We need to stop using us vs. them language. We are them.
3. Why are we competing for funding to serve patients? We need to create a system that encourages collaboration, not competition.
4. Get more informed and involved. Be a part of the solution. Attend Town Hall. Speak to those experience homelessness and find out what works.
5. Come and see the problem firsthand. Instead of seeing a problem, see a person with a problem.
6. Safe housing is a priority for funding and important for providing other services.
7. Implement and fund policies that address the social determinants of health.
8. Control and fund affordable housing (zoning, rent control, etc.).
9. Provide Narcan to inmates.
10. Community engagement and education: reach out to neighbors and other to learn about what brings people to these situations. Work with the community to support solutions.
11. Divert homeless individuals being charged with nonviolent crimes and use funding for housing instead of incarceration.
12. Have a state approach that: is informed by and recognizes human experiences; allows for local communities to take the necessary steps or actions that prioritize low-barrier approaches with wrap around services to interrupt and end the crisis cycle our neighbors are facing.
13. Come to our community discussions and create a town hall for discussion of these topics.
14. Pass legislation that allows support systems to be involved in treatment (such as families).
15. Sit down and listen. Become educated.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Pima County Community Town Hall. The following are individual actions that were shared.

I WILL...

- Identify existing resources in Pima County working to address issues surrounding homelessness, be prepared to share this information with anyone who I encounter that is open to receiving it. Work toward putting a face on homelessness in our community.
- Always serve my community.
- Stay involved! Carry Narcan.
- Continue to serve and assist and educate my community.
- Ask for more mental health resources.
- Share what I have learned.
- Reach out and help my community!
- See you at Speedway and Craycroft.
- Go to my local political leaders!
- Educate myself. Collaborate with other providers. Incorporate those affected in plans for change. Contact policy makers and to promote change.
- Spread the word!
- Continue to provide awareness of the issues in our community and work to dispel false narratives.
- Continue to be a resource for our community in connecting the vulnerable to services (resources)!
- Advocate for affordable housing for older adults, many who are experiencing loss of shelter for the first time.
- Participate in outreach to connect unhoused individuals to resources.
- Be committed to partnering and community partners and stakeholders to finding and establishing resources/ services to decrease homelessness, and substance use, while improving mental health.
- Stay tuned for the report prepared from the town hall held with people experiencing homelessness. I want to hear their perspectives as much if not more than I do providers.
- Commit to support educating everyone on Tribal Culture Identity Crisis. Traditional Community outlets. Historical and generational traumas.
- Report back what I experienced here to my tribe. I need to feel like I represented the needs of my tribe, so I will continue to attend these types of events and I will reach out to Town Hall staff.
- Reach out to housing and mental health providers to form a collaborative network of services dedicated to supporting women experiencing homelessness at our center- Sister Jose's.
- Bring awareness to the issue of homelessness in Tucson.
- Fully support an integrated effort that engages the homeless where they are and properly manages resources to affect the most good.
- Be intentional about the use of language relating to all marginalized populations; connect with and humanize.
- Put others first. Put an action plan together.
- Ensure programs developed, funded, or implemented by my department will address the whole person and the social determinates of health.

- Continue to help others heal. #cantgetwellinacell #cantpunishawaythepain #theinvest difference
- Keep loving humanity.
- Start to educate my health and wellness coalition.
- I will work on connecting systems around homelessness with the City of Tucson.
- Raise awareness to my community.
- Advocate for a sponsorship program. [For example,] private companies like T-Mobile sponsors homeless families with housing care and job opportunities.
- Continue to figure out how I can help do more at my organization to address homelessness and those affected by mental health and substance use issues while being house-less.
- Meet people where they are. Share my knowledge of resources with others, transparency.
- Educate to reduce stigma. Network. Humanity!
- Continue to advocate for those in my community struggling with mental health, substance use, and homelessness and provide trauma informed, culturally proficient care.
- Continue to bridge matters together to better serve the community. Advocate and have the difficult conversations with decision makers.
- Continue to view my community with an empathetic lens.
- Be a conduit of purpose and passion to create and evolve a community of people who uplift and support each other.
- Continue my organization's efforts to increase our collaboration with other service organizations to better the needs of our community
- Publicize resources through my office.
- Research and support policy to help connect people with housing and services.
- Continue to be an evangelist for mental health, and substance use in Pima County.
- Be better tomorrow, [more] than I was today for those I serve.
- Treat every person with respect and show kindness, empathy, and sympathy.
- Continue to provide resources to the best of my ability.
- Empower those who want recovery to know its 100% possible.
- Continue to be part of helping figure out solutions for individuals who need help with substance abuse and homelessness through my peer support.

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ASU Future Leaders Town Hall

Thursday, October 27, 2022

Phoenix, AZ



ASU Future Leaders Town Hall

October 27, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

People use substances to cope with difficult situations, which leads to poor mental health and homelessness. Like COVID, homelessness can cause mental health and substance use issues to worsen. Substance abuse can impair mental health and cause impoverishment as people spend their resources on substances. People with mental health and/or substance use issues can have difficulty getting and keeping jobs, which can lead to homelessness, which also makes it harder to get and keep a job, and each of these conditions contributes to one big cycle of misery. Being homeless impacts physical and mental health. When people have a roof over their heads they can focus on other conditions. People experiencing homelessness or mental health issues are more likely to self-medicate by turning to substances. The use of substances separates people from their communities and support systems. We should recognize that the environment influences people, and that the environment includes other people. If behavioral problems are not addressed, they can lead to inter-generational problems, and a continuing downward spiral.

It is important to address these three conditions together because one contributes or leads to the other. It is like the domino theory. It is important to apply the Housing First model because when people are more vulnerable, they need more support.

We need to meet people where they are. We should recognize that not everyone suffers all three conditions simultaneously but treating them together brings more resources to the table and assures that when they are coextensive, they will be addressed together.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Education is a big part of the solution. We need more teachers, psychiatrists, and social workers. We should get the community involved and informed, so that they will be more motivated to solve the problems. If they understand that mental health problems are real and common, and that there are solutions, they may be more willing to help. Education of older people about substance use could create greater understanding of the nature of the problem and the solutions that may be effective.

We need more shelters. We need professionals in those shelters to provide resources and evaluate people using the services. We need backup for nonprofits to assure that there is sufficient infrastructure to provide care. We should keep records to track what has helped people to make changes in behavior. We need better transportation options, so that people can access needed services.

We should remove financial barriers. These are expensive problems to have. We should consider changes to regulations and laws, and make substance use and mental health counseling more affordable. We need more affordable housing. Instead of dispatching police to mental health crises, we should send mental health crisis intervention teams. We should make it easier for marginalized communities to create intergenerational wealth through home ownership. We should take steps to de-stigmatize all three conditions. People may not seek help because they are afraid of being judged.

We need to coordinate services. We should develop more affordable housing in communities like Scottsdale where there is land available. Adopt the Housing First model. Vote for candidates who are committed to addressing these issues.

SETTING PRIORITIES

Raise awareness of these conditions

Focus on prevention of crises for people facing these conditions

Make housing more affordable.

Know where the money is going.

Education to find the root of the problem to stop it from growing.

Invest in programs that stabilizes people rather than just giving them a place to stay for the night. To do this, redirect funds from other programs that are less useful.

Focus on preventative measures: direct approach to fix the problems, community education to reduce stigma, early intervention to address mental health issues in the young, more program funding.

Elect politicians who are more engaged in dealing with these problems.

Be more collaborative and stop working in silos.

Educate people working in the field to be less intimidating and educate people generally to be less intimidated and to seek out resources on their own. Also, to focus on the present instead of looking back.

Preventative measures: establish a database for responders so that they would know about past mental health incidents at a particular address; emphasize education to de-stigmatize these issues and promote compassion; have nurse and social worker at public schools, to support students and reduce financial barriers to treatment, provide in-school treatment.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the ASU Future Leaders Town Hall. Below are individual actions that were shared.

I WILL...

- Continue to look for effective solutions to combat homelessness by providing resources and mitigating further crippling factors that cause any of these issues.
- Focus on the now, not the how.
- Share the information that I have learned and contributed to and from this session with my family and friends.
- Continue efforts to integrate healthcare/homeless systems data in order to more effectively understand and assist individuals experiencing homelessness, mental health, and substance use.
- Discuss the issues of homelessness more often; Arizona has a huge problem, and it will not go away anytime soon.

- Talk to other Arizona Residents about these issues and I will share my experience with others.
- Use my knowledge and connections to spread awareness for those who are less represented. I hope my future career also helps me advocate for them as well.
- Continue to spread awareness of this issue to the people around me and start to discuss it in my assignments if given the chance.
- Tell other people about AZ Town Hall.
- Spread awareness by informing those who need it on resources available to them that could help better their situation.
- Go out and help homeless rather than relying on government processes to do the hard work.
- Spread the word to all my peers and close family members.
- Spread awareness across my community about ways to help improve current ongoing issues
- Tell other people and spread awareness for those people and vote for people who care about these issues.
- Continue to volunteer at non-profits who are helping the community. I will continue to read and educate myself on issues & attempt to discuss these matters with any and all individuals willing to engage on different social topics.
- Share what I learned with my family, friends, and peers and continue to educate myself on these complex topics.
- Educate those around me of issues that are happening through social media and in my classes.
- Share what me and my table talked about with my family and friends.
- I will use this to complete my ASU 101 assignment and reflect.
- Learn more about it in order to find a solution to make a positive impact in our future as a society.
- Take more knowledge to these companies that take part of our everyday lives.
- Learn about other non-profit organizations that address mental health, substance use, and homelessness issues.
- Spread information and awareness about the topic I learned today with my peers in my classes.
- Look for more community service opportunities and discuss what I learned with my family and friends.
- Spread awareness by informing those who need it on resources available to them that could help better their situation.
- Share what I learned with my family, friends, and peers and continue to educate myself on these complex topics.
- Inform myself of the statistical data of these issues and motivate my peers to do the same to spread awareness.
- Apply this information discussed to my internship and when working with clients who are experiencing these issues.
- Do my own research and educate myself more about the issues at hand.
- I will also talk about what I learned today with others because it was a topic I found interesting and important to know about.

- Educate those around me of issues that are happening through social media and in my classes.
- Raise my voice more and inspire others to create a change. Also, attend more events where I can help with mental health, substance use, and homelessness.
- Share the information that I learned with my friends and family. I would also vote for those in office who will make a difference in our state. I will educate myself more in mental illness.
- Share what me and my table talked about with my family and friends.

IN COLLABORATION WITH



Bullhead City Community Town Hall

Tuesday, November 1, 2022

Bullhead City, AZ



Bullhead City Community Town Hall

November 1, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

Mental health, substance use, and homelessness are connected and interrelated with one challenge often, but not always, leading to, exacerbating, or causing the others.

For example, when someone experiences mental health challenges or abuses substances, they often will end up experiencing homelessness. Likewise, individual substance use, including dependency on prescribed meds, may cause mental health problems which may then cause a breakdown of familial and other support systems and lead to homelessness. Similarly, those with mental health issues may turn to substance use to cope which may then lead to homelessness. Or someone may lose their job, creating homelessness or mental health challenges.

Early challenges and trauma can also create mental health challenges which may lead to substance use as a coping mechanism.

We can stop this cycle by reducing the stigma around those experiencing these challenges, preventing the causes before they occur, and through early diagnosis and treatment, which includes teaching coping mechanisms to help people overcome these challenges.

To solve these issues, we need to address them all together looking at: mechanisms to treat special populations such as juveniles and veterans; how to better assist first responders and law enforcement in responding to mental health issues; educating providers on how best to listen to the needs of those served; and providing more mechanisms for coordinated collaboration and access to resources.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

While we can always use more resources, our community resources have vastly improved over recent years. We have many community resources, but people don't know about them or how to access them. We need to bridge communication, increase collaboration around these common issues, reduce duplicative services, and eliminate the revolving door.

We need a complete and regularly updated resource guide so that everyone knows what is available—one that includes who does what, where, and when they provide the services as well as contact information that anyone can use and access. We should also make efforts to bring resources to people where they are and reduce the barriers to people getting services (such as bringing services physical to them where they are or providing transportation to services). We also need to explore how to create systems that reduce competition among providers.

The Homeless Task Force could be used more to share information, connect different stakeholders, and to bring in community volunteers and other organizations for coordinated services that reduce competition and improve services to those in need.

Peer resources are important for getting people to services they need and helping people to have consistent and regular support. We should use those with lived experience to build rapport with those in need, to lower barriers to services and to provide additional support for police, first responders, hospitals, and other providers.

Quality of life or treatment court has been a useful tool for those who deny or refuse services. It can be the impetus to begin counseling and to get services which then allows people to learn life skills, get a job, and get on the right track.

To reach a broad swath of children and families in need, we need to involve our school systems. Truancy is related to many of these issues and places children at a greater risk for later experiencing mental health issue, substance use and homelessness. Working with our schools and educators can help to prevent or address these challenges at an earlier stage (including recognizing undiagnosed mental health conditions). It will also help to reduce the stigma that keeps many from seeking needed services.

We need education not only to inform educators and service providers about resources but to inform community members so that they better understand best practices and what resources may be available to assist those they encounter. This type of education and communication may also reduce issues of NIMBYism, stigma, and other barriers. Overall, we all need to listen more to each other and to those who are facing these challenges.

SETTING PRIORITIES

Six Steps to Success:

1. We need better communication, cooperation, and consistency.
2. We need better coordination of services, benefits, and resources. This includes a collective and easily accessed resource guide. It may also mean having one person who oversees updates to this resource guide and who takes other efforts to effectively coordinate collaboration. It may also come through increasing use of existing resources to better coordinate existing physical space into a hub, such as more use of the homeless shelter for related services and agencies.
3. Communication
 - a. To those who need services.
 - b. To reduce stigma in the community and to raise community awareness around existing resources and efforts.
 - c. To reduce silos, improve coordination and integration among providers and stakeholders.
4. Advocacy to our legislators to make these issues a priority at all levels which includes additional funding for needed services.
5. Expand the homeless task force to include mental health, substance use and domestic violence.
6. Improve screening within our medical community and hospitals to raise awareness to address these issues early on.
7. Develop our volunteer base.
8. Attract and retain more treatment professionals. One way to help address these needs could be to use innovations such as telehealth. We should also create more pathways and opportunities for peer support services for all ages, from youth through seniors.

9. Create and support more affordable housing.
10. Workforce integration: assistance with clothes, education, transportation, and other resources to connect people to employers.
11. Meet people where they are, not where we want them to be, with consistent peer support that comes to them.
12. Create a 10-year plan on how to address these priorities and monitor progress.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

- We want our legislators and leaders at all levels to be aware of these events and to show up with an open mind to listen and to then provide resources as needed (funding, legislation, changes to rules et) to help Be open to new and innovative ideas and allow local communities to use funding as they think best.
- Ensure resources are allocated fairly to rural areas. Provide services to veterans.
- Reduce barriers to available grant funding.
- Expand incentives for working in rural areas (for social workers, health care workers (such as loan forgiveness, etc.)).
- Require training for mental health issues to teachers and others.
- Clarify and see if limitations can be place on the use or possession of marijuana on school grounds.
- Have more localized government involvement-regional funding for a hub that would house representatives of organizations who serve in these areas (akin to an emergency operations center).
- Expand the use and branding of the Homeless Task Force to other issues.
- Invest and support a shelter model for the city and then fund the integrated services under one roof to maximize effectiveness. This should include related services that connect people and reduce barriers to services, such as shelter space for animals.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the Bullhead City Community Town Hall. Below are individual actions that were shared.

I WILL...

- Volunteer at the shelter monthly to assist with nursing tasks.
- Continue to collaborate with other agencies to upgrade resource guide.
- Continue to be the front door to services to navigate to area resources.
- Provide medical consultations at the shelter and coordinate services with local pharmacies for affordable medications to homeless clients.
- Promote adult care center.
- Support education on homelessness, drug addiction, and senior welfare issues.

- Assist local agencies getting publicized.
- Continue to be the be the "feet on the ground" for Talas Harbor Behavioral Health Hospital and other community services.
- Continue building the reentry program.
- Educate the community about social issues and community resources.
- Make sure that I am able to help whoever comes to me get the help they need.
- Volunteer where I can at the shelter and task force.
- Advocate the continuous efforts to find solutions and overcome mental health, substance use, and homelessness.
- Be part of the homeless task force and be a part of potential rebranding to address more of the issues facing us today
- Stay consistent in the reaching out of services among our communities in Mohave County.
- Retire soon but be available whenever needed!
- Do more to help!
- Talk with Jeff about attending homeless task force meetings.
- Continue to establish greater collaboration with the resource community to heighten effective responses for community need.
- Take the information other agencies shared today and share it with coworkers and others in my community to best help individuals, youths, and families in our area.
- Ask for more paper handouts for homeless teens.
- Partner up with the resources that is in our city for homeless teens.
- Work with homeless shelters through therapy and a "back to work" program for the homeless.
- Advocate for our youth and families to have red tape barriers removed so services are available to all.
- Reach out to state legislators to utilize food wisely and reasonably.
- Spread awareness though business websites about this town hall meeting and the goals for the community.
- Be a part of the solution not the problem.
- Share resource on my platforms and encourage people to share at the city council.
- Create and innovative resource list that is digital and easy to share.
- Focus on marketing to the public to educate everyone on the great resources in our community.
- Support and continue working with all community members.
- Continue to be part of the conversation.
- Continue to contact our local representatives and senator to address and fund these issues
- Urge local officials to obtain a four-year university so we can obtain local professionals for counseling, law enforcement and teachers.
- Contact: Leo Biasiucci, Sonny Borelli, Mark Kelly.

- Share information with others to spread word of available resources.
- Contact local legislators to encourage funding the homeless issue.
- Maybe become more active at a local level
- Compassionate law enforcement that connects with the community and partners with them to address the needs within a law enforcement context.
- Urge AZ leadership with help funding programs.
- Work to keep focus on local issues at state.
- Bring resources to the community.
- Focus on local needs reality.
- Be an advocate for the programs we have and let the community know the benefits that these services provide.
- Be open to ideas and resources.
- Continue to educate myself on issues, concerns, and resources to assist with homeless, mental health, substance abuse issues, and concerns.
- Continue to work with and engage local service providers to enhance the services we provide to our community to build and support the homeless engagement system we are building within the tri-state area.
- Help inform the local community of the difference within the homeless community.
- Help change the outlook on substance abuse and mental health.
- Research more on House Bill 1376 and find curriculum on the subject.
- Commit to actively participate in the development of a digital platform for community resources, data exchange, and information exchange.
- Commit to continue to advocate to have barriers broken down to have access to grant funding and resources to be able to continue to make positive changes and behavioral health services in our rural community.
- Develop a resource guide for Mohave County with community partners.
- Help those in need, join a homelessness committee.
- Pass along information from this meeting.
- Volunteer at other agencies to know better what is out there.
- Put myself out there to learn more.
- Continue to educate myself and community.
- Get engaged!
- Educate others and improve our community.
- Educate service clubs.
- Ask for more volunteers and donations.
- Work with local legislators for state funding.
- Invite legislators to see how we run the coalition to show our needs and funding.

- Make sure to communicate with other local agencies and nonprofits to coordinate our efforts to work together on community projects.
- Follow up to see how BHHS Legacy Foundation can help with the resource guide.
- Help find ways to staff clinic at Catholic Charities.
- Make sure our agency participates in the Homeless Task Force and work with the community partners in a meaningful way.
- Continue to go to the Homeless Task Force and be a voice for the residents who are tired of not being able to use the local services and dodging homeless drug addicts in the middle of the streets.

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“Exploring Solutions: Mental Health, Substance Use, and Homelessness”

Presented by Arizona Town Hall and Mel & Enid Zuckerman College of Public Health

Wednesday, November 9, 2022

Tucson, AZ and Online Via Zoom



“Exploring Solutions: Mental Health, Substance Use, and Homelessness”

Presented by Arizona Town Hall and Mel & Enid Zuckerman

College of Public Health

November 9, 2022 – Report of Recommendations

THE INTERSECTION OF MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

The conditions of mental health, substance use, and homelessness relate to each other in various ways. It is important to address these conditions together since they are syndemic and one cannot be solved without treating the others. As well, conditions may start in one area and lead into another. A substance use problem can cause struggling for employment, which may lead to homelessness. Mental health issues may be addressed through substance use, which then exacerbates the problem. Sustainable treatment should be holistic; otherwise, adverse trauma can snowball into poverty and affect someone throughout their life.

Having shelter is a baseline condition that must be addressed first to make it possible to address the other conditions effectively. All the conditions must be addressed comprehensively for any of them to be addressed effectively.

ADDRESSING MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

There are several challenges in serving this population. Stigma attaches to mental health, substance use, and homelessness on their own. Someone suffering from all three conditions faces an insurmountable amount of stigma. The relationship between people living with these three problems has a lot to do with how they interface with providers. Continuity of care is a problem. How we prepare providers to deal with this population is very important.

Foster children disproportionately end up suffering from these conditions, and we should prepare families to help foster children and children aging out of foster care. NIMBYism is a factor. Many people say they want to help and may even volunteer to help, but often they do not want to have the solution in their backyard.

It may be helpful to think in terms of bite-sized solutions, instead of tossing all possible solutions at people and expecting them to navigate the system. It can be overwhelming to address multiple tasks at once when recovering from trauma and multiple issues. We should recognize that many people struggling with these conditions are reacting to the stresses of living in a complex society. We need to help people become their best selves.

In addressing the homeless population, we should recognize that some encampments are like communities. They should be kept together not broken up. On the other hand, people experiencing these conditions should be addressed as individuals, not as a monolithic group. We should avoid othering people when they seek treatment.

Culture is important. Homelessness in the elderly population is heartbreaking. The book *Being Moral*, addresses how many elderly people struggle in the U.S., whereas in other countries they would be cared for by their families. We should focus on the cultural factors behind these problems to address the causes that contribute to the problems.

In dealing with people struggling with these conditions we need to build a sense of community, trust, and self-worth. It is preferable that people want to seek help for their own purposes rather than just being handed a solution that someone else has decided upon. One program did this by offering art projects, assistance with pets, and other programs that reinforced a sense of connection and community. To address NIMBY sentiments, it might be useful to upgrade their backyard, providing nicer areas for homeless encampments, with bathroom and shower facilities, food-growing vegetation, and other amenities.

Housing should be more integrated. We need a better approach to working with tribal nations, and to address jurisdictional conflicts cooperatively. People experiencing these conditions can share their knowledge and lived experience. We should establish a one stop shop to gather resources together in one place and make it easier for people suffering these conditions, and their families, to access them.

We should bear in mind Maslow's hierarchy of needs. His pyramid indicates that basic needs must be addressed before people can hope to achieve self-actualization. We should address basic needs first, leading to community engagement, and then higher order needs.

We should use trauma-informed care techniques and treat people as individual human beings. We should also build trust through community engagement and engage them in their own recovery, for example, asking them where they would like to start in addressing their issues. We should cultivate services that communicate with each other. We need to do more to retain employees in service agencies, because high turnover disrupts the ability to serve this population and achieve warm handoffs. The "services without walls" model, with mobile officers and services, can be very effective.

SETTING PRIORITIES

To address the conditions of mental health, substance use and homelessness in an integrated way we need to learn from our mistakes and be willing to change.

We cannot criminalize our way out of homelessness. Instead, we should decriminalize homelessness. People experiencing homelessness often face trespassing charges, which may prevent them from getting housing down the road, and thus perpetuate the cycle of homelessness. The criminal justice system should be reformed to remove barriers for people who have difficulty because of these conditions and take their special circumstances into account. People respond well to kindness and empathy. People should not be punished for their status by being overcharged with multiple crimes. We should establish a consolidated misdemeanor processing system and provide for expungement of misdemeanors.

We cannot fight our way out of homelessness. More social workers and other staff are needed to provide services. This requires more funding. To attract and retain staff we need to pay them a decent wage, give them time off, and provide other employee benefits.

It is necessary to know where to go for required resources. Unfortunately, those in need first think of going to the emergency department, which may not be the best avenue to help them. We should help people struggling with these conditions and their family members to understand what resources are available.

The ethic in the US is that people should pull themselves up by their bootstraps. We need to rethink this. Instead, we should start young, building a safety net. We should emphasize prevention and early intervention. Children in schools should receive early diagnosis, and be taught coping strategies, and how to find the resources they need. There should be more access to nutritional food. Providing reimbursement to for family members that assist with care of the homeless is another way to address the problem.

We should focus more on the fact that addressing these issues is a foundation of economic development. We need more vocations training programs. Models like Homeboy Industries, a bakery that employs former gang members, and Café 54 in Tucson, which employs people with mental health conditions, are example of how companies could help this population by employing them.

We should target the stigma through education. Programs could hire ex-clients who have lived experience to work in providing treatment. We should create resource navigators, people who specialize in finding resources and bringing them back to the community.

We should remember that media is powerful. Thought provoking public service announcements could help shift the general public's concerns or fears around co-existing with various groups.

It is important that we are each an individual human being that should receive respect and empathy together with a holistic array of resources. Foster children may be homeless; providing resources such as housing, clothing, and food can help them immeasurably.

WHAT ARIZONA'S ELECTED LEADERS NEED TO KNOW

Safety and security are very important. We should establish a program with three pillars: safety and security, health care, and livelihood generation. We could possibly retrofit unused governmental properties. Give people a chance to build their own community, work to earn income, have a place to live, a place to receive treatment.

We need to approach these issues more holistically and coordinate resources and care. Communication between resources and services is a good way to start. Separate silos of resources may only be able to provide certain solutions; together, these resources can provide more holistic coverage. Several large, bureaucratic federal agencies fund and address pieces of this issue. We should rethink and retool how these agencies work together. We should mandate integrated treatment models for substance use and mental health disorders (i.e., a dual diagnosis program model).

Talking with elected officials and presenting them with actions that need to be taken is essential. Services provided for transportation may now be used for shelter. Profound strategy changes could be had through informed and engaged trainings that support respect and active listening. De-stigmatizing these conditions can help attitudes towards those in need.

The availability of housing is critical. This population needs Housing First. We should establish protected funding for Housing First, so that it is not subject to political whims and does not change. Universal health care should be a right. We should build public spaces that are more welcoming to unsheltered people. We need an environment that is not so landlord friendly. We should consider establishing rent control. There should be limitations on vacations rental, short term rentals, and the number of luxury apartments. Development should be conditions on the construction of a minimum amount of affordable housing.

INDIVIDUAL COMMITMENTS TO ACTION

Recognizing that the power to change the future begins with each individual, participants committed to take personal actions based on their experience and discussions during the “Exploring Solutions: Mental Health, Substance Use, and Homelessness” Community Town Hall. Below are individual actions that were shared.

I WILL...

- Not pass those that are unhoused without smiling, greeting them, and “seeing” them. I do not like the idea of folks in the community feeling invisible.
- Talk with my friends and spouse about this town hall and share some ideas I have heard.
- Address stigma and talk about these issues more openly.
- Talk to local homeless family members.
- Continue to advocate at the state and local level.
- Continue to seek design solutions within the built environment that will address these issues.
- Keep teaching classes about substance abuse.
- Continue working in this field.
- Continue to provide outreach to individuals experiencing homelessness, mental illness, and substance use disorder by offering resources, helping them to advocate for themselves, as well as advocating for a better system to help those experiencing any of these things.
- Spread my knowledge and connect with other organizations.
- Continue to teach undergraduate students about substance use & related issues.
- Keep advocating for making this world a better place, especially for a vulnerable population.
- Continue to keep all marginalized groups in discussion. I will not stop fighting for all marginalized groups, especially those with no roof over their head.
- Continue to have conversations on these topics.
- Continue to educate others about the complexity of substance use, homelessness, and mental health.
- Share the ideas I heard today with others providing direct services in the field; always strive toward building new connections & collaborations with community partners.
- Continue to work to center the voices of people with lived experiences at the tables that I sit at.

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**Mel & Enid Zuckerman
College of Public Health**

MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

BACKGROUND REPORT

MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

THE 114TH ARIZONA TOWN HALL

BACKGROUND REPORT

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CHAPTER 1 — INTRODUCTION

Morrison Institute for Public Policy

Acronyms in this Chapter

- ACC–AHCCCS Complete Care Plans
- AHCCCS–Arizona Health Care Cost Containment System
- HUD–U.S. Department of Housing and Urban Development
- LGBTQ–Lesbian, Gay, Bisexual, Transgender, Queer
- PATH–Projects for Assistance in Transition from Homelessness
- PIT–Point-in-Time Count
- PSH–Permanent Supportive Housing
- RBHA–Regional Behavioral Health Authorities
- SMI–Serious Mental Illness

Mental illness, substance use and homelessness impact people from all walks of life. It is likely that each reader of this report will in some way be connected to these issues—maybe you have a friend, family member or acquaintance who has struggled with one or more of these issues, maybe you yourself have been impacted, or maybe you are someone who wants to find fiscally efficient methods for addressing treatment and rehabilitation so that funds can be reallocated elsewhere—in one way or another, this is an issue that touches everyone.

Arizona Town Hall can make a difference. This background report, along with our [local and statewide Town Halls](#), can increase awareness and educate the community about the challenges associated with these issues. Using a fact-based and people-centered lens, we can help to de-stigmatize homelessness, mental illness, and addiction and catalyze collective impact to find solutions that work.

Things you take for granted when you have a home: (1) the ability to take a shower whenever you want, (2) sheets that haven't been slept on by hundreds of other people, (3) a real kitchen, (4) the ability to store your things away in a safe place, (5) the sound of your keys when you pull them out of your pocket to unlock your very own door (see Chapter 16 — Focus on African American Communities).

Homelessness can happen to anyone, anytime. People experience homelessness for many reasons: losing a job, substance use, mental illness, eviction, domestic violence or relationship breakdown. However, there are also larger structural forces behind the rise in homelessness. Poverty, racial discrimination, limited or low-quality treatment options for mental illness and substance use, and a lack of affordable housing are underlying factors that cause or perpetuate homelessness (see Chapter 9 — Structural Causes of Homelessness, Mental Illness and Substance Use).

In official surveys, someone is considered homeless if they lack a fixed nighttime residence. Additionally, there are many people who live in sub-standard housing, crowded conditions, RVs or who are staying with family or friends. This group is considered “marginally housed” and is much harder to count. According to the 2020 Point-in-Time (PIT) Count, there were 580,000 people without a fixed nighttime residence in the U.S. and 11,000 in Arizona in one night.¹ Adding marginally housed people likely increases this number 4-fold.² This means that an estimated 44,000 people in Arizona were unhoused or marginally housed at the time of the survey—well over twice the amount of people permitted in a full Phoenix Suns arena—and this is likely an undercount.

This report focuses on a subgroup of the unhoused community, those with mental illness and substance use disorder. Mental illness, substance use, and homelessness often occur together. The 2020 national PIT Count categorized 21% of counted unhoused people as severely mentally ill and 17% as having a substance use disorder.³ Although not available in the PIT Count, other national data show that many individuals with a mental health disorder also have a substance use disorder (18%).⁴ More specific but older reports show a high prevalence of co-occurring disorders among those experiencing homelessness in the U.S., with percentages ranging from 26%–37% across studies (compared to 3.8% in the general population).^{5,6}

It is important to note that the causal relation between these issues varies. Sometimes it is homelessness that leads to substance use and/or mental health issues, and sometimes it is substance use and/or mental illness that leads to homelessness. From there, it can be a vicious downward spiral.

The co-morbidities between these conditions create challenges for treatment and policy development. Advocates and treatment delivery systems increasingly recognize the connection between homelessness, substance use and mental illness and aim to address these conditions together. The state of Arizona has tried to integrate solutions and care using the Arizona Health Care Cost Containment System (AHCCCS)—Arizona’s Medicaid agency—which provides around 3,000 permanent supportive housing (PSH) spots for people with serious mental illness or those designated as “SMI” for short.⁷ AHCCCS has also tried to integrate services for people with complex medical and behavioral needs through the creation of Arizona Complete Care plans (ACC) and Regional Behavioral Health Authorities (RBHA) for people with serious mental illness. Through the Projects for Assistance in Transition from Homelessness (PATH), AHCCCS pays for outreach and services to individuals experiencing chronic homelessness with serious mental illnesses. In 2019, contractors reached out to 5,921 individuals, most of them on the streets, enrolling about 38% in the program.⁸ Many were connected to mental health clinics, some to primary care services, supportive housing, and employment assistance (see Chapter 4 — Integrated Treatment and Care in Arizona).

1 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations,” U.S. Department of Housing and Urban Development, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_NatITerrDC_2020.pdf.

2 “The 2018 Annual Homeless Assessment Report (AHAR) to Congress,” U.S. Department of Housing and Urban Development, 2019, <https://www.huduser.gov/portal/sites/default/files/pdf/2018-AHAR-Part-2.pdf>.

3 “Continuum of Care.”

4 “Results from the 2019 National Survey on Drug Use and Health,” Substance Abuse and Mental Health Services Administration, 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

5 Carole C. Upshur et al., “Prevalence and Predictors of Substance Use Disorders Among Homeless Women Seeking Primary Care: An 11 Site Survey,” *The American Journal on Addictions* 26, no. 7, 2017: 680–88, <https://doi.org/10.1111/ajad.12582>.

6 Kele Ding, Matthew Slate, and Jingzhen Yang, “History of Co-Occurring Disorders and Current Mental Health Status among Homeless Veterans,” *BMC Public Health* 18, no. 1, 2018: 751, <https://doi.org/10.1186/s12889-018-5700-6>.

7 “Addressing Health Care and Housing With AHCCCS,” Arizona Health Care Cost Containment System, 2021, https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AddressingHealthcareAndHousing_Infographic.pdf.

8 “Projects for Assistance in Transition from Homelessness (PATH) Grant,” Arizona Health Care Cost Containment System, 2021, <https://www.azahcccs.gov/Resources/Downloads/Grants/PATH/2019PATHOUTCOMESDATA.pdf>.

Service delivery related to treatment and recovery continues to evolve based on current information and research on evidence-based interventions and treatment modalities, such as Housing First and trauma-informed care (see Chapter 5 – Mental Health Treatment and Recovery and Chapter 11 – Overview of Best Practices for Treatment and Care). There are also services that aim to increase the likelihood of long-term stabilization and relapse prevention for people in recovery (see Chapter 6 – Substance Use Treatment, Recovery, and Relapse Prevention; Chapter 13 – Community Integration; and Chapter 14 – Accessing Services for Recovery and Stabilization).

Despite these efforts, many people continue to suffer at the intersection of mental health, substance use and homelessness. As the experiences and perspectives in this report illustrate, those who are at this intersection have to navigate a complex system of services where communication among agencies and providers is often siloed. As a result, those who need treatment fall through cracks in the system, often cycling between the streets, emergency rooms, crisis care, jails and prisons (see Chapter 3 – The “Revolving Door”).

While the exact cost to end homelessness is unknown, research suggests that the costs associated with providing stabilization services, such as housing and mental health treatment, are much smaller than the public costs associated with the persistence of homelessness. These costs are caused by many activities, including police response, incarceration, emergency room visits, street clean-up and so on.^{9 10 11 12 13} In other words, providing support and treatment is not only a more humane approach; it is also a more cost-effective solution than having someone cycle through emergency care and legal systems (see Chapter 8 – The Human and Financial Toll). The accumulation of funds saved annually could then be allocated to other social, political or economic priorities.

At the same time, ending homelessness is not only a question of money. The status quo also persists because of political power, institutional inertia and public preferences. Thus, highlighting the need for solutions-based conversations to include reform around decision-making processes, institutional practices and societal views, as well as the portrayal and treatment of individuals experiencing homelessness.

This report is meant to shed light on the complex set of issues that surround the intersection of mental health, substance use and homelessness. We do this by combining the perspectives, knowledge and experiences of many practitioners and experts in the field, including members of service delivery organizations, government agencies and academic institutions. As such, here are a few things for you to note as the reader of this report:

- Language use will vary based on the organizational and individual perspective or training of each author. For example, some authors prefer to refer to people with mental health issues while others call it mental illness or some authors may use Native American, while others use American Indian.
- Authors may use data and statistics from the same source but refer to different subsets of a population, for example, African Americans, Native Americans, or veterans. Because some information is only available in certain years, authors may use older data to communicate specific points. This can result in the numbers varying slightly for similar events in different chapters.

9 William N. Evans et al., “The Impact of Homelessness Prevention Programs on Homelessness,” *Science*, vol. 353, no. 6300, 2016: 694–99, <https://doi.org/10.1126/science.aag0833>.

10 Daniel Flaming, Halil Toros, and Patrick Burns, “Home Not Found: The Cost of Homelessness in Silicon Valley,” *Economic Roundtable*, 2015, https://destinationhomesv.org/wp-content/uploads/2021/01/er_homenotfound_report_6.pdf.

11 Thomas Chalmers McLaughlin, “Using Common Themes: Cost-Effectiveness of Permanent Supported Housing for People with Mental Illness,” *Research on Social Work Practice* 21, no. 4, 2011: 404–411, <https://journals.sagepub.com/doi/10.1177/1049731510387307>.

12 David Cloud and Chelsea Davis, “Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications,” *Vera Institute of Justice*, 2013, <https://www.vera.org/publications/treatment-alternatives-to-incarceration-for-people-with-mental-health-needs-in-the-criminal-justice-system-the-cost-savings-implications>.

13 “Comparing the Costs of Jail Incarceration and Stabilizing Services for Homeless Mentally Ill Individuals,” *County of Santa Barbara*, 2011, <https://santabarbara.legistar.com/gateway.aspx?M=F&ID=05bf1da9-a734-43e0-93fd-54ca33867e77.pdf&From=Granicus>.

- While we have tried to make this report as Arizona-specific as possible, covering urban and rural areas, sometimes only national data is available and hence reported. Similarly, on some issues, the only localized numbers accessible are those from Maricopa County. We have tried to be clear about where data is coming from, and we encourage you to consider this while reading the report.
- Be mindful of the organizational position an author is writing from. While all chapters are fact-checked and present the best available information, the world looks different from the viewpoint of a mental health practitioner than from the viewpoint of a director of a government agency.
- We have encouraged authors to include experiential knowledge from their lived experience because this is not only valuable but, in many cases, the only information available. This means chapters may include both statements backed by academic research and statements starting with “in my experience.”

As the editors of this report, our job was to compile the chapters that were guest-authored by experts into a digestible and nuanced whole that contextualizes and explains this complex topic. This report is not meant to advocate for services for one group over another or to champion one voice, perspective or approach as “best” – rather, through the voices of community experts and inclusion of relevant research, it seeks to provide a factual and comprehensive snapshot of the scope and intersecting complexities surrounding mental health, substance use and homelessness, as well as to highlight service delivery options for individuals at this intersection in Arizona.

We begin by presenting a background chapter that provides an overview of mental illness, substance use and homelessness, outlining information on their scope and interconnectedness. The next chapter uses the analogy of a “Revolving Door” to illustrate how these complex issues interact with safety and emergency services, often resulting in people cycling through social services, incarceration and homelessness. Chapter 4 explains how Arizona’s Medicaid program has integrated physical and behavioral health services. Chapters 5 and 6 highlight treatment approaches and interventions for mental illness and substance use, respectively. Chapter 7’s authors explain how the behavior of people experiencing homelessness, mental illness and/or substance use is over-criminalized, leading to legal issues and ineffective or no treatment for many. Chapter 8 focuses on the toll homelessness exacts from individuals, families and the larger public. Chapter 9 explains the larger structural causes behind homelessness, including poverty, inequality and discrimination. Chapter 10 dives into the various government agencies that are involved at the intersection of mental health, substance use and homelessness. Chapter 11 discusses general principles of approaching interventions, including Client-Centered Care and Housing First. In Chapter 12, the authors discuss approaches and initiatives related to housing. Chapter 13 addresses how to re-connect individuals who were formerly unhoused to the community and employment. Chapter 14 showcases how community navigators can help clients navigate the complex landscape of available services. Chapter 15 illuminates how the exchange of health records can improve care for people at the intersection of mental illness, substance use and homelessness.

Recognizing that not all individuals and communities are equally impacted by these issues, the 10 chapters that conclude this report detail the disproportionate impacts of homelessness, mental illness and substance use among certain subpopulations. Specifically, these chapters allow a more in-depth view of the unique challenges experienced by African American communities; Hispanic/Latino communities; formerly incarcerated individuals; youths and young adults, including the LGBTQ population; rural communities; Native American persons in rural areas; Native American persons in urban areas; seniors; the veteran community; and individuals experiencing domestic violence/sexual violence/intimate partner violence.

CHAPTER 2 — BACKGROUND

Morrison Institute for Public Policy

Acronyms in this Chapter

- AHCCCS—Arizona Health Care Cost Containment System
- CoC—Continuum of Care
- DSM—Diagnostic and Statistical Manual
- HUD—U.S. Department of Housing and Urban Development
- NCES—National Center for Education Statistics
- PIT—Point-in-Time Count
- SMI—Serious Mental Illness
- SUD—Substance Use Disorder

DEFINING THE ISSUES

Mental Health Disorders

Generally, someone is considered to have a mental illness, mental disorder or mental health issue—these terms will be used interchangeably throughout the text—if they have been diagnosed by a licensed medical or mental health professional. To do so, practitioners rely on criteria for specific diagnoses that are laid out by the Diagnostic and Statistical Manual (DSM), a document published and regularly updated by the American Psychiatric Association.¹⁴ The DSM considers individuals to have a mental disorder when they have some kind of biological or psychological dysfunction that results in a disturbance in thinking, emotion or behavior. Additionally, they must experience significant subjective distress or impairment in social, occupational or other important activities. High-quality surveys usually define “Any Mental Illness” as having been diagnosed with any condition included in the DSM after a clinical interview.¹⁵

A subset of individuals with mental health issues are those with serious mental illness (SMI). SMI is “a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.”¹⁶ Serious functional impairment is most commonly caused by schizophrenia, severe major depression or bipolar disorder. Examples of serious functional impairment include problems with basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family or occupational realms.

14 “Diagnostic and Statistical Manual of Mental Disorders (DSM-5®),” American Psychiatric Association, 2013, <https://doi.org/10.1176/appi.books.9780890425596>.

15 “Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2019 National Survey on Drug Use and Health,” Substance Abuse and Mental Health Services Administration, 2020, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-07-01-001-PDF.pdf.

16 “Mental Illness,” National Institute of Mental Health, 2021, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>.

Despite efforts to raise awareness and make treatment more accessible, a stigma around mental health issues persists. Many people, including psychiatrists, view individuals with mental illnesses in a negative light, often attributing danger or blame to them. Sufferers can internalize these negative appraisals, leading them to eschew treatment and the support they need.¹⁷ This stigma is misplaced and counterproductive. The majority of people with SMI are not violent or dangerous.¹⁸ At the same time, they are slightly more likely to be violent than the general population; however, in these cases, an SMI diagnosis often coincides with other risk factors for violence like a history of childhood abuse, recent violent victimization or substance use.¹⁹ Some experts argue that treating “mental illness like any other medical illness” has helped reduce stigma.²⁰ However, others think that the reality of mental illness is not only more complicated, but also that questions of politics and power deserve more attention. For instance, as we will see later, poverty and discrimination are some of the largest catalysts of mental health issues.²¹

Substance Use Disorder

Substance Use Disorder (SUD), often referred to as addiction, is another common form of mental illness included in the DSM. SUD occurs when an individual continues using drugs (e.g., alcohol, cocaine, opiates) despite the use causing significant harm to them. People with SUD have an intense focus on obtaining and using certain drugs, despite being aware that the drugs impair their ability to function in daily life. Persistent substance use can lead to changes in brain biology that are often very hard to reverse.²²

Addiction was once largely viewed as a moral failing or character flaw, weak people making bad choices, but is now widely understood by the scientific community to be a chronic illness that is largely outside of an individual's control and difficult to cure.²³ While defining SUD as a disease has been controversial²⁴, researchers describe it as a neuropsychological dysfunction with numerous contributing factors, including a person's genetics, age of first use, psychological factors connected to a person's unique history and personality, as well as environmental factors, such as the availability of drugs, family and social support, financial resources, cultural norms, and exposure to stress.²⁵ This means, treatment logically involves modifying physiological and environmental factors, in addition to a person's own best efforts. As a result of these scientific insights, most countries (at least officially) see punishing individuals suffering from SUD as unethical and inhumane and prefer to treat addiction as a public health issue, which is also more cost-effective.²⁶

17 Wulf Rössler, “The Stigma of Mental Disorders,” *EMBO Reports* 17, no. 9, September 2016: 1250–53, <https://doi.org/10.15252/embr.201643041>.

18 Richard Van Dorn, Jan Volavka, and Norman Johnson, “Mental Disorder and Violence: Is There a Relationship Beyond Substance Use?,” *Social Psychiatry and Psychiatric Epidemiology* 47, no. 3, March 1, 2012: 487–503, <https://doi.org/10.1007/s00127-011-0356-x>.

19 Eric B. Elbogen, Paul A. Dennis, and Sally C. Johnson, “Beyond Mental Illness: Targeting Stronger and More Direct Pathways to Violence,” *Clinical Psychological Science* 4, no. 5, September 1, 2016: 747–59, <https://doi.org/10.1177/2167702615619363>.

20 Ashok Malla, Ridha Joobar, and Amparo Garcia, “‘Mental Illness Is like Any Other Medical Illness’: A Critical Examination of the Statement and Its Impact on Patient Care and Society,” *Journal of Psychiatry & Neuroscience* 40, no. 3, May 2015: 147–50, <https://doi.org/10.1503/jpn.150099>.

21 Felicity Thomas et al., “Moral Narratives and Mental Health: Rethinking Understandings of Distress and Healthcare Support in Contexts of Austerity and Welfare Reform,” *Palgrave Communications* 4, no. 1, April 10, 2018: 1–8, <https://doi.org/10.1057/s41599-018-0091-y>.

22 Markus Heilig et al., “Addiction as a Brain Disease Revised: Why It Still Matters, and the Need for Consilience,” *Neuropsychopharmacology* 46, no. 10, September 2021: 1715–23, <https://doi.org/10.1038/s41386-020-00950-y>.

23 Neil Levy, “Addiction Is Not a Brain Disease (and It Matters),” *Frontiers in Psychiatry* 4, 2013, <https://www.frontiersin.org/article/10.3389/fpsy.2013.00024>.

24 Nick Heather, “Q: Is Addiction a Brain Disease or a Moral Failing? A: Neither,” *Neuroethics* 10, no. 1, 2017: 115–24, <https://doi.org/10.1007/s12152-016-9289-0>.

25 “Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health,” Office of the Surgeon General, U.S. Department of Health and Human Services, 2016, <https://www.ncbi.nlm.nih.gov/books/NBK424849/>.

26 Nora D. Volkow et al., “Drug Use Disorders: Impact of a Public Health Rather than a Criminal Justice Approach,” *World Psychiatry* 16, no. 2, June 2017: 213–14, <https://doi.org/10.1002/wps.20428>.

Comorbidity of Substance Use and Other Mental Health Disorders

Many individuals with a substance use disorder also have a mental health disorder (40%) and vice versa (18%).²⁷ While the relationship between these issues is complex and case-specific, researchers consider three factors to be the most important:

- Mental health disorders increase vulnerability to substance use, especially because drugs can often lead to temporary symptom relief.
- Sustained substance use can trigger or exacerbate mental disorders, for instance, by making it harder to process trauma or creating social isolation.
- Substance use and other mental health disorders can be caused by similar conditions, like genetic factors or traumatic and stressful life experiences.²⁸

Dual diagnosis is challenging because symptoms overlap, so one disorder is easily mistaken for another. For instance, mood disturbances can be caused by drug use or may be a condition in its own right. Regardless, co-occurring disorders requires simultaneous or integrated treatment because they are often more severe and recovery is more complicated.²⁹ Integrated treatment usually includes not only therapy and medication but also social workers that can coordinate help on issues of housing, legal problems, and physical health.³⁰ Unfortunately, the treatment systems for mental illness and substance use (as well as health insurance coverage) have traditionally been separated. For instance, one study found that only 18% of addiction treatment programs and 9% of mental health programs were capable of treating dual diagnosis patients.³¹ Patients can find themselves in a referral loop between different providers without receiving appropriate treatment. Some substance use treatment programs may prohibit the use of prescription drugs necessary for a mental illness. All of this translates into a lack of effective treatment in this population because it is difficult to see relief in one condition when the other remains unaddressed.³²

27 Beth Han et al., "Prevalence, Treatment, and Unmet Treatment Needs of U.S. Adults with Mental Health and Substance Use Disorders," *Health Affairs (Project Hope)* 36, no. 10, October 1, 2017: 1739–47, <https://doi.org/10.1377/hlthaff.2017.0584>.

28 "Common Comorbidities with Substance Use Disorders Research Report," National Institute on Drug Abuse, 2020, <https://www.drugabuse.gov/download/1155/common-comorbidities-substance-use-disorders-research-report.pdf?v=5d6a5983e0e9353d46d01767fb20354b>.

29 Thomas M. Kelly and Dennis C. Daley, "Integrated Treatment of Substance Use and Psychiatric Disorders," *Social Work in Public Health* 28, 2013: 388–406, <https://doi.org/10.1080/19371918.2013.774673>.

30 Kelly, "Integrated Treatment of Substance Use."

31 Mark P. McGovern et al., "Dual Diagnosis Capability in Mental Health and Addiction Treatment Services: An Assessment of Programs across Multiple State Systems," *Administration and Policy in Mental Health* 41, no. 2, 2014, <https://doi.org/10.1007/s10488-012-0449-1>.

32 "Substance Use Disorder Treatment for People With Co-Occurring Disorders," Substance Abuse and Mental Health Services Administration, 2020, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf.

Homelessness

Mental health and substance use issues have a complex relationship with homelessness (see section titled Defining the Cycle). The U.S. Department of Housing and Urban Development defines homelessness as when an individual lacks fixed, regular and adequate nighttime residence, (i.e., those who are living in a shelter, or spending nights in cars, parks, streets or public buildings).³³ An individual is considered chronically homeless when they have a disability—physical, mental, or emotional impairment—and either have been homeless for at least 12 months or have been homeless at least 4 times within the last 3 years, adding up to at least 12 months.³⁴

Surveys of people experiencing homelessness are usually conducted in one night annually by volunteers (Point-in-Time Count). However, these official definitions and measures understate the issue of homelessness. In addition to those who are not counted, many live in sub-standard housing, crowded conditions, or are doubling up with families or friends ('marginally housed').³⁵ Others are spending more than 50% of their household income on rent, are behind in rent payments, have difficulty with rent payments or are forced to move frequently ('housing instability'). Therefore, it might be best to think of the issue on a spectrum of housing insecurity that starts with high rent burdens and ends in people living on the streets (see Figure 1).

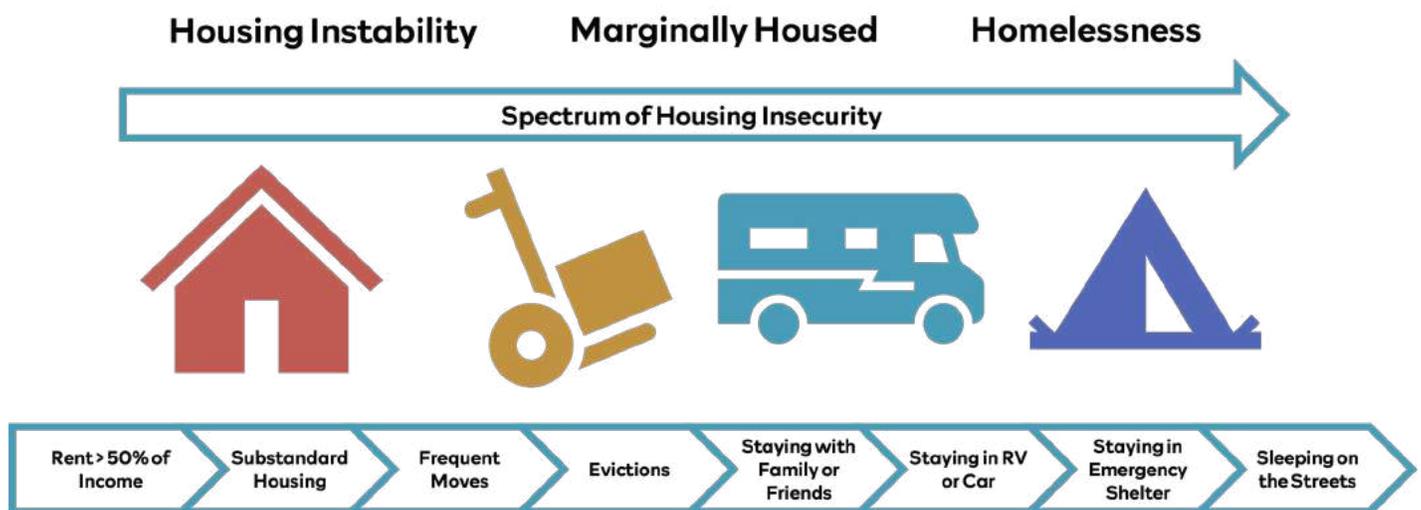


Figure 1. Spectrum of housing insecurity.

33 Homeless Definition," U.S. Department of Housing and Urban Development, 2011, https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf.

34 "Part 91 - Consolidated Submissions for Community Planning and Development Program" Code of Federal Regulations, title 24, vol. 1 (2021): 486-535, <https://www.govinfo.gov/content/pkg/CFR-2021-title24-vol1/pdf/CFR-2021-title24-vol1.pdf>; "Part 578 - Continuum of Care Program," Code of Federal Regulations, title 24, vol. 3 (2021): 219-67, <https://www.govinfo.gov/content/pkg/CFR-2021-title24-vol3/pdf/CFR-2021-title24-vol3.pdf>.

35 Joseph Murphy and Kerri Tobin, Homelessness Comes to School, (Thousand Oaks, California: Corwin Press, 2011), <https://doi.org/10.4135/9781452275314>.

DEFINING THE CYCLE

Mental illness, substance use, and homelessness often exist in a vicious cycle, where one contributes to the other, making escape near impossible.³⁶ An individual's mental illness, especially a serious mental illness, can make it hard to earn a stable income and carry out daily activities, leading to difficulties maintaining housing. Developing a SUD is often an important mediator that puts an individual further at risk of homelessness, for instance, by causing social isolation.³⁷ Risky alcohol use and illicit drug use are found to cause homelessness in some studies but not others.^{38 39} However, the relationship between mental illness and homelessness is correlational and not causal in nature. In other words, although many individuals experiencing homelessness have a mental illness, the illness itself is not necessarily the cause of them becoming unhoused. Instead, it is a lack of access to treatment, supporting resources and affordable housing—in short, poverty—that intervene to produce homelessness.⁴⁰ Because of that, people with a history of poverty, adverse childhood experiences, social disadvantage, lower levels of education and a history of being discriminated against are more likely to become homeless when experiencing a mental illness, including SUD.⁴¹ However, they are also more likely to experience homelessness in the absence of mental illness.

Homelessness itself, and related experiences (e.g., victimization, criminal justice interactions), are often a traumatic experience that can trigger or exacerbate mental illness.⁴² At the same time, mental illness precludes individuals from accessing resources (e.g., regular employment) that would allow them to avoid or escape homelessness. Among the unhoused community, substance use is very common, which makes it harder to access shelter or housing because many services require sobriety. It is commonly assumed that homelessness contributes to substance use, either as a coping mechanism or an adaptation to a subculture of substance use on the streets. However, evidence on this relationship is mixed, with more robust studies suggesting that other factors, such as poverty or adverse childhood experiences, may cause both homelessness and substance use.^{43 44 45 46}

36 Lilanthe Balasuriya, Eliza Buelt, and Jack Tsai, "The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality," *Psychiatric Times* 37, no. 5, 2020, <https://www.psychiatristimes.com/view/never-ending-loop-homelessness-psychiatric-disorder-and-mortality>.

37 Andrew M. Fox et al., "Untangling the Relationship Between Mental Health and Homelessness among a Sample of Arrestees," *Crime & Delinquency* 62, no. 5, May 1, 2016: 592–613, <https://doi.org/10.1177/001128713511571>.

38 Dirk W. Early, "An Empirical Investigation of the Determinants of Street Homelessness," *Journal of Housing Economics* 14, no. 1, 2005: 27–47, <https://doi.org/10.1016/j.jhe.2005.03.001>.

39 Duncan McVicar, Julie Moschion, and Jan C. van Ours, "From Substance Use to Homelessness or Vice Versa?," *Social Science & Medicine* 136–137, July 1, 2015: 89–98, <https://doi.org/10.1016/j.socscimed.2015.05.005>.

40 Glen Bramley and Suzanne Fitzpatrick, "Homelessness in the U.K.: Who Is Most at Risk?," *Housing Studies* 33, no. 1, January 2, 2018: 96–116, <https://doi.org/10.1080/02673037.2017.1344957>.

41 Sandra Feodor Nilsson, Merete Nordentoft, and Carsten Hjorthøj, "Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: A Systematic Review and Meta-Analysis," *Journal of Urban Health* 96, no. 5, October 1, 2019: 741–50, <https://doi.org/10.1007/s11524-019-00377-x>.

42 Ankur Singh et al., "Housing Disadvantage and Poor Mental Health: A Systematic Review," *American Journal of Preventive Medicine* 57, no. 2, August 1, 2019: 262–72, <https://doi.org/10.1016/j.amepre.2019.03.018>.

43 Marybeth Shinn et al., "Predictors of Homelessness among Families in New York City: From Shelter Request to Housing Stability," *American Journal of Public Health* 88, no. 11, 1998, 1651–57, <https://doi.org/10.2105/AJPH.88.11.1651>.

44 Timothy P. Johnson et al., "Substance Abuse and Homelessness: Social Selection or Social Adaptation?," *Addiction* 92, no. 4, 1997: 437–45, <https://doi.org/10.1111/j.1360-0443.1997.tb03375.x>.

45 Guy Johnson and Chris Chamberlain, "Homelessness and Substance Abuse: Which Comes First?," *Australian Social Work* 61, no. 4, 2008: 342–56, <https://doi.org/10.1080/03124070802428191>.

46 McVicar, "From Substance Use to Homelessness."

This cycle is reinforced by several other factors. People experiencing homelessness struggle daily to procure access to adequate nutrition, water, bathrooms and shelter, which take priority over long-term needs, like psychiatric care. Homelessness often leads to deteriorating physical health, especially when individuals suffer from chronic conditions like heart disease or diabetes, which themselves can contribute to homelessness, that require long-term treatment.⁴⁷ Experiencing homelessness increases people's interactions with the criminal justice system. Homeless people are much more likely to be arrested for minor offenses than housed people, including loitering, camping, drug use and subsistence theft.⁴⁸ A history of arrests and convictions, in turn, makes it difficult to procure housing and employment.⁴⁹ As a result, chronically homeless people cycle through jails, emergency rooms, hospitals, shelters and the streets, often causing extreme suffering and high public costs.⁵⁰ Thus, any successful policy intervention must break two cycles: First, the mutually reinforcing relationship of deteriorating mental health, substance use and homelessness; and second, the loop between hospitals, jails and the streets for those who are experiencing homelessness.

47 Amanda Stafford and Lisa Wood, "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants," *International Journal of Environmental Research and Public Health* 14, no. 12, December 2017: 1535, <https://doi.org/10.3390/ijerph14121535>.

48 Janey Rountree, Nathan Hess, and Austin Lyke, "Health Conditions Among Unsheltered Adults in the U.S.," California Policy Lab, 2019, <https://www.capolitylab.org/health-conditions-among-unsheltered-adults-in-the-u-s/>.

49 Lucius Couloute, "Nowhere to Go: Homelessness Among Formerly Incarcerated People," Prison Policy Initiative, August 2018, <https://www.prisonpolicy.org/reports/housing.html>.

50 Julia C. Bausch, Alison Cook-Davis and Benedikt Springer, "Housing is Health Care: The Impact of Supportive Housing on the Costs of Chronic Mental Illness," Morrison Institute for Public Policy, 2021, https://morrisoninstitute.asu.edu/sites/default/files/housing_is_health_care_report_2021.pdf.

DEFINING THE SCOPE

Nationally, 20.6% of adults had a mental illness in 2019. 5.2% had serious mental illness.⁵¹ 7.7% of adults had a substance use disorder in the past year, 3.8% of adults had a co-occurring mental illness and SUD, and 1.4% of adults had a co-occurring serious mental illness and SUD (see Figure 2).

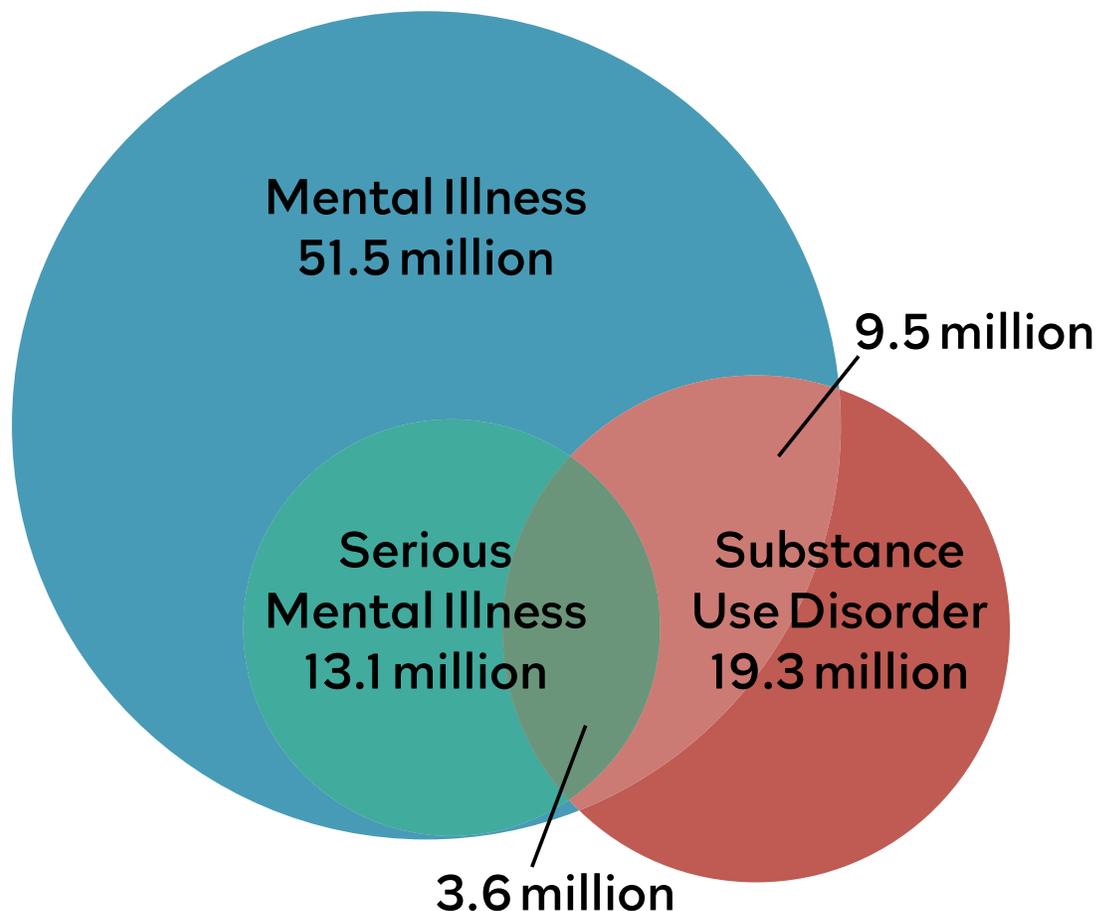


Figure 2. Overlap between homelessness, mental illness, substance use among adults in the U.S. in 2019. The total U.S. population is 332 million and about 580,000 people are experiencing homelessness nationwide.⁵²

In Arizona, 20.1% of adults had a mental illness in 2019, 5.6% had a serious mental illness, and 7.1% had a SUD, slightly above the national average (see Figure 3).⁵³

51 "Results from the 2019 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

52 "Results from the 2019 National Survey on Drug Use and Health."

53 "NSDUH State-Specific Tables," Substance Abuse and Mental Health Services Administration, 2020, <https://www.samhsa.gov/data/report/2018-2019-nsduh-state-specific-tables>.

Mental Illness and Substance Use Disorder Arizona, 2019 (in Millions)

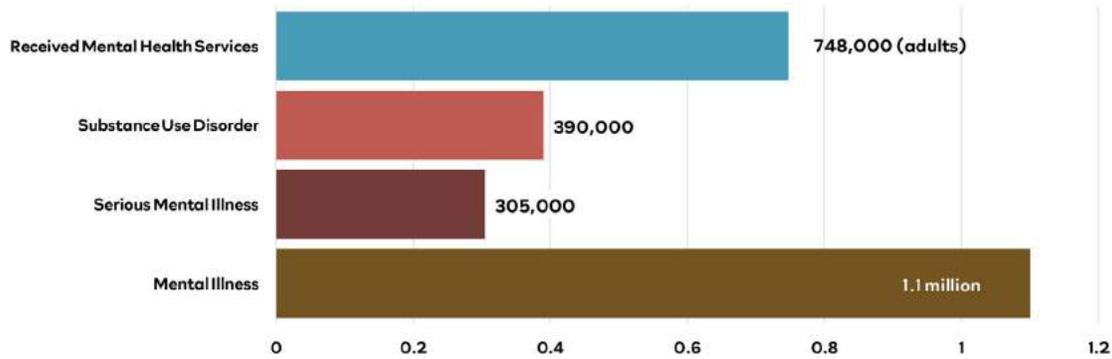


Figure 3. Mental illness and substance use disorder among adults, Arizona 2019.⁵⁴

According to the 2020 Point-in-Time Count, there were 580,000 people experiencing homelessness in the U.S. (0.2% of the population). Of the individuals experiencing homelessness, 120,000 were classified as chronically homeless, 121,000 were classified as being severely mentally ill, and 99,000 were classified as having substance use disorder.⁵⁵

Around 20% lived in rural areas. About 55% were counted in emergency shelters and transitional housing facilities. Mental illness, substance use, and homelessness often occur together. While not available in the PIT Count, data from the last 5–15 years shows a high prevalence of co-occurring disorders among those experiencing homelessness in the U.S., with percentages ranging from 26%–37% across studies.^{56 57}

It is important to note that these numbers are likely lower than the actual count of those experiencing homelessness since the survey is only conducted one night of the year, mostly by volunteers. In 2018, the Department of Housing and Urban Development conducted a survey of Continuum of Care (CoC) across the U.S. and found that there were approximately 1.45 million individuals experiencing sheltered homelessness within one year (those staying in emergency shelters, safe havens or transitional housing programs).⁵⁸ Combining this ratio with that of unsheltered individuals from the Point-in-Time Count leads to a theoretical 2.2 million adults experiencing homelessness nationally (0.67% of the population). The National Center for Education Statistics (NCES) counted 1.5 million children experiencing homelessness who were enrolled in public schools from 2017–2018.⁵⁹ Even with a conservative estimate of one parent per two children, this would increase the estimate of the homeless population 4-fold. At the same time, NCES counts people living doubled up, staying with family or in motels, all of which are excluded from the Point-in-Time Count, either by definition or practice.

54 "NSDUH State-Specific Tables."

55 "Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations," U.S. Department of Housing and Urban Development, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2020.pdf.

56 Carole C. Upshur et al., "Prevalence and Predictors of Substance Use Disorders among Homeless Women Seeking Primary Care: An 11 Site Survey," *The American Journal on Addictions* 26, no. 7, 2017: 680–88, <https://doi.org/10.1111/ajad.12582>.

57 Kele Ding, Matthew Slate, and Jingzhen Yang, "History of Co-Occurring Disorders and Current Mental Health Status among Homeless Veterans," *BMC Public Health* 18, no. 1, 2018: 751, <https://doi.org/10.1186/s12889-018-5700-6>.

58 "The 2018 Annual Homeless Assessment Report (AHAR) to Congress," U.S. Department of Housing and Urban Development, 2019, <https://www.huduser.gov/portal/sites/default/files/pdf/2018-AHAR-Part-2.pdf>.

59 "Federal Data Summary School Years 2015–16 Through 2012–18," National Center of Homeless Education, 2020, <https://nche.ed.gov/wp-content/uploads/2020/01/Federal-Data-Summary-SY-15.16-to-17.18-Published-1.30.2020.pdf>.

Figure 4 shows homelessness in Arizona according to the Point-in-Time Count, 10,979 individuals in 2020. This is an undercount. A report by the Arizona Department of Economic Security counted 63,000 people served by CoCs in 2019.⁶⁰ This is more than the population of Queen Creek or 0.87% of Arizona’s population. Public schools in Arizona enrolled 21,100 children experiencing homelessness in the school year 2018–2019.⁶¹ Most of them stay with someone who is not their parent (i.e., they are counted as “doubled up”). 12% of youth experiencing homelessness live in shelters or transitional housing, 9% live in hotels and motels, 3% live on the streets, and 2% are unaccompanied.

Figure 4. Homelessness in Arizona, Point-in-Time Count. shows selected characteristics of the homeless population in 2020. Figure 6 shows race, ethnicity and gender of the unhoused population.

Homelessness, especially when combined with mental health and substance use issues, has impacts beyond the individuals directly involved (see Chapter 8 – The Human and Financial Toll). It affects family and friends. In causes threats to public health, public safety and breaks down community life. Lastly, it causes huge public costs that can be avoided through prevention.⁶²

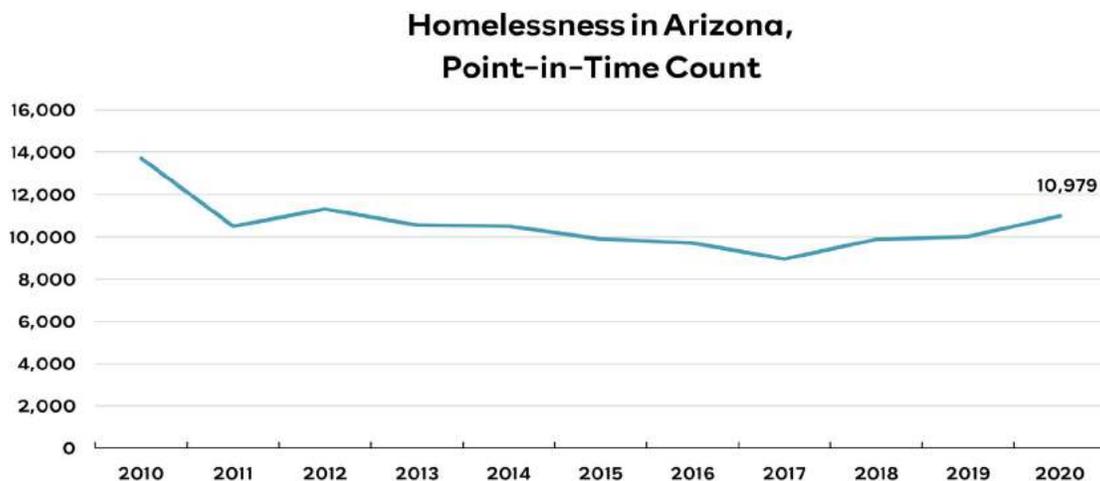


Figure 4. Homelessness in Arizona, Point-in-Time Count.⁶³

60 "Homelessness in Arizona, Annual Report," Arizona Department of Economic Security, 2019, <https://des.az.gov/sites/default/files/dl/Homelessness-Annual-Report-2019.pdf?time=1607644800091>.

61 "Consolidated State Performance Report, Part 1. Arizona," National Center of Homeless Education, 2020, <https://www.azed.gov/sites/default/files/2020/12/AZ-CSPR%20MVONLY%20SY%202018-19%20.pdf>.

62 Sarah B. Hunter, Melody Harvey, Brian Briscoe, and Matthew Cefalu, "Evaluation of Housing for Health. Permanent Supportive Housing Program," RAND Corporation, 2017, https://www.rand.org/pubs/research_reports/RR1694.html.

63 "Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations – Arizona," U.S. Department of Housing and Urban Development, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_State_AZ_2020.pdf.

Selected Characteristics from Point-in-Time Count, Arizona, 2020

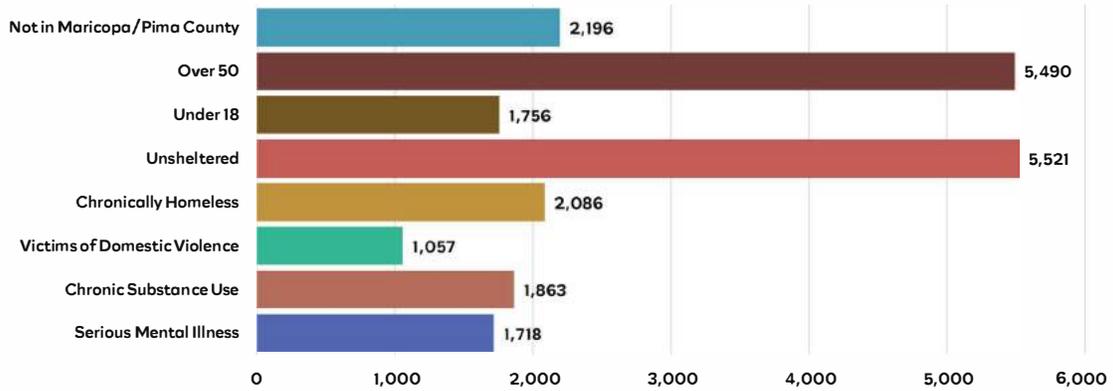


Figure 5. Selected characteristics from Point-in-Time Count, Arizona 2020.⁶⁴

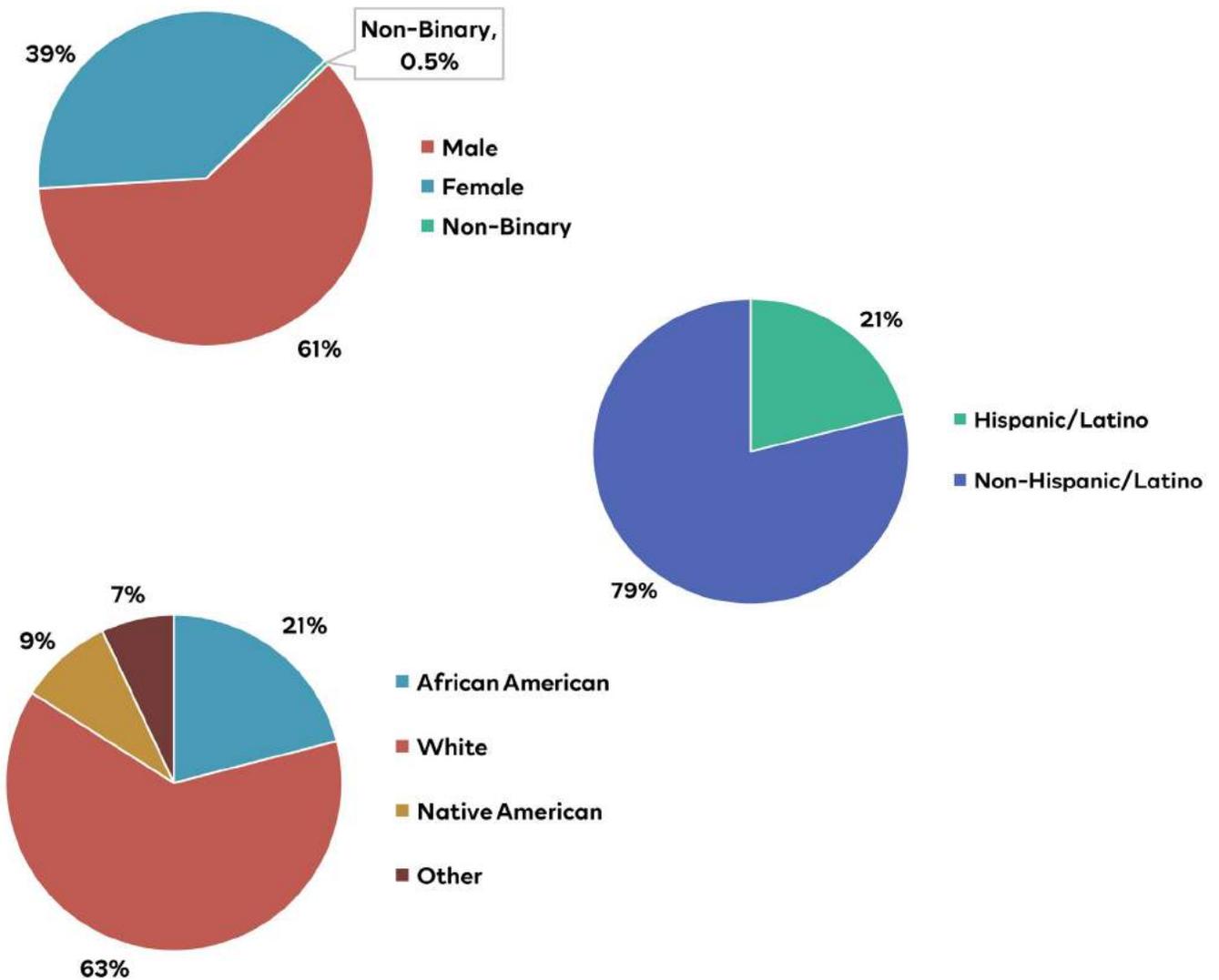


Figure 6. Selected characteristics from Point-in-Time Count, Arizona 2020.⁶⁵

64 "Continuum of Care Homeless Assistance Programs."

65 "Continuum of Care Homeless Assistance Programs."

HOUSING INTERVENTIONS

Throughout the report, authors mention and describe various housing interventions designed to help people become or stay housed. Table 1 provides a brief overview of those interventions.

Table 1. Housing interventions.

Type	Duration	Description
Emergency Shelter	Temporary respite (often open only at night)	Varying levels of support services and costs.
Transitional Housing	Up to 2 years	Site-based location that provides wrap-around services to help individuals achieve self-sufficiency by the end of tenancy.
Rapid Re-housing (RRH)	Up to 2 years	Housing provider assists in finding an apartment, paying the deposits, and rent for the first few months. Support services to achieve self-sufficiency at the end of rental assistance.
Permanent Supportive Housing (PSH) or Permanent Housing (PH)	Long-term	Various models include support services to manage serious mental illness, substance use and/or disability. Individuals must contribute 30% of their income. Assistance can be project-based, or individuals might rent from private landlords.
Rental Assistance ('Vouchers')	Long-term	Various programs, importantly federal Housing Choice Vouchers (Section 8), assist low-income individuals with rent. Individuals must contribute 30% of their income. Assistance can be project-based, or individuals might rent from private landlords. Vouchers can also be a funding source in other housing interventions.
Affordable Housing	Long-term	Typically, houses or apartment buildings constructed with federal or state subsidies. Rent is restricted and tenants need to have incomes below 60% to 30% of the area median income. Older buildings are sometimes called 'naturally affordable' when low-income tenants pay less than 30% of their income on rent without government intervention.

MENTAL HEALTH AND SUBSTANCE USE TREATMENT MODALITIES

Throughout the report, authors mention and describe a continuum of treatment modalities for mental health and substance use issues. Table 2 provides a brief overview of those interventions.

Table 2. Mental health and substance use treatment modalities.

Type	Description
Assertive Community Treatment (ACT)	Comprehensive 24/7 services to individuals with serious mental illness and substance use issues delivered at their home/community. Combines treatment with social, educational and employment-related support services.
Critical Time Intervention (CTI)	Time-limited case management model to assist individuals with serious mental illness with transitioning out of a hospital, shelter, prison, or other institution. Based on providing the client with emotional and practical support while helping them strengthen ties to community supports and resources.
Residential Treatment Services ('Rehab')	Residential substance use and/or mental health treatment, short term (30-90 days) or long term (6-12 months).
Secure Treatment Facility	Serves individuals who need 24/7 close supervision, otherwise similar to residential treatment. More like a home than a hospital, but entry and exit are restricted.
Detoxification Facility	Provides medical supervision for individuals going through substance withdrawal.
Crisis Residential Treatment Programs	Provide short-term, intensive and supportive services in a home-like environment. Can be secure/non-secure.
Mobile Crisis Team	Group of health professionals responding to mental health crises in the community/on the streets. Prevent situations from escalating and can refer people to further treatment or other services.
Motivational Interviewing (MI)	Person-centered strategy used to elicit patient motivation to change a specific negative behavior. MI engages clients, elicits change and evokes patient motivation to make positive changes.
Psychiatric Urgent Care/ Crisis Stabilization Units	Alternative to emergency room for acute mental health crisis. Treatment up to a few days.
23-Hour Crisis Stabilization	Inpatient assessment and interventions. Can last up to 23 hours until patient is discharged, or appropriate level of care is determined.
Psychiatric Hospital	Intensive inpatient treatment for serious mental illness.
Partial Hospitalization Program (PHP)	Step down from 24-hour psychiatric care. Substance use and/or mental health treatment Monday through Friday for extended hours. Individuals return home each night
Intensive Outpatient Program (IOP)	Substance use and/or mental health treatment multiple times a week over an extended period of time (minimum 3 hours/day, 3 times/week).
Outpatient Treatment Services ('Therapy')	Treatment for mental illness and/or substance use disorder. Individual or group-based counseling. Often 1 time per week but can vary based on the individual.
Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT)	Tool that helps identify who should be recommended for each housing and support intervention. Moving the discussion from who is eligible to who is in greatest need of the intervention.

In the following, we highlight two more issues that are important in understanding the challenges at the intersection of homelessness, mental health, and substance use: First, the Fair Housing Act, both in how it protects and fails to protect individuals from housing discrimination; and second, the Arizona statutes contained in Title 36, which regulate involuntary mental health treatment.

FAIR HOUSING ACT

The Fair Housing Act of 1968, often called Title VIII, was part of 1960s civil rights legislation intended to end housing discrimination and segregation. The act prohibits discrimination in the sale, rental, and financing of housing on the basis of race, color, national origin, religion, sex, familial status and disability (some of these classes were added later). The act is enforced by the U.S. Department of Housing and Urban Development (HUD) and its local partner agencies, in Arizona the Attorney General's Office, and the Equal Opportunity Department of the City of Phoenix. Enforcement relies solely on a complaint-driven process. An individual experiencing housing discrimination can file a complaint with HUD. HUD or a partner agency investigates the complaint and, if it finds sufficient evidence, can offer mediation, levy penalties or take the defendant to court. Alternatively, individuals can sue directly in state or federal court. The Fair Housing Act has not lived up to its promise. The compliance process is often too lengthy to provide relief to individuals, and the penalties for landlords are too low for effective deterrence. Furthermore, approaches based on individual action have proven unsuccessful in remedying structural inequalities that exist in the housing market. As a result, the U.S. remains nearly as segregated as it was when the original bill was passed.⁶⁶ Residential segregation continues to distribute opportunities unequally.

TITLE 36 (STATUTE FOR COURT ORDERED TREATMENT)

Most mental health treatment is sought out on a voluntary basis. However, all states, including Arizona, have a procedure that leads to involuntary inpatient and/or outpatient treatment. Title 36, Chapter 5 of the Arizona Revised Statutes regulates civil treatment orders in Arizona. A treatment order is the legal authority to provide a person with psychiatric treatment, even against the person's will.

The process starts when an application for involuntary evaluation is filed. This may be filed by any adult and is often filed by law enforcement, mental health service providers, or crisis evaluators. This involuntary evaluation is reviewed by the Court and may last up to 72 hours. People who are involuntarily detained for evaluation are all appointed an attorney and have the opportunity for a hearing before a judge to request release.

After 72 hours, if a person remains symptomatic and involuntary for treatment, then a petition for court ordered treatment is filed and the person is transferred to a hospital and evaluated by two psychiatrists. If both psychiatrists conclude that the person meets the relevant criteria, then a hearing is scheduled within six business days before a judge. At the hearing, the judge must consider the psychiatrists' affidavits and also must hear testimony from two additional witnesses. To be placed on a court order for treatment, a person may be classified as seriously mentally ill and must not voluntarily recognize the need for treatment. Additionally, the court must find that the person is either a danger to themselves or others, be "persistently or acutely disabled," or have a grave disability that makes them incapable of caring for themselves. Finally, the court must conclude that there is no less restrictive alternative to court ordered treatment.

66 Nikole Hannah-Jones, "Living Apart: How the Government Betrayed a Landmark Civil Rights Law," ProPublica, 2015, <https://www.propublica.org/article/living-apart-how-the-government-betrayed-a-landmark-civil-rights-law?token=YVW5qJ0mfg-45Dmhi6RMKrQpGXfwxgh08>.

A judge can order inpatient treatment at a hospital, community-based outpatient treatment, or a combination. Most treatment orders are a combination of inpatient and outpatient. The outpatient clinics are responsible for providing case management services, including medication, during the time of the court order. Court-ordered treatment can last up to 365 days and includes a maximum number of inpatient days.

While substance use does not prevent a person from being evaluated for civil commitment, individuals with only a substance use disorder are excluded from involuntary treatment under Arizona law. People with substance use disorder who also have qualifying mental health diagnoses are eligible for court ordered treatment.

CHAPTER 3 — THE “REVOLVING DOOR”

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Acronyms in this Chapter

AHCCCS—Arizona Health Care Cost Containment System

BIPOC—Black, Indigenous, People of Color

FUSE—Frequent Users Services Enhancement

HIPAA—Health Insurance Portability and Accountability Act

SMI—Serious Mental Illness

The revolving door model is helpful in understanding how the issues of mental health, substance use, and homelessness intersect and interact with other safety nets and emergency services. An exploration of revolving doors can illustrate this intersection.

Skyscrapers are one of the most common places to find revolving doors. The design of these high-rise buildings allows for a large occupancy capacity in a small area of land. Another characteristic of this building design is they “are known to experience a lot of pressure, which is caused by air rushing through the building.”⁶⁷ This pressure can be problematic because it creates a draft throughout the building, resulting in difficulties with climate control, among other things. The invention of the revolving door in the late 1800s created functionality to the entrance design that addressed some of the issues inherent in the building’s design.

In addition to being aesthetically pleasing, revolving doors serve several primary functions. First, revolving doors are created to specifically ensure that the entrances are insulated from the outside and do not create a draft, so they mitigate the build-up of pressure in the structure. They also allow the climate in the building to be more easily regulated. Finally, revolving doors act as a way to control traffic in and out of the building: manual doors have less impact on the traffic flow than automatic doors, which can more readily control the flow of people in and out of the building. Further, some revolving doors are designed not only to control in-flow and out-flow for capacity reasons but also to limit access both into and out of buildings for security purposes.

Imagine that the topics of mental health and substance use are represented by separate high-rise buildings, with revolving doors on the front and back of each building (see Figure 7). The buildings or systems are situated so their back doors open to a shared courtyard, which is homelessness. There are other buildings that share access to this courtyard, such as hospitals, jails, prisons, emergency homeless shelters and psychiatric urgent care facilities. This courtyard can only be accessed through the buildings. While there are other pathways into homelessness, this chapter addresses the people stuck between the systems that are intended to help them. Populations in these conditions are most likely chronically homeless. It is estimated that 27% of unhoused people are homeless for a least a year and suffer from a serious mental illness or other debilitating condition.⁶⁸ The 2020 Point-in-Time Count classified 2,000 people in Arizona as being chronically unhoused.⁶⁹

67 “Revolving Doors: All You Need to Know,” Architecture Art Designs, accessed December 13, 2020, <https://www.architectureartdesigns.com/revolving-doors-all-you-need-to-know/>.

68 “Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations,” Housing and Urban Development, December 17, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2020.pdf.

69 “Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations – Arizona,” Housing and Urban Development, December 15, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_State_AZ_2020.pdf.



Figure 7. The "revolving door."

The need to control traffic flow from the street at the front entrances of these buildings is low because they are not highly desirable destinations. The design of the manual revolving door at the entrance is usually sufficient to address any inflow traffic concerns and allows for the systems to operate within their capacity.

Leaving these buildings is more difficult than entering them. The exits in the front and back are automatic revolving doors, with controlled access to limit who uses them. The people who are allowed to exit from the front of the building find themselves back in the community with access to all it has to offer. Unfortunately, people at the intersection of homelessness, mental health and substance use are often only given access to exit through the back doors, where they find themselves stranded in the courtyard of homelessness. These people are left with limited options: stay in the courtyard with no support or shelter, find their way in a back door of another building/system, or go back into the building they just came from. They have few options that lead to the outside community.

People who exit through the front door are placed in an environment where there are conditions in place that allow them to acquire and maintain housing. They are exiting homelessness. These conditions are connections to resources, systems and institutions—no one is housed without these. Being homeless is not a characteristic of someone—rather, it is the absence of the right conditions that allow a person to access the connections to resources and institutions that are required to be housed. In fact, relationships with landlords, employers and social service delivery systems have been identified as some of the predominant connections that have the greatest impact on people experiencing homelessness.⁷⁰ It follows that a pivotal component to ending homelessness is connections. These connections can be called social capital, which is defined as “the links, shared values and understandings in society that enable individuals and groups to trust each other and work together.”⁷¹ A front door exit allows people to experience the benefits of social capital. For example, a survey found that more people secure jobs through personal contacts than through advertisements.⁷² These types of connections are not available to people who exit through the back door.

The door through which a person might be allowed to exit is determined by policies, regulations and the individual life circumstances of each person. Policies and regulations impacting exiting are created both within each building (or system) and via external forces, such as governmental processes and other systems, such as the health care and insurance industries. Often, these rules have the best intentions and are meant to protect the safety of staff and clients. However, the result for people at the intersection of homelessness, mental health and substance use is often that institutions cannot help them, releasing them back into the courtyard of homelessness. For example, there does not seem to be any easily identifiable legislation governing hospitals, jails or mental health facilities that require these systems to ensure individuals are discharged or released into stable housing or even shelters. Alternatively, there is nothing prohibiting these institutions from releasing people into homelessness, so a hospital can discharge people into the streets with full knowledge that they do not have anywhere to go. This is evidenced through a report from an intake coordinator at the Human Services Campus: 19 people were dropped off at the downtown Phoenix campus from medical facilities between September 2018 and January 2019 without any coordination with the Human Services Campus staff.⁷³

Unfortunately, it is all too easy to exit back into the courtyard of homelessness. Systems, institutions and rules often fail people in need, leaving them with few options. This is illustrated by the following examples, based on real cases:

A person experiencing homelessness in need of opiate addiction treatment goes to a substance use treatment center. Before they can start treatment, they must detox. However, detox beds are limited, so the person has to wait until one opens up. However, when one opens up, a person in need of alcohol detox arrives. Alcohol withdrawal is life-threatening and must be medically managed; hence, this new arrival gets the bed. The person is released after 24 hours, without having received treatment, back into the courtyard of homelessness.

70 Michael L. Shier, Marion E. Jones, and John R. Graham, “Social Communities and Homelessness: A Broader Concept Analysis of Social Relationships and Homelessness,” *Journal of Human Behavior in the Social Environment* 21, no. 5, 2011: 455–474, <https://doi.org/10.1080/10911359.2011.566449>.

71 Brian Keeley, *Human Capital: How What You Know Shapes Your Life*, (OECD Publishing, 2007), 102, <https://doi.org/10.1787/9789264029095-en>.

72 Keeley, “Human Capital.”

73 R. L. Sanders, “A Good Samaritan found Martian with an Amputated Foot at a Bus Stop. Why Was He There?,” *AZCentral.com*, January 8, 2019, <https://www.azcentral.com/story/news/local/phoenix/2019/01/08/phoenix-hospitals-dumping-homeless-patients-martin-amputated-foot-health-care-medicare-medicaid/1861487002/>.

A person with an undiagnosed mental illness is experiencing homelessness. A street outreach team connects with them. Over a few months, the team develops enough trust with the person to convince them to undergo an evaluation for serious mental illness (SMI). An SMI diagnosis would afford the person access to resources and services needed for stabilization, such as medication, support and even housing in some cases. On the day the evaluation is scheduled, the outreach team is lucky to be able to locate the person—this is often difficult—and transport them to the appointment. During the evaluation, the person admits to some substance use to ‘quiet the voices in their head.’ With no record of mental illness and the admission of substance use, the person is not granted the SMI designation. They exit through the back door, remaining homeless. Occasionally, individuals in these circumstances are given the opportunity to prove that their symptoms are caused by mental illness rather than substance use. When this happens, they are required to check in regularly, showing that they are clean and sober. If mental illness symptoms persist for a certain period of time, they will be given the SMI designation. However, at the time of the first appointment, the person is not given any treatment. They strive to remain clean while living on the streets. They make it three days without using substances. Knowing that they cannot deal with the symptoms of their mental illness on their own, they move on from this opportunity. The outreach team is not able to locate them anymore and loses touch. The person remains homeless.

A person, who is experiencing homelessness, is staying in an emergency shelter. They have a substance addiction. Due to withdrawal symptoms, they act out while in the shelter and verbally assault a staff member or client, threatening to harm the person. This behavior prompts the shelter to kick them out and ban them from returning for a while. The person exists out the back door, with no treatment and no option besides staying on the streets. After a couple of nights, the person is able to obtain drugs again. Eventually, they have another episode, this time physically assaulting someone in front of a convenience store. The police are called. They arrest and charge the person but offer no treatment, releasing the person back on the streets. The person misses their court date since they have no access to transportation or even a calendar to know what day it is. The court issues an arrest warrant. Meanwhile, the person has no idea about the warrant and has forgotten all about the arrest. They find a new shelter that specializes in substance use intervention. They begin treatment and manage to remain sober for six months. They work as a day laborer and save enough money to rent a room. However, the landlord insists on a background check, discovering the outstanding warrant. The landlord refuses to rent. The person is very distraught about this and uses drugs again. The shelter kicks the individual out due to drug use. The person finds themselves back on the streets despite multiple interactions with institutions and systems that should have helped.

The resources and life circumstances of each individual, such as race, education, socio-economic status, access to resources and relationships with others can also impact whether someone will exit through the front or the back.⁷⁴ For instance, Black, Indigenous, and People of Color (BIPOC) are overrepresented in the unhoused population (see Chapters 16-25 for more).

74 Sandra Feodor Nilsson, Merete Nordentoft, and Carsten Hjorthøj, “Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: A Systematic Review and Meta-Analysis,” *Journal of Urban Health* 96, no. 5, October 2019: 741–50, <https://doi.org/10.1007/s11524-019-00377-x>.

Furthermore, these buildings or systems are independently operated and designed to be autonomous with little regard to their relation to the buildings around them. The revolving doors support the climate and culture in each building and serve as a barrier that ensures the system has no responsibility for what happens outside of the building. The buildings do not have any systems of accountability to ensure they work together. Although it may seem this design creates an effective, independent system, the separation and autonomy of the system creates isolation, often pushing people back out into the courtyard of homelessness. The location of the Human Services Campus in Phoenix provides an example of how individuals experiencing homelessness are isolated from the greater society. It is itself an isolated place that struggles to connect people: there are few businesses, the property is bordered by train tracks and a cemetery, and it is reported that ride-share and delivery drivers refuse to serve that area. In other words, this is not an ideal or effective place for people to make connections and find resources outside of the campus itself.

Part of the explanation for why the buildings are so insulated from each other is how the systems evolved. Most were developed historically for specific problems with specific populations in mind. Funding sources are often separate and cannot easily be combined without violating some regulations. Laws and definitions were often set up with the best intentions—although not always—of serving a specific population, preventing fraud and ensuring that public money is used effectively. Over time, it has become clear that the autonomy of the different buildings is not effective, especially in serving people at the intersection of homelessness, mental health and substance use.

Unfortunately, complex multi-layered systems are hard to change, especially because often local, state and federal legal changes would be required. Furthermore, existing buildings have constituencies that like things how they are. For instance, Health Insurance Portability and Accountability Act (HIPAA) requirements often prohibit the sharing of personal information across hospitals and behavioral and mental health systems without the consent of patients. This is reasonable protection for people's privacy. At the same time, consent is often difficult to obtain from patients, making it harder to coordinate care across systems, especially with non-medical institutions like shelters. Another example is court-ordered treatment (civil commitment) for mentally ill people that are a danger to themselves or others. For good reasons, the criteria to treat someone against their will or without their consent are very strict. Arizona, like most states, requires a mental illness evaluation for civil commitment and excludes substance use disorders from possible conditions. This can lead to the following scenario:

A person in crisis is taken to an involuntary psychiatric crisis unit by the police. During evaluation, the person admits to using methamphetamine. Since the symptoms cannot clearly be attributed to a mental illness vs. substance use, the person has to be released after 24 hours despite treatment needs. Neither the police nor the psychiatric crisis unit has any duty to find services or housing for the person.

Another part of the explanation of why buildings remain separated is the way funding flows and what specific outcomes are funded. Funding is usually distributed based on success metrics within one building, meaning that cross-collaboration is not rewarded. Homeless service providers get funding for housing people in their specific intervention, not for finding clients alternatives, but maybe more appropriate services. Behavioral health providers get reimbursed for services rendered and possibly the reduction of crisis service utilization. They are not incentivized to identify housing for their clients. In a capitalist system, where private for-profit service providers compete, incentives matter for outcomes. Providers often compete for limited resources and need to reduce costs. Furthermore, there is no cross-sector agreement on what actually works in addressing the causes of homelessness, mental illness and substance use.

With this image in mind, please consider what happens to the people who exit through the back doors of these buildings/systems. Regardless of which of the buildings people are leaving, it is important to note the difference in outcomes or results between the people who leave the buildings through the front doors and those who exit through the back doors. The fundamental difference between the two exit types is one allows for access to the resources necessary to ensure people have their physiological needs for food, shelter and clothing addressed as well as their need for safety and security met, which leads to the ability to connect with others. Some people have the privilege of exiting these buildings through the front doors, which allows them access to the resources that can ensure positive resolution to the issues that caused them to enter the building in the first place. They re-enter the community and have the opportunity to live free from the use of substances and/or successfully manage their mental health. They can seek and obtain employment, secure housing and transportation and attain some level of economic stability.

The people who exit through the back doors have a much grimmer future. They are stuck in the courtyard of homelessness, without a way to access the resources to meet their most basic daily needs for food, shelter and clothing—let alone the universal need for safety and security. Living in this type of scarcity can prevent people from being able to find love and belonging or fulfill their true potential.⁷⁵⁷⁶ These conditions also exacerbate health problems and lead to premature death.⁷⁷ Furthermore, this lack of having basic needs met can lead to a scarcity mindset, which has been shown through neuroimaging results to affect the neural mechanisms underlying decision making.⁷⁸⁷⁹

Many practitioners acknowledge the issue of revolving doors, and there are some initiatives to address it. Nationally, the U.S. Interagency Council on Homelessness pursues better coordination between federal agencies. In Arizona, a similar state-level effort has been discontinued. On the local level, there are several pilot projects, such as Frequent Users Services Enhancement (FUSE) and Helping Hands, that create cross-sector partnerships for individual projects. However, none have been successful at creating real systemic change.

Additionally, there are initiatives aimed at better data sharing. Arizona's Medicaid agency, AHCCCS, is pursuing the Whole Person Care Initiative. This includes a closed-loop referral system that will allow people needing assistance to receive holistic care customized to their needs and allow tracking progress. The initiative will allow health care and community-based organizations to refer people to providers who can provide the services or care they need, track the outcomes of such referrals, aggregate and share information among the providers, enhance the analysis of interventions and outcomes, as well as facilitate a higher level of collaboration among the providers. Another example is the Center for Human Capital and Youth Development at Arizona State University. They are trying to produce better estimates of the incidence and prevalence of homelessness in Arizona by linking data from health care, homelessness services, economic security, education, criminal justice and child welfare. They are also striving to identify the most successful interventions.

75 Ami Rokach, "Private Lives in Public Places: Loneliness of the Homeless," *Social Indicators Research* 72, no. 1, 2005: 99–114, <https://doi.org/10.1007/s11205-004-4590-4>.

76 S. L. Wenzel et al., "Life Goals Over Time among Homeless Adults in Permanent Supportive Housing," *American Journal of Community Psychology* 61, no. 3–4, 2018: 421–32, <https://doi.org/10.1002/ajcp.12237>.

77 David S. Morrison, "Homelessness as an Independent Risk Factor for Mortality: Results from a Retrospective Cohort Study," *International Journal of Epidemiology* 38, no. 3, June 2009: 877–83, <https://doi.org/10.1093/ije/dyp160>.

78 Inge Huijsmans et al., "A Scarcity Mindset Alters Neural Processing Underlying Consumer Decision Making," *Proceedings of the National Academy of Sciences* 116, no. 24, May 2019: 11699–11704, <https://doi.org/10.1073/pnas.1818572116>.

79 Ernst-Jan de Bruijn and Gerrit Antonides, "Poverty and Economic Decision Making: A Review of Scarcity Theory," *Theory and Decision*, March 9, 2021, <https://doi.org/10.1007/s11238-021-09802-7>.

Untreated Serious Mental Illness Causes Avoidable Tragedy

Based on an investigative report by the Arizona Republic, the following story illustrates how the systems designed to treat mental illness and substance use can fail the very people they intend to help.⁸⁰ In this case, resulting in the alleged killing of a Phoenix man. Although the circumstances and consequences that surround this story are extreme, the experience of the alleged perpetrator is not an isolated one.

During childhood, the alleged perpetrator experienced physical abuse and lived in poverty. In early adulthood, he struggled with substance use and was given the designation of "SMI" (or "Serious Mental Illness"). It is imaginable that his life path could have been different if he had received proper treatment and care. Instead, he cycled through the criminal justice system and experienced repeated homelessness—environments that are not conducive to overcoming childhood trauma and mental health issues.

In March 2018, the alleged perpetrator was released from state prison. Two weeks later, he was arrested for allegedly invading a Phoenix home and killing a man who lived there. During the two weeks between release and arrest, there were numerous opportunities for service providers to intervene more aggressively, which may have prevented the loss of a life. Instead, service providers lost contact with him. Police arrested him then put him back on the streets instead of contacting the service provider who had reserved a bed and treatment for him. Later, the police picked him up again for acting erratically on the streets and brought him to an emergency psychiatric provider. However, the provider discharged him for unclear reasons, despite his acute psychosis. Shortly after, the fatal incident took place. Neither the criminal justice system nor the behavioral health system was set up for helping a man who not only had a history of serious mental illness but also of substance use, homelessness and being resistant to treatment.

⁸⁰ Based on an investigation by Arizona Republic, not court records or conviction for a crime, see: Alden Woods, "The Mental Health System Left Curtis Bagley on the Street. Now a Man Is Dead," Arizona Republic, September 25, 2019, <https://www.azcentral.com/in-depth/news/local/arizona-health/2019/09/25/mental-health-system-let-curtis-bagley-down-now-man-dead/1624564001/>.

CHAPTER 4 — INTEGRATED TREATMENT AND CARE IN ARIZONA

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Acronyms in this Chapter

ACC–AHCCS Complete Care
ACT–Assertive Community Treatment
ADHS–Arizona Department of Health Services
AHCCCS–Arizona Health Care Cost Containment System
AIHP–American Indian Health Program
ALTCS–Arizona Long Term Care System
AHP–AHCCCS Housing Programs
CCE–Competitive Contract Expansion
CHIP–Child Health Insurance Program
CMI–Chronic Mental Illness
COE–Court-Ordered Evaluation
DHHS–U.S. Department of Health and Human Services
EVB–Evidence-Based Practices
FQS–Federal Housing Quality Standards
GMH/SU–General Mental Health Substance Use
MCO–Managed Care Organizations
NASMHPD–National Association of State Mental Health Program Directors
PSH–Permanent Supported Housing
QIC–Quality Improvement Collaborative
RFP–Request for Proposal
RBHA–Regional Behavioral Health Authorities
SAMHSA–Substance Abuse and Mental Health Services Administration
SMI–Serious Mental Illness
TIP–Targeted Investments Program
WPCI–Whole Person Care Initiative

SUMMARY

This chapter describes the history, current state and ongoing evolution of integrated care, the coordination, collaboration and, communication between physical and behavioral health care, and services within Arizona's Medicaid program, specifically for single adults.

HISTORY

Medicaid in Arizona

Let us start with the financing and state leadership of the public behavioral health program. The federal Medicaid program was established under Title XIX of the Social Security Act of 1965 to provide health care for low-income individuals and families who meet eligibility requirements related to income and other factors. While Arizona was last to adopt Medicaid in 1982, its implementation was innovative. Unlike the traditional Medicaid fee-for-service model in which the Medicaid program directly reimbursed providers for services delivered, Arizona received special permission from the federal government (1115 waiver authority) to establish the country's first Managed Care Medicaid program. Arizona established a new state agency, the Arizona Health Care Cost Containment System (AHCCCS), to contract with public and private entities to provide services. The providers receive a fixed monthly amount, or capitation payment, for each enrolled member. AHCCCS initially covered only acute care. The Arizona Long Term Care System (ALTCS) was put in place in 1987 to provide long-term care for the elderly, physically disabled and developmentally disabled. In 1990, AHCCCS phased in mental health services and behavioral health coverage in response to federal requirements. At inception, AHCCCS and Arizona's Medicaid program only directly funded physical health services, while behavioral health services were "carved out" using funding from the Arizona Department of Health and the counties. This arrangement created two separate systems of care—one for physical health issues and another for behavioral health issues. While coordination of care was expected, it proved challenging.

Arnold v. Sarn

In March 1981, a class action lawsuit (*Arnold v. Sarn*) was filed by the Arizona Center for Law in the Public Interest on behalf of a class of adults designated as having a serious mental illness (SMI), alleging a breach of duty by Arizona Department of Health Services (ADHS), the Arizona State Hospital, and Maricopa County Board of Supervisors. The suit sought to enforce the community mental health treatment system (A.R.S. §§ 36-550 through 36-550.08) for persons determined SMI in Maricopa County. The remaining population were identified as having General Mental Illness and Substance Use (referred to as GMH/SU), and at that time, no provisions were made for this group. The basis of the lawsuit was the significant lack of funding for the SMI population even though the state statutes indicated that services must be provided. In 1986, the trial court entered judgment holding the state violated its statutory duty, which was confirmed by the Arizona Supreme Court in 1989.

In the intervening years, numerous settlement attempts were made. In January 2014, a final settlement agreement was reached where the state stipulated to increase services in the following areas: Assertive Community Treatment (ACT) teams, Supportive Housing, Supported Employment, and Peer and Family Services, all practices validated by the Federal Substance Abuse Mental Health Services Administration (SAMHSA). It is important to note that while *Arnold v. Sarn* only pertained to Maricopa County, the state has implemented and applied many of the requirements statewide. At this time, the Arizona Department of Health contracted with Regional Behavioral Health Authorities (RBHA), which were county-specific Managed Care Organizations that directly contracted with providers to serve persons determined SMI.

Arizona was not alone in receiving criticism for its behavioral health services. State behavioral health systems across the country can be described both optimistically as the mental health safety net and pessimistically as a fragmented array of services. Our experiences across the country have led us to believe that in many locations, the array of available behavioral health services is often insufficient to meet the needs of the current and growing

population. Arizona, on the other hand, has been considered a national leader in developing a wide array of services and supports and is considered a leader in behavioral health services. The Arizona Behavioral Health system is certainly not perfect—there are still individuals who are not receiving all of the services they need in a timely manner. However, the system is constantly adjusting to gaps in services and seeks to address constructive criticism from providers, professionals, advocates and individuals served.

Medicaid Expansion

In 2000, Arizona voters approved Proposition 204, which expanded AHCCCS coverage to individuals with income at or below 100% of the federal poverty level. The ballot measure dedicated settlement monies received as a result of a lawsuit filed against manufacturers of tobacco products. Arizona's share of the settlement monies was estimated at \$3.2 billion over a 25-year period. Prior to the passage of Proposition 204, AHCCCS recipient's net income could not exceed 34% of the federal poverty level. In 2014, Arizona expanded coverage to individuals with incomes at or below 133% of the federal poverty level, as incentivized by the Affordable Care Act.

Integrated Care

The need for integrated physical and behavioral health services for individuals with an SMI designation is crucial to their overall health and wellness. Individuals with mental health issues have a significantly higher risk of co-occurring chronic physical health disorders.⁸¹ In 2006, the National Association of State Mental Health Program Directors (NASMHPD) published a landmark report based on the first multi-state study of excessive mortality among persons with an SMI designation.⁸² While many individual studies had long documented that people with a mental illness die at a younger age than the general population, the NASMHPD report was the first to describe a nationwide public health tragedy in this population. The study concluded that people with a serious mental illness die, on average, 25 years younger than their general population counterparts. In Arizona, the study reported that individuals with a serious mental illness have a life span that is between 25–30 years shorter than average. In addition, the study found that upwards of 60% of these deaths were due to manageable and preventable health conditions routinely addressed in primary health care settings, including diabetes, cardiovascular and respiratory disease, which are aggravated by poor health habits (e.g., inadequate physical activity, poor nutrition, smoking, substance use) and challenges in navigating complex health care systems.

At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general health care needs. In a survey of over 1,000 Primary Care Physicians, four out of five (80%) said that unmet social needs are directly leading to worse health for all Americans.⁸³ The same percentage of physicians indicated that patients' social needs are as important to address as their medical conditions. This is especially true for physicians serving patients in low-income, urban communities who reported that necessary social supports are often lacking for the individuals they treat. Braveman et al. reported that modifiable social factors—including income, education,

81 Craig W. Colton and Ronald W. Manderscheid, "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death among Public Mental Health Clients in Eight States," *Preventing Chronic Disease* 3, no. 2, 2006, <https://stacks.cdc.gov/view/cdc/20014>.

82 Joe Parks et al., "Morbidity and Mortality in People with Serious Mental Illness" National Association of State Mental Health Program Directors, 2006, https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08_0.pdf.

83 "Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health, Summary of Findings from a Survey of America's Physicians," Robert Wood Johnson Foundation, Fenton, 2011, https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwif71795.

wealth and socioeconomic conditions might be more important in explaining health differences by race or ethnicity.⁸⁴ The health care industry has repeatedly identified that lifestyle changes through health promotion activities are the answer to reducing chronic disease. These interventions are designed to promote healthy lifestyles and reduce adverse health behaviors such as smoking and physical inactivity, and they are more likely to be successful if they also support self-efficacy and emotional well-being. Thus, the solution lies in better coordination between general care and behavioral health care. Individuals who are eligible for services need to have rapid and easy access to care, and there is always a challenge to making sure the resources are culturally sensitive and welcoming.

For individuals with an SMI designation, integrated care began in Maricopa County through Regional Behavioral Health Authorities (RBHAs) in 2014, followed by the balance of state in 2015. In 2018, AHCCCS established Arizona Complete Care which integrated physical and behavioral health plans for the majority of AHCCCS members. Persons designated SMI continued to receive integrated care through the RBHAs in their service areas. AHCCCS is expanding the provision of services through AHCCCS Complete Care (ACC) Contractors to include integrated services for Title XIX/XXI eligible individuals with an SMI designation utilizing a competitive process called a Competitive Contract Expansion (CCE). Effective October 1, 2022, the Contract expansion also includes administration of Non-Title XIX/XXI funded services including, but not limited to, crisis services and Court-Ordered Evaluations (COE).

Introducing Integrated Care to a system where Behavioral Health was a carve-out since its inception was a long-term process, but continual progress has been achieved since it began in 2018. The implementation of Integrated Care has had a positive impact on health care outcomes, health care costs and consumer satisfaction.⁸⁵ Some key successes are indicated in Table 3.

Table 3. Health care outcomes of integrated care.

Utilization Of Primary Care Services by SMI Members in RBHAs	
Percentage of adults who accessed preventive/ambulatory health services	Increased 4.6%
Management of Behavioral Health Conditions for SMI Members Enrolled in RBHAs	
Percentage of adult beneficiaries who remained on an antidepressant medication treatment (84 days)	Increased 3.7%
Percentage of adult beneficiaries who remained on an antidepressant medication treatment (180 days)	Increased 6.1%
Percentage of beneficiaries with a follow-up visit after hospitalization for mental illness	Increased 61.5%
Percentage of beneficiaries with a follow-up visit after emergency department (ED) visit for mental illness	Increased 7.8%
Percentage of beneficiaries with a follow-up visit after ED visit for alcohol and other drug abuse or dependence	Increased 8.4%
Percentage of beneficiaries receiving any mental health services	Increased 8.6%
Percentage of beneficiaries receiving outpatient mental health services	Increased 8.8%

84 Paula A. Braveman et al., "Socioeconomic Status in Health Research: One Size Does Not Fit All," The Journal of the American Medical Association 294, no. 22, 2005: 2879–2888, <https://doi.org/10.1001/jama.294.22.2879>.

85 "Arizona Demonstration Renewal Proposal (2021-2026)," AHCCCS, 2020, https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AZ_Final_1115WaiverRenewalPacket.pdf.

CURRENT STATE

Today, the Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. AHCCCS provides coverage to over 2.2 million members in Arizona. AHCCCS also administers several non-Title XIX programs funded by the state and federal grants received from the Substance Abuse and Mental Health Services Administration (SAMHSA). The majority of AHCCCS programmatic expenditures are administered through Managed Care programs, though AHCCCS also manages a Fee-for-Service program primarily for members who are Native American. AHCCCS contracts with Managed Care Organizations (MCOs) including, but not limited to, Regional Behavioral Health Authorities (RBHAs), AHCCCS Complete Care (ACC) contractors, and Arizona Long Term Care System (ALTCS) plans that are responsible for providing acute and behavioral health services and long-term care services (ALTCS only) to members through provider agencies. AHCCCS has over 110,000 active providers in Arizona, including individual medical and behavioral health practitioners, medical equipment companies and transportation entities.

Covered services for regular Medicaid members include, but are not limited to, primary health care, mental health counseling, psychiatric and psychologist services, and treatment for substance use disorders, including Opioid Use Disorder. The Regional Behavioral Health Authorities (RBHAs) continue to serve individuals with an SMI designation. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the AHCCCS fee-for-service managed care program.

Since *Arnold v. Sarn*, the Arizona Behavioral Health program has implemented several evidence-based practices, including Assertive Community Treatment Teams, Supported Employment Services, Peer Support Services and Supported Housing. These services have expanded beyond the required capacity, as noted in Table 4.

Table 4. Service requirements and capacity after *Arnold v. Sarn*.

Service Type	Required by the Settlement	April 2021 Capacity
Assertive Community Treatment Teams	8	24
Supported Employment Service Capacity	750	1,178
Peer Support Service Capacity	1,500	2,139
Supported Housing Units	1,200	5,225

CURRENT STATE

Today, AHCCCS continues its efforts to meet its goals of improving the quality of health care while bending the cost curve. In addition to these service improvements, a number of cross-cutting activities have occurred. Due to this article's size limitations, we will focus on three additional overarching initiatives. These include (1) Social Determinants of Health and (2) Targeted Investment Program and (3) Supported Housing.

Social Determinants of Health

Growing national research on the social determinants of health suggests that access to quality health care contributes 20% to an individual's overall health and well-being while social risk factors, behaviors and physical environment contribute 80%. Critical social risk factors that influence an individual's overall health include food and housing insecurity; lack of transportation; access to educational, economic and job opportunities; legal or justice system involvement; and social isolation.⁸⁶

AHCCCS has historically embraced the vital role social risk factors play in our member's health outcomes and addressed these complex issues through efforts to enhance the service delivery of Medicaid-covered services while also relying on a broad range of funding sources for services and supports not available under the Arizona Medicaid program. In 2019, AHCCCS launched the Whole Person Care Initiative (WPCI) to further enhance existing efforts to identify and address the social risk factors which impact the health outcomes of AHCCCS members. Current priorities for the WPCI focus on the following social risk factors: The Social Determinants of Health identify the conditions in which people are born, grow, live, work and age. They include factors like 1) education, 2) employment, 3) physical environment, 4) socioeconomic status, and 5) social support networks. In 2021, AHCCCS in collaboration with Health Current, our State Health Information Exchange developed a closed loop referral system which will be able to identify community resources that meet individuals' needs (see Chapter 15 – Creating Connections, Improving Lives: Health Information Exchange (HIE) in Arizona).

Targeted Investments Program

The AHCCCS Complete Care program and the Whole Person Care initiative have outlined substantial expectations, which can include requiring more space, more staff, better integration practices and a host of other activities which may be costly for providers. The Targeted Investments Program (TIP) is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to meet these expectations and develop systems for integrated care. Managed-care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. The program uses data analytics and quality management to achieve program benchmarks. The program is in its sixth year, and there are many agencies enrolled.

AHCCCS added a Quality Improvement Collaborative (QIC) to help interprofessional provider teams meet and exceed TIP performance measure targets. The QIC consists of providers working together using timely actionable information with a performance management system featuring a peer learning forum to share best practices and disseminate the practical content needed to achieve the TIP performance measure targets. This project is led by Arizona State University scientists.

86 Elizabeth H. Bradley and Lauren A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, (New York, NY: PublicAffairs, 2013).

Supportive Housing (See Chapter 12 — The Crossroad of Housing)

One of the key components of a holistic social determinants of health approach is housing. Medication management, therapeutic interventions and integrated care have continued to evolve as effective treatment approaches; however, stable and supportive housing has also been found to be one of the most crucial factors in successful recovery from a mental illness. In addition, it has been shown to improve clinical outcomes and reduce service costs.⁸⁷ Often, the traditional housing model is insufficient for the SMI population that has not achieved recovery and struggles to live independently. For these individuals, there are few other forms of suitable housing available that meet their needs to successfully live in the community. Supportive housing offers a solution to this problem.

Supportive housing combines housing and supportive services to help individuals increase stability, productivity and functionality in their lives (see Figure 8). Supportive housing is a major factor of recovery for individuals with mental health conditions and substance use disorders based on stability, reduction of stressors and consistent access to providers. A recent study by Morrison Institute for Public Policy found that the financial costs of individuals with Chronic Mental Illness (CMI; a subset of SMI) in permanent supportive housing were 28.7% lower than individuals with CMI experiencing chronic homelessness.⁸⁸ Health care represented the largest category of expenses across housing settings, within which behavioral health comprised the largest percentage of costs. In a small-sample case study of a high support housing setting (Lighthouse Model), total average costs per person decreased 12.1% over two to three years of residence. Behavioral health costs declined 36%, while spending on physical health, pharmacy and skills training increased, demonstrating a shift in spending away from crisis management and toward recovery and personal development. Additionally, the tenants in this setting had no criminal justice interactions during the study period.

One major legacy of the *Arnold v. Sarn* litigation and subsequent stipulations is the state's funding of housing subsidies for persons designated SMI. AHCCCS Housing Program (AHP) consists of permanent supportive housing and supportive health programs. AHP is community-based permanent supportive housing where a member should have a renewable lease, the right of entry and exit not restricted by program and can voluntarily select services. The state allocation for AHP is for approximately 3,000 members throughout Arizona.

Supports available for all outpatient levels of care include mobile crisis teams, partial hospitalization programs, day programs, assertive community treatment, peer and family support services, supported employment, and all other covered behavioral health programs.

87 David Rudoler et al., "Cost Analysis of a High Support Housing Initiative for Persons with Severe Mental Illness and Long-Term Psychiatric Hospitalization," *Canadian Journal of Psychiatry* 63, no. 7, 2018: 492–500, <https://doi.org/10.1177/0706743717752881>.

88 Julia C. Bausch, Alison Cook-Davis, and Benedikt Springer, "Housing is Health Care: The Impact of Supportive Housing on the Costs of Chronic Mental Illness," Morrison Institute for Public Policy, 2021, https://morrisoninstitute.asu.edu/sites/default/files/housing_is_health_care_report_2021.pdf.

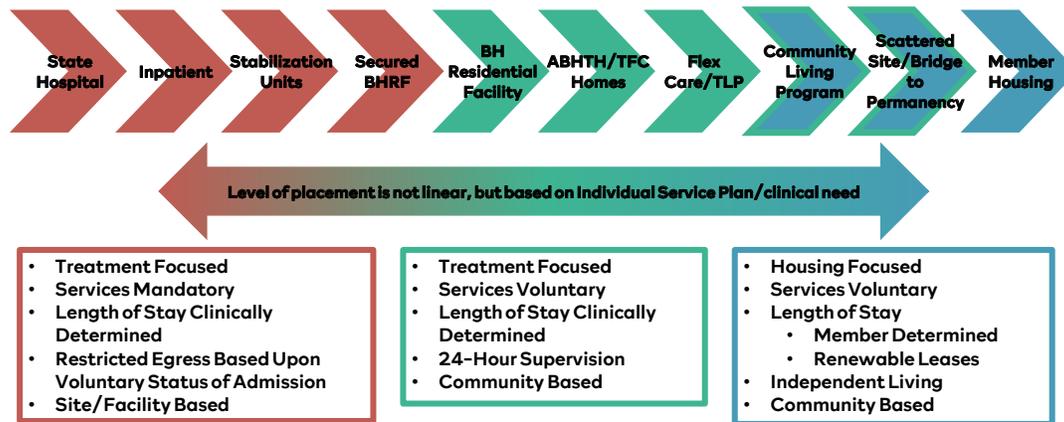


Figure 8. Overview of continuum of behavioral health settings ranging from treatment facilities (left) to community-based housing, including permanent supportive housing (right). Members access programming and settings based upon their individualized service need and not by linear progression from one service or setting to another.

Currently, AHCCCS is requesting permission for a Housing and Health Opportunities (H2O) demonstration via an 1115 waiver subject to Center for Medicare and Medicaid Services approval. The AHCCCS H2O demonstration targets individuals who are experiencing homelessness or at risk of homelessness and who have at least one or more of the following conditions or circumstances:

- Individuals with a Serious Mental Illness (SMI) designation or in need of behavioral health and/or substance use treatment.
- Individuals determined high risk or excessive cost based on service utilization or health history.
- Individuals with repeated avoidable emergency department visits or crisis utilization.
- Individuals who are pregnant.
- Individuals with chronic health conditions and/or co-morbid conditions (e.g., end-stage renal disease, cirrhosis of the liver, HIV/AIDS, co-occurring mental health conditions, physical health conditions, and/or substance use disorder).
- Individuals at high risk of experiencing homelessness upon release from an institutional setting (e.g., Institutions for Mental Disease/IMDs, psychiatric inpatient hospitals, correctional facilities).
- Young adults ages 18 through 24 who have aged out of the foster care system.
- Individuals in the Arizona Long Term Care System (ALTCS) who are medically able to reside in their own home and require affordable housing in order to transition from an institutional setting.

The goal of the AHCCCS H2O demonstration is to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. Under this demonstration, the agency will seek to 1) increase positive health and wellbeing outcomes for target populations including the stabilization of members' mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction; 2) reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, emergency department utilization and inpatient hospitalization; 3) reduce homelessness and improve skills to maintain housing stability.

This chapter has described the history, current state and ongoing evolution of integrated care, the coordination, collaboration and communication between physical and behavioral health care, and services within Arizona's Medicaid program. While improvement and progress are ongoing, current initiatives address many of the common challenges at the intersection of homelessness, mental health, and substance use.

CHAPTER 5 — MENTAL HEALTH TREATMENT AND RECOVERY

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Acronyms in this Chapter

ACT—Assertive Community Treatment

ART—Alternate Response Team

CTI—Critical Time Intervention

MAT—Medication-Assisted Treatment

PIT—Point-in-Time

SMI—Serious Mental Illness

SUD—Substance Use Disorder

CONTEXT AND SCOPE

The 2020 Point-in-Time (PIT) survey counted 580,466 persons experiencing homelessness nationally. Of these individuals, 21% (120,642) had a mental illness, and 17% (98,646) had a Substance Use Disorder (SUD). In Arizona, the 2020 PIT count showed rates of mental illness across the Continua of Care ranging from 13%–32%. Rates of SUD ranged from 15%–20% (see Table 5). Experiencing homelessness is associated with a greater risk for mental illness for adults and children.^{89 90} However, the relation between homelessness and mental illness is bi-directional. Sometimes experiencing homelessness is what causes or worsens a mental illness, and other times, it is mental illness, or the co-occurrence of a mental illness and SUD, that leads to someone experiencing homelessness (see Chapter 2 — Background).

Table 5. Persons experiencing homelessness with mental illness or SUD.

Continua of Care	Total	Count (percent) with mental illness	Count (percent) with SUD
Maricopa Regional	7,419	965 (13%)	1,110 (15%)
Tucson/Pima County	1,324	425 (32%)	324 (25%)
Balance of State	2,236	328 (15%)	419 (19%)
Total	10,979	1,718 (16%)	1,853 (17%)

89 Allison B. Wilson and Jane Squires, "Young Children and Families Experiencing Homelessness," *Infants and Young Children* 27, no. 3, 2014: 259–271, https://journals.lww.com/iyjournal/Abstract/2014/07000/Young_Children_and_Families_Experiencing_5.aspx.

90 "Behavioral Health Services for People Who Are Homeless," Substance Abuse and Mental Health Services Administration, 2021, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-04-003.pdf.

The most common mental illness among persons experiencing homelessness is Substance Use Disorder (SUD).⁹¹ Many people experience SUD in addition to another mental health issue, a condition known as a “co-occurring” disorder or “dual diagnosis.”^{92 93} A review of the literature from the U.S., U.K., and Germany reported pooled prevalence rates for alcohol use (37%) and drug use (22%) disorders among persons experiencing homelessness that far exceed the general U.S. population (5.3% and 3.0%, respectively).^{94 95} The next most common mental illnesses reported in the study were schizophrenia spectrum disorders and major depression—illnesses that are both treatable.

LEVELS OF CARE

Someone who is experiencing homelessness may go to a shelter, community center or provider agency to seek services. More often, however, people are connected to services through community outreach by a peer support specialist, also known as a navigator. Navigators receive training and clinical supervision from a licensed professional and often have lived experience with homelessness which uniquely positions them to empathize and connect with those they are serving. Navigators play a critical role in helping the unhoused community find and access the services they need (see Chapter 14 — Accessing Services for Recovery and Stabilization).

Service delivery falls broadly into three treatment level categories: Crisis care, Inpatient treatment and Outpatient services. These are described in depth in Chapter 6 — Substance Use Treatment, Recovery, and Relapse Prevention and outlined briefly in Table 6.

91 Stefan Gutwinski, Stefanie Schreiter, Karl Deutscher, and Seena Fazel, “The Prevalence of Mental Disorders among Homeless People in High-income Countries: An Updated Systematic Review and Meta-regression Analysis.” *PLoS Medicine* 18, no. 8, 2021, <https://doi.org/10.1371/journal.pmed.1003750>.

92 “Substance Use Disorder Treatment for People with Co-Occurring Disorders,” Substance Abuse and Mental Health Services Administration, 2020, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf.

93 “Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the U.S.,” Substance Abuse and Mental Health Services Administration, 2011, https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf.

94 “Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2019 National Survey on Drug Use and Health,” Substance Abuse and Mental Health Services Administration September 2020, <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#sud>.

95 Gutwinski, Schreiter, Deutscher, Fazel, “The Prevalence of Mental Disorders.”

Table 6. Levels of mental health treatment and care.

Type	Duration	Description
Crisis	Crisis Residential Treatment Programs	Provide short-term, intensive and supportive services in a home-like environment. Can be secure/non-secure.
Crisis	Mobile Crisis Team	Group of health professionals responding to mental health crises in the community/on the streets. Prevent situations from escalating and can refer people to further treatment or other services.
Crisis	Psychiatric Urgent Care/Crisis Stabilization Units	Alternative to the emergency room for acute mental health crises. Treatment up to a few days.
Crisis	23-Hour Crisis Stabilization	Inpatient assessment and interventions. Can last up to 23 hours until the patient is discharged, or appropriate level of care is determined.
Inpatient	Residential Treatment Services ('Rehab')	Residential substance use and/or mental health treatment, short term (30-90 days) or long term (6-12 months).
Inpatient	Secure Treatment Facility	Serves individuals who need 24/7 close supervision, otherwise similar to residential treatment. More like a home than a hospital, but entry and exit are restricted.
Inpatient	Detoxification Facility	Provides medical supervision for individuals going through substance withdrawal.
Inpatient	Psychiatric Hospital	Intensive inpatient treatment for serious mental illness.
Outpatient	Partial Hospitalization Program (PHP)	Step down from 24-hour psychiatric care. Substance use and/or mental health treatment Monday through Friday for extended hours. Individuals return home each night.
Outpatient	Intensive Outpatient Program (IOP)	Substance use and/or mental health treatment multiple times a week over an extended period of time (minimum 3 hours/day, 3 times/week).
Outpatient	Outpatient Treatment Services ('Therapy')	Treatment for mental illness and/or substance use disorder. Individual or group-based counseling. Often, 1 time per week but can vary based on the individual.

BARRIERS TO TREATMENT

Despite various levels of care and an accumulation of knowledge about treatment best practices, considerable barriers to treatment access and retention exist for people experiencing mental illness and homelessness.⁹⁶ There are a number of factors that make treatment more challenging, including lack of access to the internet or a phone, unreliable or no transportation, lack of awareness about services available, and difficulty adhering to treatment regimens.⁹⁷ As a result, persons experiencing homelessness often end up utilizing crisis or emergency care services as opposed to a potentially more appropriate level of care (i.e., outpatient therapy).⁹⁸ Additionally, it can be difficult to understand and navigate the integrated care system in Arizona. Persons experiencing homelessness already lack support and resources and thus, often depend on the coordination of government services and systems for treatment and recovery, which at times can prove challenging (see Chapter 3 – The “Revolving Door”).

EVIDENCE-BASED PRACTICES

There are evidence-based practices and treatment approaches that we know are beneficial for working with persons experiencing homelessness. Information about many of these are found throughout this report, including motivational interviewing, intensive case management, trauma-informed care, Housing First (see Chapter 11 – Overview of Best Practices for Treatment and Care), Medication Assisted Therapy (see Chapter 6 – Substance Use Treatment, Recovery, and Relapse Prevention), and Assertive Community Treatment (see Chapter 10 – Governmental Actions and Processes).

An additional modality worth noting for working with individuals experiencing homelessness and mental illness is Critical Time Intervention (CTI). CTI is a case management program for persons designated as having a “Serious Mental Illness” (SMI; see Chapter 2 – Background) as they transition out of hospitals, shelters and similar facilities. Case managers are trained and supervised by a licensed clinician. The goal of CTI is to prevent recurrent homelessness by providing support to clients during this “critical time of transition back to the community.” This typically happens over the course of nine months in three phases, with each phase lasting three months (see Figure 9). In the first phase, the case manager gets to know the client, assesses their mental health needs, and makes a plan with the client for staying connected to supports and services once they leave the institution. In phase two, the client puts the plan into action while the case manager monitors and adjusts the plan based on the client’s needs and progress. Then, in the third phase, the case manager helps the client develop a plan to achieve their long-term goals. With each phase, the case manager scales back their involvement and direct client support, transitioning support fully to the client’s caregivers and community service providers by the end of phase three.⁹⁹

96 “Behavioral Health Services for People Who Are Homeless, Treatment Improvement Protocol (TIP),” Substance Abuse and Mental Health Services Administration, Series 55, 2013, https://www.ncbi.nlm.nih.gov/books/NBK138725/pdf/Bookshelf_NBK138725.pdf.

97 Lauren R. Fryling, Peter Mazanec, and Robert M. Rodriguez, “Barriers to Homeless Persons Acquiring Health Insurance through the Affordable Care Act,” *The Journal of Emergency Medicine* 49, no. 5, 2015: 755–62, <https://doi.org/10.1016/j.jemermed.2015.06.005>.

98 Bisan A. Salhi, Melissa H. White, Stephen R. Pitts, and David W. Wright, “Homelessness and Emergency Medicine: A Review of the Literature,” *Academic Emergency Medicine* 25, no. 5, 2018: 577–593, <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/acem.13358>.

99 “Evidence Summary for the Critical Time Intervention,” Arnold Ventures, Social Programs That Work, August 2018, <https://evidencebasedprograms.org/document/critical-time-intervention-evidence-summary/>.

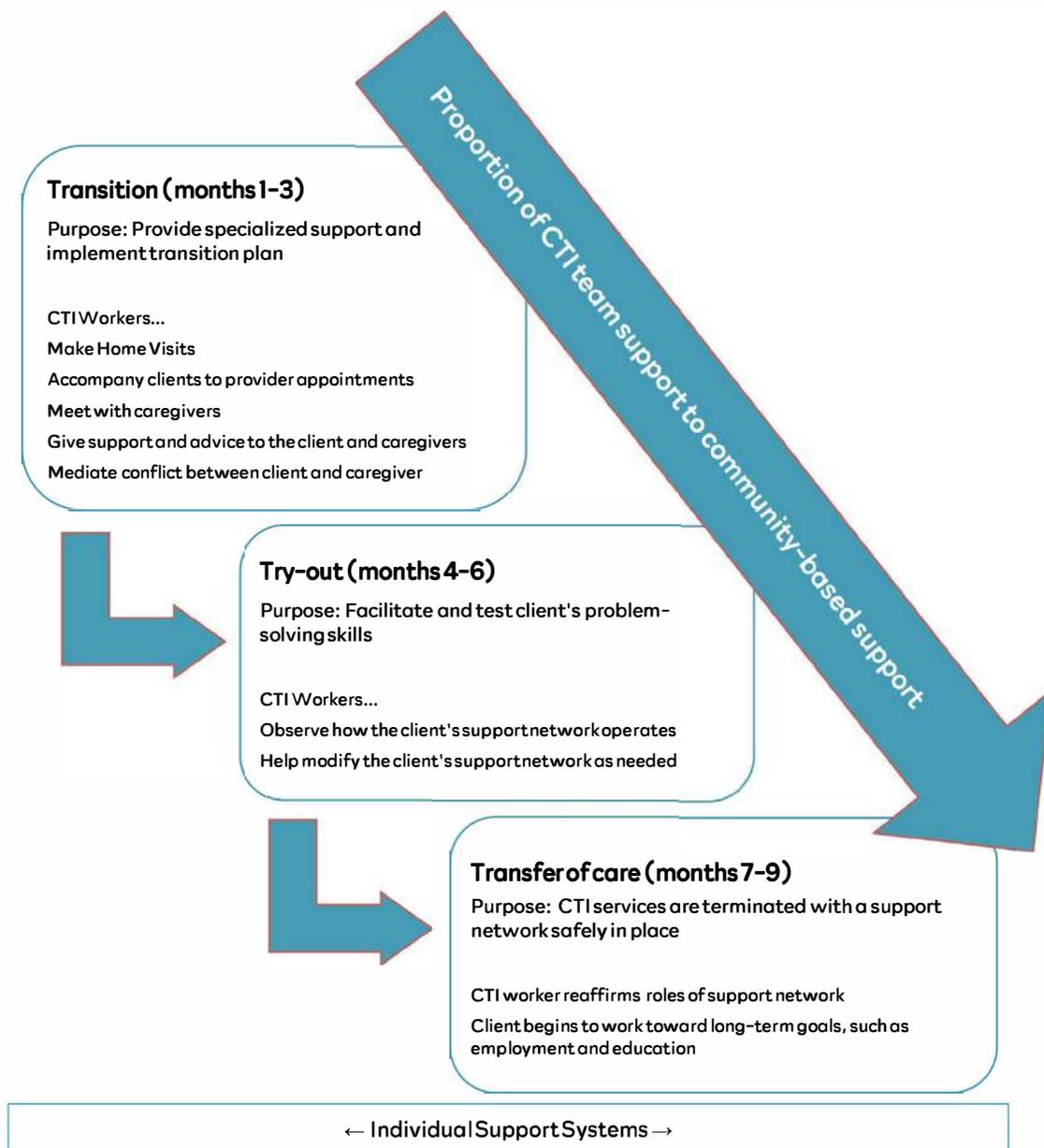


Figure 9. Critical Time Intervention service model—adapted from Herman et al.¹⁰⁰

Randomized control trial studies using CTI among persons designated as SMI have produced promising outcomes, including a reduced likelihood of experiencing homelessness and psychiatric hospitalization within the 18-months following the intervention. Even more, CTI has been shown to be more cost-effective than “usual care.”¹⁰¹

As we learn more about the complex needs of individuals experiencing homelessness and co-occurring disorders, treatment approaches will continue to be refined and tailored to address the disproportionate impacts of these issues faced by certain subpopulations (see Chapters 16-25 for more).

100 Daniel Herman et al., “Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High-Risk Groups,” *The Journal of Primary Prevention* 28, no. 3, 2007: 295-312, <https://doi.org/10.1007/s10935-007-0099-3>.

101 “Evidence Summary for the Critical Time Intervention.”

PREVENTION

Preventing homelessness allows for the largest potential reduction in human suffering. The traditional response to homelessness has been reactive: responding to homelessness after it has occurred. A newer, prevention-based response to homelessness for people designated as SMI focuses heavily on housing stability and staying connected to community resources and supports. This framework suggests direct and ongoing interaction with community-based service providers across all realms of prevention (i.e., primary, secondary, and tertiary). As seen in Figure 10, quicker, less expensive services, such as rental assistance or legal aid, are offered to the greatest number of people through community-based providers, while the most intensive and costly services are reserved for fewer clients who require long-term supportive services, such as Permanent Supportive Housing and mental health treatment.¹⁰²

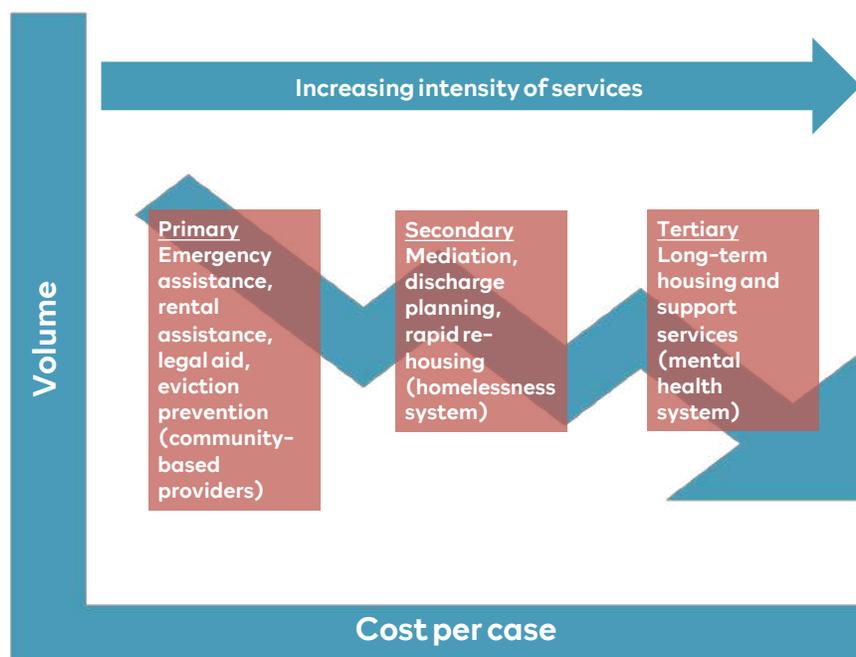


Figure 10. Homelessness prevention framework for individuals with Serious Mental Illness.¹⁰³

Early recognition of mental health issues also has the potential to prevent homelessness. In a large-scale longitudinal analysis of adverse childhood experiences, history of depression and psychiatric hospitalization were significantly associated with homelessness among young adults in the U.S.¹⁰⁴ If mental illness is detected early enough, individuals and families can be referred to supportive services before problems escalate.¹⁰⁵ This calls into consideration the role that teachers, school nurses and support staff can play in early intervention of mental illness—and by extension, homelessness. In a recent survey, mental and emotional disorders were ranked as the third most prevalent chronic health condition seen by school nurses in Arizona. They also indicated that mental health is the number one remaining “pandemic-related need” for students, and 71% said that they would like to

102 Ann Elizabeth Montgomery, Stephen Metraux, and Dennis Culhane, “Rethinking Homelessness Prevention among Persons with Serious Mental Illness,” *Social Issues and Policy Review* 7, no. 1, 2013: 58–82, <https://doi.org/10.1111/j.1751-2409.2012.01043.x>.

103 Montgomery, Metraux, and Culhane, “Rethinking Homelessness Prevention.”

104 Katherine H. Shelton, Pamela J. Taylor, Adrian Bonner, and Marianne Van Den Bree, “Risk Factors for Homelessness: Evidence from a Population-Based Study,” *Psychiatric Services* 60, no. 4, 2009: 465–472, <https://doi.org/10.1176/appi.ps.60.4.465>.

105 “Prevention and Early Intervention in Mental Health,” *Mental Health America*, accessed February 10, 2022, <https://www.mhanational.org/issues/prevention-and-early-intervention-mental-health>.

receive training on mental health screening.¹⁰⁶ Prior studies show that mental health training for teachers can improve mental health knowledge and attitudes about mental health.¹⁰⁷

INNOVATIONS IN ARIZONA

Below are a few of the innovations happening throughout Arizona, which highlight how the state is addressing issues that relate to mental health, substance use and homelessness.

1. Alternate Response Team (ART) in Flagstaff, Arizona. The Flagstaff City Council approved an innovative approach to police response to nonviolent calls brought about by a collaboration between the city and Terros Health, a behavioral health organization. If a call comes in related to mental health, substance use or other “nonviolent distress,” the dispatcher may choose to send an Alternative Response Team, or ART, which consists of an EMT and social worker. This not only allows the person experiencing distress a better opportunity to receive the appropriate level of care, but it also allows the police force to focus their energy on violent crime.¹⁰⁸
2. City of Phoenix Strategies to End Homelessness. The City of Phoenix included “Increase access to mental health services” as a strategy to end homelessness [in a 2020 report](#). Phoenix outlined short, medium- and long-term goals to work toward this strategy, including funding research in the field, exploring alternative responses to 9-1-1 crisis calls for those experiencing mental health challenges, providing a resource navigator at the municipal court, advocating for emergency hospital evaluation to ensure appropriate care, and advocating for changes in Medicaid to allow funding for more mental health facilities.
3. Senate Bill 1376. Passed in June 2021, SB1376 requires that mental health instruction be included in school curriculum in Arizona. SB1376 calls for consultation with mental health experts and advocates and the Department of Education to outline curriculum content that incorporates the relationship between physical and mental health with the intention of enhancing students’ “understanding, social and emotional learning, attitudes, and behavior that promote health and well-being.”¹⁰⁹

There is an undeniable connection between poor mental health, including substance misuse and homelessness. While there is a lot more work to be done to prevent and end homelessness in the state, Arizona has taken a number of steps to support mental health treatment and recovery for its communities. It is important to continue the conversation about innovative approaches that have the potential to reduce the human and financial costs associated with the complex intersection of mental health, substance use and homelessness.

106 Soraya Marashi, “Arizona Addresses Student and Educator Mental Health Needs with School-Based Programs,” State of Reform, November 5, 2021, <https://stateofreform.com/featured/2021/11/arizona-student-mental-health/>.

107 Jennifer O’Connell, Helen Pote, and Roz Shafran, “Child Mental Health Literacy Training Programmes for Professionals in Contact with Children: A Systematic Review,” *Early Intervention in Psychiatry* 15, no. 2, 2021: 234–247, <https://doi.org/10.1111/eip.12964>.

108 “Flagstaff Police Dispatch Gets a New Alternate Response Team,” NAZ Today, October 22, 2021, https://www.naztoday.com/news/flagstaff-police-dispatch-gets-a-new-alternate-response-team/video_360c2f7b-3415-579f-855a-3021a25580ec.html.

109 Schools; Curriculum; Mental Health, Chapter 445, S.B. 1376, 55th Leg., 1st Sess. §15-701.02 (A.Z. 2021), <https://www.azleg.gov/legtext/55leg/1R/laws/0445.pdf>.

CHAPTER 6 — SUBSTANCE USE TREATMENT, RECOVERY, AND RELAPSE PREVENTION

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Acronyms in this Chapter

ASAM—American Society of Addiction Medicine

IOP—Intensive Outpatient Programs

SAMHSA—The Substance Abuse and Mental Health Services Administration

SMART—Self-Management Recovery and Training

Substance use treatment, recovery and relapse prevention have many approaches that support individuals in the journey of being substance-free and moving through the continuum of care from use to sobriety. Arizona service providers offer a variety of evidence-based professional services and experienced-based treatment approaches that address everything from symptomology to recovery and aftercare sobriety. While approaches vary, treatment usually begins with detoxifying the body from substances and creating a process that allows cognitive functions to accurately identify the need for continued sobriety. Recovery is a lifelong process that is supported by aftercare services, a supportive social network and physical and emotional wellness, in addition to a sense of purpose or meaning in life.

Arizonans have access to various types of services, including inpatient detoxification treatment, community-based support groups, clinical outpatient substance use treatment services, as well as long- and short-term residential treatment facilities. There can be barriers associated with access to some of these services. Depending on the program, clients may be offered a single service by one provider or a combination of services by multiple providers.

BARRIERS TO TREATMENT

Barriers to treatment depend on location, living situation and financial ability to pay. Arizona's rural communities have less detox, short-term residential treatment and outpatient services. Long-term residential treatments are rarely available. Not all rural communities have all services, and the delivery of each of these services is limited by service providers. Locating treatment services can be overwhelming and frustrating to an individual who is ready to make changes but is unsure how. The Arizona 211 hotline is one resource that can help locate services; however, if you are not specific about the kind of services you need, it might still be challenging to identify the right one (see Chapter 20 — Focus on Rural Communities). There are more available services in the metro than in rural areas, but even within city limits, it can be challenging to choose the most effective service type. While getting treatment is more available in some areas and more acceptable in others, there is often still some level of stigma attached to getting help or choosing to place current personal obligations on hold in order to seek treatment. Stigma can come from cultural expectations, family, friends and even religious institutions (see Chapter 6 — Substance Use Treatment, Recovery, and Relapse Prevention). Whether the stigma is actual or perceived, it can delay getting help in a timely manner and increase the chances of continued use with its associated risks.

Transportation has and continues to be a barrier to treatment because treatment locations may not be accessible by the public transit system. During the pandemic, a reduction in the frequency of bus and train routes limited peoples' access to services even more. Clients reported a lower frequency of buses, long waits for medical transportation and fewer options to get from point A to B, resulting in significantly higher travel times. In 2020 and 2021, many service providers moved to a telehealth format for the protection of clients and providers from COVID-19. Telehealth services can be challenging for populations that lack the equipment or the ability to pay for phone or internet services, such as individuals experiencing homelessness. Restrictions on gatherings also limited access to support groups, counseling services and recovery plans. For many, access to these supports is an important part of their daily lives in recovery. We are too early into the pandemic to see the magnitude of the impacts on substance use, recovery and prevention; nevertheless, the impact is being felt in the form of barriers.

DETOX SERVICES

Substance use creates a physiological dependence on the presence of the substance; the absence of the substance causes the body to become physically ill. Once an individual has made the decision to become substance-free, detox is inevitable. Medication-assisted treatment is an option for clients who are withdrawing from certain substances given their medical risks. For example, it is recommended that benzodiazepine or alcohol detoxification is done in a medical facility under the supervision of a medical professional since withdrawal from these substances can result in death.¹¹⁰ Not all substance withdrawal will require a medically assisted treatment or detoxing in a facility, but they are more helpful than detoxing alone. Detoxifying the body from substances can cause physical and mental distress that may result in the need for hospitalization. According to criteria by the American Society of Addiction Medicine (ASAM), there are five levels of withdrawal management for adults, which may impact the types of services available at any given time. The physical withdrawal symptoms in conjunction with the stress of meeting one's basic needs as well as external responsibilities can increase destabilization in the recovery process. Organizations that utilize a holistic approach to detoxification with services that address the basic needs for safety, housing, financial, social and mental health services increase the likelihood of a safe detox and continued substance use treatment, enhancing the opportunities for long-term recovery.¹¹¹

COMMUNITY-BASED RECOVERY

Community-based recovery programs have standard protocols to help meet the individuals' needs for substance use-related treatment and support. Recovery groups utilize elements of self-help and peer support from a sponsor, often organized in a 12-step model of recovery (e.g., Alcoholics Anonymous) or the Self-Management Recovery and Training (SMART) model of recovery. These programs are often community-based, which makes them more accessible and substance-specific, helping participants connect with people who share experiences in their addiction journey. Community-based programs such as Alcoholics Anonymous or Narcotics Anonymous are offered at no cost to the participants and utilize the 12-step model of recovery and sobriety. Twelve-step programs are versatile in that they allow participants to focus on a higher power of their own choosing without feeling boxed into a specific religious practice. These models subscribe to the idea that substance use is uncontrollable without the support of a higher power helping sufferers to acknowledge the problem, leading individuals down the path of self-discovery, and righting the wrongs of the past. Self-Management and Recovery Training (SMART) is a

110 "Can Heroin, Benzo or Alcohol Withdrawal Cause Death?," American Addiction Centers, August 23, 2021, <https://americanaddictioncenters.org/withdrawal-timelines-treatments/risk-of-death>.

111 "Detoxification and Substance Abuse Treatment," Substance Abuse and Mental Health Services Administration, 2015, <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf>.

self-help model that utilizes an in-person and virtual community group with four guiding principles: building and maintaining motivation, coping with urges, managing thoughts, feelings, and behaviors, as well as living a balanced life.¹¹²

OUTPATIENT TREATMENT SERVICES

Outpatient treatment involves services that are provided at least partially at a hospital, clinic or other outpatient facility. Outpatient treatment models are professionally driven and have evidence-based approaches to addressing recovery and sobriety. One-on-one outpatient counseling for substance use is an interactive process that evaluates personal history as a factor that contributes to substance use, addresses specific issues of continued use, and supports the client with making changes as well as maintaining recovery and stabilization. Individual counseling provides a 1:1 modality where the emphasis of treatment is on processing the individuals' thoughts, emotions and experiences with limited educational information shares about substance use. Psychoeducational groups are another form of outpatient treatment service that teach clients about substance use, cause and effects, thoughts and emotions with less time spent on processing an individual's struggle with substance use. In my experience, both are beneficial and are selected based on the severity of substance use and/or personal preference. Intensive Outpatient Services (IOP) is a higher level of care that includes participating in substance use treatment multiple times a week over an extended period of time (minimum 3 hours/day, 3 times/week).¹¹³ These services include assessment, counseling, crisis intervention, education on recovery and prevention, as well as addressing other issues associated with substance use. IOP is generally provided in a group setting; however, it can include supplemental individual work to address specific needs of the person in treatment. This type of treatment is more beneficial for people with housing and access to transportation, as it does not offer a residential component. IOP can be used in conjunction with community-based treatment for extra support to the person struggling with addiction.

RESIDENTIAL TREATMENT SERVICES

Residential treatment programs offer both long- and short-term treatment opportunities. Treatment can range from 30 to 90 days or from 6 months to a year. Shorter residential programs offer housing and treatment; however, they also require clients to look for work in order to be able to financially sustain their life when the treatment is completed. Short-term residential facilities have a smaller window of time to address substance use and are ideal for an individual with a shorter history of substance use and/or immediate obligations that limit the available time for treatment. Both short- and long-term treatment programs address abstinence from substance use and relapse prevention for continued sobriety. Shorter-term residential treatment programs are solution-focused, reconnecting participants to the external community for continued support. Long-term residential treatment programs have more time to provide an in-depth holistic approach to treating substance use disorders. They look at the causes or factors contributing to substance use and provide treatment to mitigate the contributing factors. Subsequently, they also reconnect individuals to the external community for continued support. Both types of programs can provide medication-assisted treatment as an additional layer while the

112 "Introduction to SMART Recovery," Smart Recovery, accessed December 15, 2021, <https://www.smartrecovery.org/intro/>.

113 "ASAM to AHCCCS Level of Care Crosswalk," Arizona Health Care Cost Containment System, 2019, https://www.azahcccs.gov/PlansProviders/Downloads/CurrentProviders/ASAM_AHCCCS_LevelOfCareCrosswalk.pdf.

client deals with the thoughts and patterns of behavior that impact addiction. Addressing external factors such as family relationships, social networks, trauma history, as well as pathways of use, increases the opportunity for successful outcomes.¹¹⁴

HALFWAY HOUSES AND TRANSITIONAL LIVING FACILITIES

Halfway houses and transitional living facilities are low-cost options for individuals who desire some level of treatment with the flexibility to remain active in the community. These houses are sober living communities that support sobriety with more focus on independence than residential programs. Halfway houses/transitional living facilities are short-term in nature and designed to help individuals gain more sobriety time, practice the tools learned in treatment and provide a bridge between treatment and returning home. Halfway houses are a good resource for individuals coming out of incarceration or other treatment facilities trying to reestablish their lives in the community. They provide a place where basic needs are met, a community that practices sobriety and a structure that allows residents to re-engage in life without the use of substances.

In the last decade, a variety of sober-living facilities has emerged, some of them halfway houses that offer some treatment, others basically just group homes, posing under a variety of names. In many communities, these types of institutions are hardly regulated, and for-profit entities that do not provide effective treatment have proliferated.¹¹⁵¹¹⁶ In some instances, sober living houses seek out clients with good health insurance, billing insurance providers for unnecessary or non-existent tests and treatments, all while neglecting their patients.¹¹⁷ Nonetheless, there are many honest providers and halfway houses remain an important tool in the kit of recovery options.¹¹⁸ It is therefore important to carefully choose reputable and legitimate providers.

RELAPSE PREVENTION

Relapse prevention begins with detox as it sets the stage for success in treatment and ultimately long-term sobriety. Researchers have identified employment and stable housing as necessary factors in relapse prevention.¹¹⁹ Aftercare services can reinforce the relapse prevention techniques learned in treatment. Recent research also shows a positive correlation between using mindfulness techniques and relapse prevention.¹²⁰ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) ascertains that there are four major dimensions that support recovery: health, home, purpose and community.¹²¹ Relapse prevention plans that do not address all these components leave a person open to issues that could trigger a relapse and undermine sobriety.

114 Jordan A. Conrad, Stephanie Jimenez, and Jennifer I. Manuel, "Pathways to Substance Use: A Qualitative Study of Individuals in Short-Term Residential Treatment," *Journal of Social Work Practice in the Addictions* 21, no. 4, 2021: 363–381, <https://doi.org/10.1080/1533256X.2021.1973830>.

115 David Segal, "City of Addict Entrepreneurs," *The New York Times*, December 27, 2017, <https://www.nytimes.com/interactive/2017/12/27/business/new-drug-rehabs.html?>

116 Peter Haden, "'Body Brokers' Get Kickbacks to Lure People with Addictions to Bad Rehab," *NPR*, August 15, 2017, <https://www.npr.org/sections/health-shots/2017/08/15/542630442/body-brokers-get-kickbacks-to-lure-people-with-addictions-to-bad-rehab>.

117 Teri Sforza et al., "How Some Southern California Drug Rehab Centers Exploit Addiction," *Orange County Register*, May 21, 2017, <https://www.ocregister.com/2017/05/21/how-some-southern-california-drug-rehab-centers-exploit-addiction/>.

118 Leonard A. Jason et al., "Communal Housing Settings Enhance Substance Abuse Recovery," *American Journal of Public Health* 96, no. 10, 2006: 1727–29, <https://doi.org/10.2105/AJPH.2005.070839>.

119 J. I. Manuel et al., "Barriers and Facilitators to Successful Transition from Long-Term Residential Substance Abuse Treatment," *Journal of Substance Abuse Treatment* 74, 2017: 16–22, <https://doi.org/10.1016/j.isat.2016.12.001>.

120 Andrew S. McClintock et al., "Mindfulness Practice Predicts Interleukin-6 Responses to a Mindfulness-Based Alcohol Relapse Prevention Intervention," *Journal of Substance Abuse Treatment*, 105, 2019: 57–63, <https://doi.org/10.1016/j.isat.2019.07.018>.

121 "Recovery and Recovery Support," *Substance Abuse and Mental Health Services Administration*, April 23, 2020, <https://www.samhsa.gov/find-help/recovery>.

Discharge plans that include follow-up with an outpatient service provider within seven days of discharge have higher success rates than those with no continued support services or no service past seven days but within 30 days.¹²²

DUAL DIAGNOSIS

Co-occurring substance use combined with mental health disorders can complicate efforts to secure treatment. Treatment providers can struggle with which diagnosis to begin due to the complexity of clients being free of substances and clearly expressing the symptomology of the mental health disorder. A person with a co-occurring diagnosis may find that treatment access is limited. For example, an individual may be using substances to cope with depression or anxiety. Treating the substance use alone leaves the mental health condition untreated and increases the risk of relapse. Treating the mental health diagnosis without addressing the substance use can increase psychological challenges that are substance use related and decreases the chance of successful treatment. Individuals seeking treatment may not be aware that they are experiencing co-occurring issues and may only seek treatment for the substance use because it is more visible.

Finding the right road to recovery can be complicated by the fact that many service providers specialize in either mental health treatment or substance use treatment, which can lead to frustration for individuals seeking treatment. There are some treatment providers who provide co-occurring treatment in a longer-term setting. For instance, residential programs at Phoenix Rescue Mission are designed to treat co-occurring substance use and mental health disorders, in addition to providing vocational development and aftercare supports.

ACCESSING SERVICES

Arizona does not have a centralized substance use treatment point of entry to provide substance use referrals. For some, accessing treatment services can be as easy as calling the customer service number on the back of the insurance card or completing an internet search of specific types of services. The uninsured and the underinsured may find that locating affordable services can become a barrier to treatment. Because service provision is often need-specific, people dealing with homelessness, mental health diagnosis and substance use disorders can have significant barriers to accessing treatment. Treatment providers often have specific admission criteria that can unintentionally exclude this population. Treating co-occurring disorders while providing long-term residential services with little to no admission appears to be a gap in services that becomes a significant hurdle for the population experiencing homelessness, mental illness, and substance use.

The road to recovery can be a long, complex journey with trial and error in finding the right treatment path. Recognizing the need for treatment and pursuing the avenues that enhance or sustain sobriety is courageous and necessary. Not all substance use treatment services will work for all people. Treatment depends on the severity of needs, the personal preference of the client and the accessibility of treatment services. Developing a plan that includes a detoxification period, engaging in treatment that addresses substance use and preparing a solid relapse prevention plan that is enhanced by community supports, increases the chances of successful sobriety.

121 "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, April 23, 2020, <https://www.samhsa.gov/find-help/recovery>.

122 Steven L. Proctor, Jaclyn L. Wainwright, and Philip L. Herschman, "Importance of Short-Term Continuing Care Plan Adherence on Long-Term Outcomes among Patients Discharged from Residential Substance Use Treatment," *The American Journal of Drug and Alcohol Abuse* 43, no. 6, 2017: 734–741, <https://doi.org/10.1080/00952990.2017.1329315>.

CHAPTER 7 — CRIMINALIZATION OF THE CONDITION

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The criminalization of mental illness, substance use, and homelessness is the result of ineffective systems. Rather than improving public housing, substance use treatment and mental health systems, the criminal justice system has been used as the proverbial rug to sweep away these systems' failures.

Owing to a popular push to deinstitutionalize the mental health care system and a move towards a community health care model, jails have become the new warehouse for the most seriously mentally ill. This effort in the 1970s led to many "mentally ill who were not adequately medicated or supervised and who soon ran afoul of the law."¹²³ In recent years, U.S. jails have come to house ten times more mentally ill people than state hospitals.¹²⁴ In Arizona alone, according to the Arizona Department of Corrections, Rehabilitation, and Reentry, more than 9,010 inmates, which is 26% of the total prison population, need consistent mental health care.¹²⁵ Jails are not an adequate substitute for inpatient mental health treatment or effective community-based treatment.

Similarly, stiff minimum sentences for nonviolent drug offenders, the result of an ill-fated war on drugs, virtually guaranteed that addicts would come to fill state prisons (see Chapter 9 — Structural Causes of Homelessness, Mental Illness and Substance Use). For example, "under the repetitive enhancement, an addict with one prior conviction for drug possession caught selling a gram of cocaine faces a sentence that is almost double that of a dealer caught with a kilo of cocaine for the first time."¹²⁶ Unsurprisingly, 65% of those housed in U.S. prisons have a substance use disorder.¹²⁷ Additionally, we know that "community-based treatment approaches are more effective for substance users than incarceration in reducing recidivism."¹²⁸ As with mental health care, substance use treatment is not cost effective nor best delivered behind bars.

Homelessness and its criminalization are a different beast, but still, the heart of the problem lies with policy. Laws that ban sleeping, loitering or lying down in public places have proliferated, as have the number of cities that ban sleeping in vehicles.¹²⁹ Individuals experiencing homelessness are being squeezed on both ends, with laws that constrict where they can sleep on one end and the increasing unavailability and unaffordability of housing on the other. Federal housing vouchers in Phoenix and other cities, which one might expect these laws to be pushing them towards, maintain a lottery to even gain access to the waiting list and wait times on such lists average around three years across the Phoenix metropolitan area.¹³⁰

123 E. Fuller Torrey et al., "The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey," Treatment Advocacy Center, 2014, <https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>.

124 Hon. R.L. Gottsfield, Larry A. Hammond, and Donna Lee Elm, "Fixing Arizona's Mass Incarceration Dilemma," Morrison Institute for Public Policy, August 2017, <https://morrisoninstitute.asu.edu/node/198>.

125 "Corrections at a Glance," Arizona Department of Corrections, Rehabilitation and Reentry, November 2021, <https://corrections.az.gov/sites/default/files/REPORTS/CAG/2021/cagnov-21.pdf>.

126 Judith Greene, "Turning the Corner: Opportunities for Effective Sentencing and Correctional Practices in Arizona," Arizona Attorneys for Criminal Justice, January 2011, <https://www.justicestrategies.org/sites/default/files/publications/AZ%20Turning%20the%20Corner%20Final%20Report.pdf>.

127 "Criminal Justice Drug Facts," National Institute on Drug Abuse, June 2020, <https://www.drugabuse.gov/publications/drugfacts/criminal-justice>.

128 Gottsfield, Hammond, and Elm, "Fixing Arizona's Mass Incarceration."

129 Tristia Bauman et al., "No Safe Place: The Criminalization of Homelessness in U.S. Cities," National Law Center on Homelessness & Poverty, 2014, https://nlchp.org/wp-content/uploads/2019/02/No_Safe_Place.pdf.

130 Courtney Holmes, "Section 8 Housing Vouchers in Short Supply for Arizona Families," ABC 15, March 3, 2021, <https://www.abc15.com/news/rebound/coronavirus-money-help/section-8-housing-vouchers-in-short-supply-for-arizona-families>.

The difficulty with homelessness is the way in which it and the policies towards it refract through the aforementioned conditions. Many mentally ill substance users are homeless, and the intertwining of these realities complicates the efforts of policymakers. For many, it isn't just a homelessness problem; their reality is all these crises at once.

Changing the "out of sight, out of mind policy" outlook towards these marginalized groups is one route towards solving the criminalization problem. A step forward has been the increasing proliferation of specialty courts such as the Mental Health Courts in Maricopa and Pima counties.¹³¹ Through court-overseen treatment, social work and other methods these courts seek to solve problems instead of tossing those under their jurisdiction into jail.

The continued criminalization of marginalized people highlights a lack of imagination on the policy front. Sectors of the government that deal with mental health issues, substance use, and homelessness do not work together enough. The overlapping of these issues creates unique problems that require a synthesized approach. Housing agencies alone cannot solve homelessness, just as substance use treatment cannot solve substance use disorder on its own. The criminal code has a role in solving these problems but wielding it alone can and has made things worse. Sweeping the mess under the rug is ineffective and merely kicks the proverbial can down the road.

131 "Civil Mental Health Court," Maricopa County, accessed 2021, <https://www.maricopa.gov/882/Mental-Health-Court>.

CHAPTER 8 — THE HUMAN AND FINANCIAL TOLL

Amy Schwabenlender, Executive Director, Human Services Campus, Inc.

First, there is a text message, “There is a client death on Campus.”

Then another text message, “It is an apparent suicide.”

For the next several hours, employees of the Human Services Campus work with police detectives and await the coroner. Employees never knew the young person well enough to understand all of the challenges they were facing. We will likely never know why they made the decision to end their life that day. This is just one story from a person who works in the “homeless services sector”—never knowing how people will show up.

Data about homelessness is readily available, and those of us working in this space aim to use this data to build awareness about the issue and those who are impacted while remembering that each data point represents someone who is struggling. There are human beings behind the numbers, the assumptions, the myths and the diagnoses representing peoples’ experiences with homelessness, mental illness and substance use. For example, the Human Services Campus in Phoenix serves 800 people per day, seven days per week. Some for just a day, others for much longer. Over a year, 6,600 different individuals are served.¹³² Figure 11 shows the numbers behind the people seeking assistance, just at this one access point to services in Maricopa County.

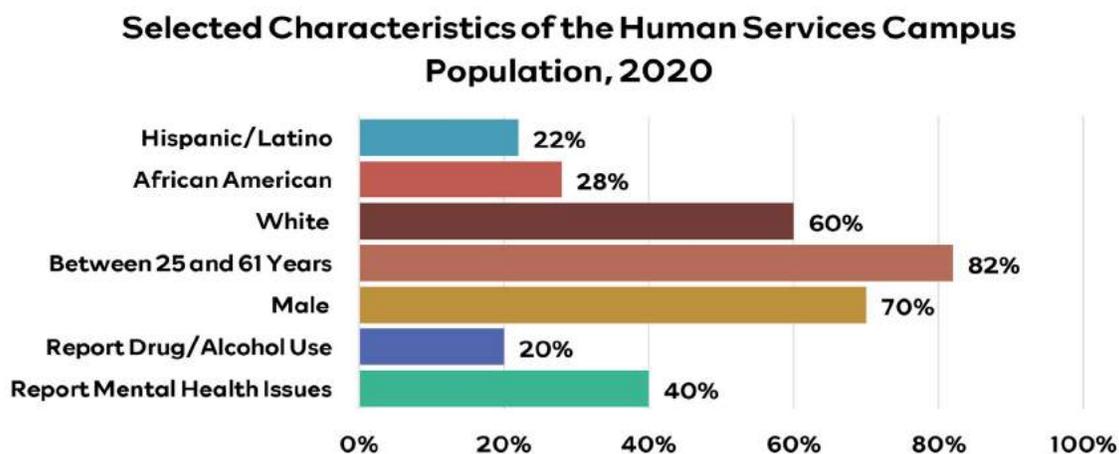


Figure 11. Selected characteristics of the Human Services Campus population, 2020.¹³³

By the time a person falls into homelessness, it is likely they are already experiencing physical and/or mental health challenges. The constant decision-making and chronic stress that comes with being unhoused can compound these issues. Decisions such as riding a bus to an appointment or waiting in line for a meal, waiting to check in to an emergency shelter, or receiving a COVID vaccine. When a person does not know where they will sleep at night, whether or not they will be safe, whether or not their possessions or pets will still be with them when they awake, they are subject to toxic stress, and this lifestyle takes a toll.

¹³² Human Service Campus, Internal Data, 2021.

¹³³ “Data for Single Adults at the Human Services Campus, Calendar Year 2020,” Homeless Management Information System (HMIS), 2021.

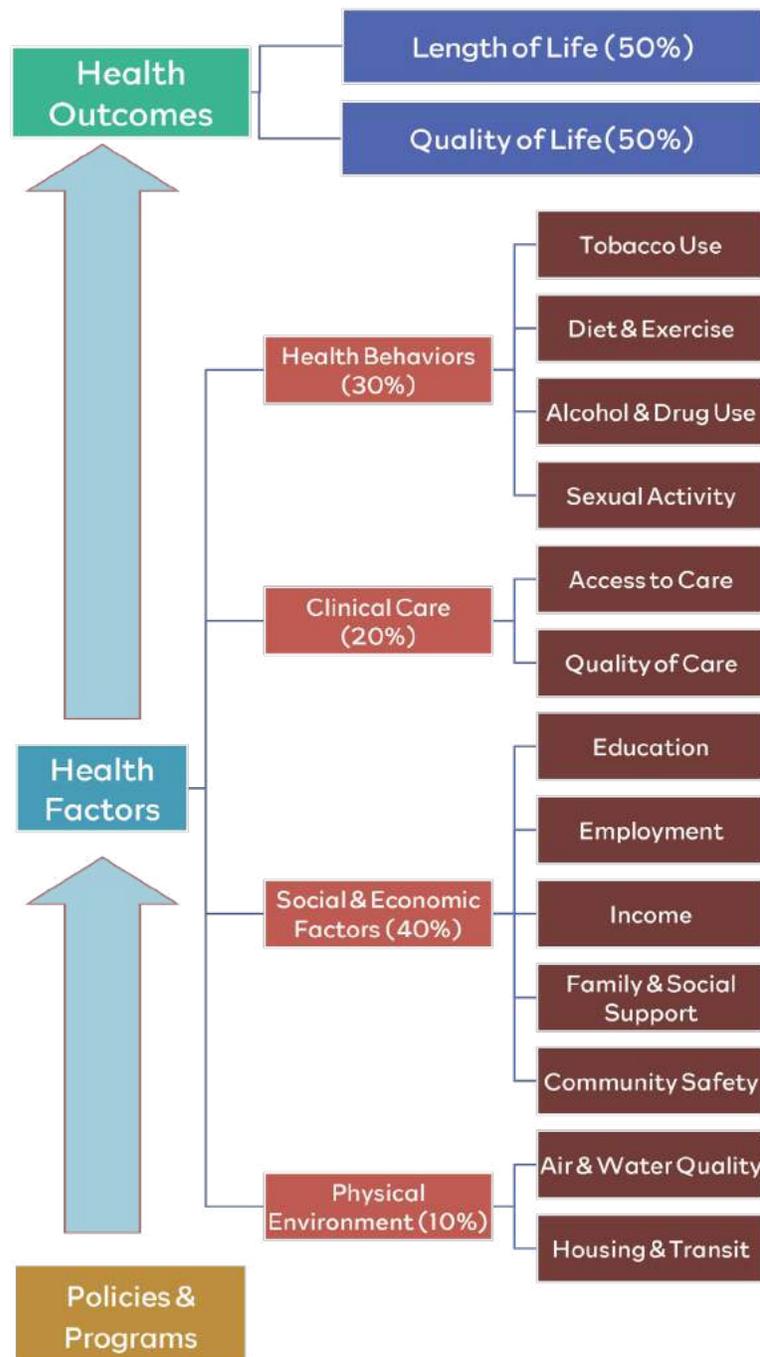


Figure 12. Social determinants of health.¹³⁴

According to the Social Determinants of Health framework, a multitude of factors contribute to a person's "whole health" (see Figure 12).¹³⁵ These health outcomes include social and economic factors, health behaviors, clinical care and their physical environment (i.e., air, water, housing and transit). Policies and programs influence these factors and have the potential to improve health outcomes.

134 "County Health Rankings Model," County Health Rankings & Roadmaps, University of Wisconsin, 2016, <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model>.

135 Sanne Magnan, "Social Determinants of Health 101 for Health Care: Five Plus Five," NAM Perspectives, 2017, <https://doi.org/10.31478/201710c>.

People who lack safe, affordable and permanent housing are missing the foundation that enables them to work on education, employment and income. Without a home, clinical care becomes strained, and behaviors may change to cope and maintain a will to survive. Studies show that adult homelessness is significantly predictive of worse health outcomes, economic “precariousness,” and risk behaviors that accelerate a lack of health.¹³⁶ Someone may use drugs or alcohol to self-medicate, or they may engage in “survival sex” to gain a sense of safety and security.¹³⁷¹³⁸ People without homes are not healthy. As a result, people who experience homelessness have a lower-than-average life expectancy. The average life span of someone in the unhoused community is approximately 50 years, an age that is almost 20 years lower than housed populations.¹³⁹

Beyond the toll of health impacts, the stigmatization of homelessness influences the way people are talked about and treated. The external environment for people who are unhoused is largely unfriendly. If you are wearing dirty clothing, have messy hair or carry a body odor, then you must be “homeless.” And if you are “homeless,” then you must be a violent criminal, a “crazy person,” lazy and/or not working hard enough to help yourself. When the adjective “homeless” is used unnecessarily to reinforce an image and generalization, it perpetuates the myth that all people experiencing homelessness are the same and stigmatizes the very people who most need help. For example, on August 7, 2019, ABC15 published an article titled “PD: Homeless woman steals ambulance, crashes into fence near 9th Ave. and Jefferson.”¹⁴⁰ This headline could have read, “Woman steals ambulance, crashes into fence.” Housing status is not relevant to the situation and is not listed in most news stories, except when the housing status is “homeless.”

There is also a toll on people’s support networks which varies depending on the individual experiencing homelessness, substance use and/or mental health issues. Some individuals overextend their stay with family and friends, burning bridges with their support networks. Meanwhile, there are others who don’t connect with their support network because of past burnt bridges. Family and friends often search for people they love but are not reunited in time before the individual is found deceased. Family and friends are left wondering, “Why didn’t they ask for help?” and, “I wish I would have known they ended up homeless.”

The human toll on professionals who work in the services sector is significant. Employees suffer from burnout and fatigue and aren’t always equipped with clinical training.¹⁴¹ The homeless services sector becomes the safety net of last resort for many of these individuals, yet professionals rarely know the whole story for each person who walks through the door.

136 Sarah C. Oppenheimer, Paula S. Nurius, and Sara Green, “Homeless History Impacts on Health Outcomes and Economic and Risk Behavior Intermediaries: New Insights from Population Data,” *Family in Society: The Journal of Contemporary Social Services* 97, no. 3, 2016: 230–242, <https://doi.org/10.1606/1044-3894.2016.97.21>.

137 Mike Mariani, “Exchanging Sex for Survival,” *The Atlantic* online, June 26, 2014, <https://www.theatlantic.com/health/archive/2014/06/exchanging-sex-for-survival/371822/>.

138 Thomas P. O’Toole et al., “Self-Reported Changes in Drug and Alcohol Use After Becoming Homeless,” *American Journal of Public Health* 94, no. 5, May 2004: 830–35, <https://doi.org/10.2105/AJPH.94.5.830>.

139 James J. O’Connell, “Premature Mortality in Homeless Populations: A Review of the Literature,” *National Health Care for the Homeless Council*, 2005, <https://sbdwww.org/wp-content/uploads/2011/04/PrematureMortalityFinal.pdf>.

140 “PD: Homeless Woman Steals Ambulance, Crashes into Fence Near 9th Ave. and Jefferson,” *abc15.com*, August 7, 2019, <https://www.abc15.com/news/region-phoenix-metro/central-phoenix/pd-homeless-woman-steals-ambulance-crashes-into-fence-near-19th-avenue-and-pierce>.

141 Jeannette Waegemakers Schiff and Annette M. Lane, “PTSD Symptoms, Vicarious Traumatization, and Burnout in Front Line Workers in the Homeless Sector,” *Community Mental Health Journal* 55, no. 3, 2019: 454–62, <https://doi.org/10.1007/s10597-018-00364-7>.

At nonprofit organizations with broad missions to end homelessness, employees are continuously doing more with less—fundraising and recruiting volunteers to help. But who is going to monitor a bathroom and emergency shower on the weekend or clean the toilets? It is not commonly volunteers. And in the spaces of shelter, navigation, intake and assessment, it is often not clinical staff either. This leaves a small subset of underpaid, under resourced and emotionally taxed professionals who carry out this work.¹⁴² Often, the professionals who are highly valued in these positions have their own lived experiences with homelessness, substance use, justice involvement, domestic violence and/or mental health challenges. The repetitive and second-hand trauma associated with this work can result in negative outcomes and re-traumatization for these professionals.¹⁴³

THE FINANCIAL TOLL: COSTS TO TAXPAYERS

With a lack of resources in the homelessness system, there is not always an appropriate option to address peoples' needs. This lack of resources comes at a cost to taxpayers when the most appropriate course of action is not available. Many individuals turn to calling 9-1-1 as the first response when someone is visibly in distress, or the person may even call themselves. However, when fire and police departments respond to a call, they often take people to jails or emergency rooms. These are not cost-effective or legitimate solutions as they aim to punish a person's behavior versus addressing the underlying causes of their situation.

When a community does not have enough emergency shelter capacity, or when shelters are not the right fit for a person, people who are unhoused end up on public streets. These unsheltered individuals seek safety, shade and water, and often their choices and behaviors also result in trash and blight in public areas. People in need of help tend to cause concern and fright among those who observe the behavior and don't know the underlying causes. These individuals may end up in front of businesses or commercial property, in alleyways, or on sidewalks. Due to the myths related to homelessness, members of the public may find the behavior of a person experiencing homelessness intimidating. The lack of resources for these individuals comes at a cost, however, business owners may lose customers, and municipalities must pay for street cleaning, trash and hazardous waste removal, and police response due to trespassing, public toileting, and threats of crime.

Homelessness costs taxpayers a significant amount of money. In 2021, the federal government distributed around \$46.7 million to Arizona's Continuum of Care programs.¹⁴⁴ In 2019, the state of Arizona pitched in about \$1.2 million to fund homelessness services.¹⁴⁵ In most cases, it is far more cost-effective to prevent homelessness than to manage it after it begins. For instance, studies have shown that even one-time rental payment assistance can be successful in avoiding homelessness by avoiding an eviction.¹⁴⁶ Many studies have tried to estimate the costs of homelessness to the public, focusing on different populations.¹⁴⁷ Individuals experiencing chronic homelessness,

142 Vanessa Rios, "Frontline Workers: Urban Solutions for Developing a Sustainable Workforce in the Homeless Services Sector of Los Angeles County," Antioch University Los Angeles, 2018, <https://www.antioch.edu/wp-content/uploads/2018/05/RIOS-VANESSA.-URBAN-SOLUTIONS-FOR-DEVELOPING-A-SUSTAINABLE-WORKFORCE.-.pdf>.

143 Waegemakers Schiff and Lane, "PTSD Symptoms, Vicarious Traumatization."

144 "HUD Renews Funding for Thousands of Local Homeless Program," Department of Housing and Urban Development, January 29, 2021, https://www.hud.gov/press/press_releases_media_advisories/HUD_No_21_017.

145 "State of Homelessness 2020," Arizona Department of Economic Security, 2020, <https://des.az.gov/sites/default/files/dl/Homelessness-Annual-Report-2020.pdf?time=1615214499188>.

146 William N. Evans, James X. Sullivan, and Melanie Wallskog, "The Impact of Homelessness Prevention Programs on Homelessness," *Science* 353, no. 6300, 2016: 694–99, <https://doi.org/10.1126/science.aag0833>.

147 Dennis P. Culhane, "The Cost of Homelessness: A Perspective from the U.S.," *European Journal of Homelessness* 2, no. 1, 2008: 97–114, https://repository.upenn.edu/spp_papers/148/.

often with substance use and mental health issues—so-called frequent users—can cost the public up to \$83,000 a year when counting costs of shelter, medical services and justice involvement.¹⁴⁸ There are significant cost savings associated with identifying this population and bringing it into permanent supportive housing according to several studies.¹⁴⁹¹⁵⁰ Even when no significant cost savings are found as in a recent evaluation of a Denver-based permanent supportive housing project, there are much better outcomes for individuals, mostly by avoiding arrests and incarceration.¹⁵¹

The lack of funding and lack of coordination across jurisdictions and departments contributes to a systemic cycle of homelessness rather than a movement towards a reduction in the level of homelessness. For example, with the recent influx of federal funding for housing and shelter responses, each jurisdiction receiving funds makes independent decisions about how to spend the dollars for “their residents.” This positions people who are unhoused as belonging to one city or another. However, people do not move that way through services, meaning that they do not identify as a resident of a particular city. Jurisdiction A may use Emergency Housing Vouchers for a specific sub-population, say families. Jurisdiction B may use Emergency Housing Vouchers for victims of domestic violence. The individual decision-making by these entities does not align to a coordinated approach to change the systems that lead to and keep people unhoused. The individual experiencing is left confused, receiving little communication as to their application status, and oftentimes moving through the jurisdictions with no place to land.

The alignment of funding and resources to human-centered solutions and systemic change could reduce harm across the board and would likely save lives. Even more, a redirection of funding could better support neighborhoods as a coordinated response would address the social determinants of health, leading to healthier neighborhoods.

148 Daniel Flaming, Halil Toros, and Patrick Burns, “Home Not Found: The Cost Of Homelessness In Silicon Valley,” Economic Roundtable, 2015, https://destinationhomesv.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf.

149 Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, “Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing,” Housing Policy Debate 13, no. 1, 2002: 107–63, <https://doi.org/10.1080/10511482.2002.9521437>.

150 Julia C. Bausch, Alison Cook-Davis, and Benedikt Springer, “Housing is Health Care: The Impact of Supportive Housing on the Costs of Chronic Mental Illness,” Morrison Institute for Public Policy, 2021, https://morrisoninstitute.asu.edu/sites/default/files/housing_is_health_care_report_2021.pdf.

151 Mary K. Cunningham, “Breaking the Homelessness–Jail Cycle with Housing First: Results from the Denver Supportive Housing Social Impact Bond Initiative,” Urban Institute, 2021, <https://www.urban.org/research/publication/breaking-homelessness-jail-cycle-housing-first-results-denver-supportive-housing-social-impact-bond-initiative>.

CHAPTER 9 — STRUCTURAL CAUSES OF HOMELESSNESS, MENTAL ILLNESS AND SUBSTANCE USE

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Acronyms in this Chapter

LGBTQ+—Lesbian, Gay, Bisexual, Transgender, Queer

PTSD—Post-Traumatic Stress Disorder

SPARC—Supporting Partnership for Anti-Racist Communities

Homelessness, historically, has had an overly individual focus. We often ask what personal failing—drug addiction or laziness—or what adversity—family instability or job loss—led an individual to lose their housing. However, homelessness is a result of more complex structural problems, such as poverty, injustice, oppression and racism, that lead to inequities in social, economic and health outcomes. For example, there is significant racial disproportionality in homelessness in the U.S., in particular the overrepresentation of Black/African American people, which has received scant attention from policymakers until recently.¹⁵² Current efforts to examine homelessness from an equity perspective invite us to gain new insight into how systemic racism, in particular, perpetuates disparities among individuals who face housing insecurity or who are homeless.

This chapter introduces structural causes of homelessness as well as the systemic problems that impede individuals' exit from homelessness. We conclude with approaches for advancing equity through both policy and practice for our most vulnerable communities.

SYSTEMIC RACISM DEFINED

Distinguished from acts of racism perpetuated by one person to another, systemic or structural racism refers to the inherent racism and discrimination that are rooted in our history, culture, norms and ideologies. It encompasses the economic, social and legal policies and practices in our institutions that perpetuate inequity in our pursuit to rent an apartment or buy a home, apply for a job, get a mortgage loan, and send our children to a good school.¹⁵³ Systemic racism also contributes to disparities accessing mental health and substance use treatment among people of color, creating barriers to engaging and completing treatment compared to their white counterparts.¹⁵⁴ Systemic racism maintains an oppressive social order in which we all participate. It preserves a social order through “behavior and actions that are normative, habituated and often unconscious,” which advantages white

152 Marian Moser Jones, “Does Race Matter in Addressing Homelessness? A Review of the Literature,” *World Medical and Health Policy* 8 no. 2, 2016: 139–56, <https://doi.org/10.1002/wmh3.189>.

153 John A. Powell, “Structural Racism: Building upon the Insights of John Calmore,” *North Carolina Law Review* 86, no. 2, 2008: 791–816, <https://scholarship.law.unc.edu/nclr/vol86/iss3/8>.

154 Sara Matsuzaka and Margaret Knapp, “Anti-Racism and Substance Use Treatment: Addiction Does Not Discriminate, but Do We?,” *Journal of Ethnicity in Substance Abuse* 19, no. 4, 2020: 567–93, <https://doi.org/10.1080/15332640.2018.1548323>.

persons and serves white identity needs to the detriment of people of color.¹⁵⁵ Systemic racism leads to inequities between people of color and white persons—like wealth, homeownership and employment opportunities—thereby contributing to homelessness.

STRUCTURAL STIGMA DEFINED

Structural stigma is a societal response enacted through laws, policies and social systems “that aims to exclude, reject, shame and devalue groups of people on the basis of a particular characteristic/s.”¹⁵⁶ Individuals who experience homelessness contend with structural stigma simply because of their housing status. For instance, policies that exclude people experiencing homelessness from access to health care, education, or employment or the use of public spaces (e.g., parks) institutionalize stigmatization and have the potential to extend and exacerbate episodes of homelessness. The stigmatization of being homeless is commonly coupled with mental illness and/or a substance use problem, irrespective of whether the individual has either condition. The interplay of stereotyping and labeling individuals experiencing homelessness as “lazy,” “dangerous,” “crazy,” “a druggie,” or “an alcoholic” and characterizing them as “different” results in significant loss of status in society. These levels of discrimination—that occur at the street corner, in the neighborhood and across all our institutional systems—lead to social inequities experienced by the homeless population.¹⁵⁷

CURRENT STATE

Systemic Racism

Intentional oppression has excluded people of color—particularly Black/African American and American Indians/Alaska Native persons—from having equitable access to housing, employment and opportunities for economic mobility. Historical policies set forth by the Federal Housing Authority in the 1930s, such as redlining, whereby banks refused to insure mortgages in and near Communities of Color, especially African American neighborhoods, furthered housing segregation between white and Black/African American communities. This created pockets of concentrated poverty in neighborhoods where African American persons predominantly lived at the time and continues to perpetuate the economic inequities Black/African American persons and people of color face in our country today.¹⁵⁸ Almost a century later, despite a series of facts aimed at combating segregation and discrimination including the passage of the Fair Housing Act in 1968, structural racism persists. The consequence of inequities in our housing policies and regulations over several generations—predatory lending practices, racial discrimination by lenders, mortgage loan rejection—have resulted in significant opportunities for white individuals and families to accumulate wealth through homeownership and significant barriers for people of color. The societal conditions that have led to wealth accumulation for whites explain the racial wealth gap and the continued disparity in assets between whites and people of color. Even among families earning near the poverty line, white families

155 Eduardo Bonilla-Silva, “What Makes Systemic Racism Systemic?,” *Sociological Inquiry* 91, no. 3, March 2021: 513–33, <https://doi.org/10.1111/soin.12420>.

156 James D. Livingston, “Mental Illness-Related Structural Stigma: The Downward Spiral of Systemic Exclusion Final Report,” Mental Health Commission of Canada, October 2013, https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHCC_OpeningMinds_MentalIllness-RelatedStructuralStigmaReport_ENG_O_O.pdf.

157 Bruce Link and Mark L. Hatzenbuehler, “Stigma as an Unrecognized Determinant of Population Health: Research and Policy Implications,” *Journal of Health Politics, Policy and Law* 41, no. 4, 2016: 653–73, <https://doi.org/10.1215/03616878-3620869>.

158 Janelle Jones, John Schmitt, and Valerie Wilson, “50 Years after the Kerner Commission: African Americans Are Better off in Many Ways but Are Still Disadvantaged by Racial Inequality,” Economic Policy Institute, February 26, 2018, <https://www.epi.org/files/pdf/142084.pdf>.

have about \$18,000 in wealth, while African American families have a median net wealth of \$0.¹⁵⁹ The continued existence of discriminatory policies coupled with centuries of inequitable treatment and limited opportunity for people of color are sources of housing inequality that enable systemic racism to persist today.

In response to racial disproportionality in homelessness, the Center for Social Innovation launched the Supporting Partnership for Anti-Racist Communities (SPARC) study in 2018. It concluded that racism is a fundamental cause of homelessness. Across five communities, SPARC found that Black/African American persons, who represented 18.3% of the population surveyed, were overrepresented among those in poverty (34.1%) and those experiencing homelessness (64.7%; Figure 13).¹⁶⁰ Current national data show similar trends with Black/African American persons representing 39% of the population experiencing homelessness even though Black/African American persons make up 13.4% of the U.S. population.¹⁶¹ Black families make up 54% of families staying in homeless shelters.¹⁶²

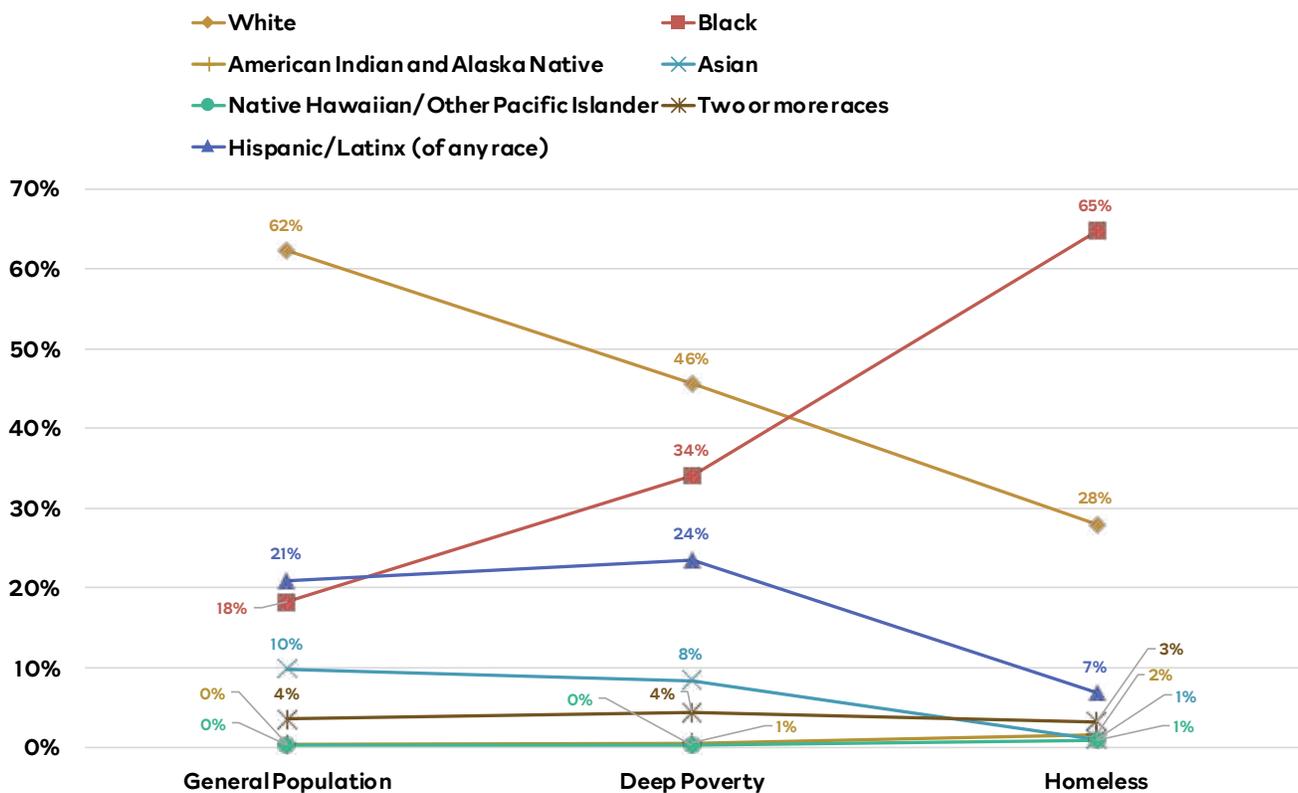


Figure 13. Race/ethnicity breakdown of the general population, the population in deep poverty and the homeless population in five SPARC communities.¹⁶³

159 William Darity Jr. et al., "What We Get Wrong About Closing the Racial Wealth Gap," Samuel DuBois Cook Center on Social Equity, April 2018, <https://socialequity.duke.edu/wp-content/uploads/2020/01/what-we-get-wrong.pdf>.

160 Jeffrey Olivet et al. "SPARC: Supporting Partnerships for Anti-Racist Communities Phase One Study Findings," Center for Social Innovation, March 2018, <https://c4innovates.com/wp-content/uploads/2019/03/SPARC-Phase-I-Findings-March-2018.pdf>.

161 Meghan Henry et al., "The 2020 Annual Homeless Assessment Report (AHAR) to Congress," U.S. Department of Housing and Urban Development, January 2021, <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>.

162 "The 2018 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness," December 2018, U.S. Department of Housing and Urban Development, <https://www.huduser.gov/portal/sites/default/files/pdf/2018-AHAR-Part-1.pdf>.

163 Olivet et al. "SPARC."

Poverty

We all face challenges and adversities in our lifetime. Yet, a large number of Americans start their lives at a great disadvantage when they are born into families living in significant economic insecurity. Roughly 20% of children in the U.S. live in poverty.¹⁶⁴ Moreover, more than 20 million children and adults in our country experience “deep poverty,” barely surviving at less than half the poverty line.¹⁶⁵ In addition to poverty, there are notable factors that are sources of vulnerability that increase one’s risk of remaining in poverty. Low educational attainment, mental or physical disabilities, disruptive events such as job loss or illness consequently accelerate one’s risk for living in poverty.¹⁶⁶¹⁶⁷¹⁶⁸ A family history of domestic violence, substance use, or incarceration are also associated with higher risks of remaining or falling into poverty or becoming homeless.¹⁶⁹¹⁷⁰¹⁷¹ Poverty, a byproduct of income inequality which is the unequal distribution of opportunity, is worsened by systemic barriers.

Systemic barriers to accessing health care (e.g., cost of health insurance, access to reliable transportation) and discriminatory practices that “constrain an individual’s opportunities, resources, and wellbeing” are realities that individuals in poverty confront, in particular people of color.¹⁷² Income inequality is linked to poor mental health and increased vulnerability for mental illness as well as homelessness.¹⁷³¹⁷⁴¹⁷⁵ Intertwined, systemic racism, structural stigma and poverty exacerbate poor mental health, especially among people of color. For example, Black/African American persons living below the poverty level are two times more likely to experience serious psychological distress compared to those with incomes above the poverty level.¹⁷⁶ Individuals with lower socioeconomic status, in particular people of color, are less likely to access mental health treatment or receive adequate care when they are treated.¹⁷⁷ Research shows that counties with a higher percentage of Black/African American and Hispanic/Latinx residents were less likely to have any outpatient substance use disorder facility that accepts Medicaid–

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- 164 “Poverty Status of People, by Age, Race, and Hispanic Origin: 1959–2013,” U.S. Census Bureau, 2014, <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html>.
- 165 Serena Lei, “The Unwaged War on Deep Poverty,” Urban Institute, December 15, 2013, <https://www.urban.org/features/unwaged-war-deep-poverty>.
- 166 David Brady, Ryan M. Finnigan, and Sabine Hübgen, “Rethinking the Risks of Poverty: A Framework for Analyzing Prevalences and Penalties,” *American Journal of Sociology* 123, no. 3, 2017: 740–86, <https://doi.org/10.1086/693678>.
- 167 Pam Fessler, “Why Disability and Poverty Still Go Hand in Hand 25 Years After Landmark Law,” NPR, July 23, 2015, <https://www.npr.org/sections/health-shots/2015/07/23/424990474/why-disability-and-poverty-still-go-hand-in-hand-25-years-after-landmark-law>.
- 168 Bob Herman, “Medical Costs are Driving Millions of People into Poverty,” *Axios*, September 19, 2016, <https://www.axios.com/medical-expenses-poverty-deductibles-540e2c09-417a-4936-97aa-c241fd5396d2.html>.
- 169 Nata Duvvury, Aoife Callan, Patrick Carney, and Srinivas Raghavendra, “Intimate Partner Violence: Economic Costs and Implications for Growth and Development,” World Bank, 2013, <https://www.worldbank.org/content/dam/Worldbank/document/Gender/Duvvury%20et%20al.%202013%20Intimate%20Partner%20Violence.%20Economic%20costs%20and%20implications%20for%20growth%20and%20development%20VAP%20No.3%20Nov%202013.pdf>.
- 170 Robert Kaestner, “Does Drug Use Cause Poverty?,” National Bureau of Economic Research, 1998, https://www.nber.org/system/files/working_papers/w6406/w6406.pdf.
- 171 Robert DeFina and Lance Hannon, “The Impact of Mass Incarceration on Poverty,” *Crime & Delinquency* 59, no. 4, 2013: 562–86, <https://doi.org/10.1177/001128708328864>.
- 172 Mark L. Hatzenbuehler, Jo C. Phelan, and Bruce G. Link, “Stigma as a Fundamental Cause of Population Health Inequalities,” *American Journal of Public Health* 103, no. 5, 2013: 813–21, <https://doi.org/10.2105/AJPH.2012.301069>.
- 173 Thomas H. Byrne, Benjamin F. Henwood, and Anthony W. Orlando, “A Rising Tide Drowns Unstable Boats: How Inequality Creates Homelessness,” *The ANNALS of the American Academy of Political and Social Science* 693, no. 1, 2021: 28–45, <https://doi.org/10.1177/0002716220981864>.
- 174 Erick Messias, William W. Eaton, and Amy N. Grooms, “Economic Grand Rounds: Income Inequality and Depression Prevalence Across the U.S.: An Ecological Study,” *Psychiatric Services* 62, no. 7, 2011: 710–12, https://doi.org/10.1176/ps.62.7.pss6207_0710.
- 175 Kate E. Pickett and Richard G. Wilkinson, “Child Wellbeing and Income Inequality in Rich Societies: Ecological Cross-Sectional Study,” *British Medical Journal* 335, no. 1080, 2007: 1–7, <https://doi.org/10.1136/bmi.39377.580162.55>.
- 176 “Table 46: Serious Psychological Distress in the Past 30 Days among Adults Aged 18 and over, by Selected Characteristics,” Centers for Disease Control and Prevention, 2017, <https://www.cdc.gov/nchs/data/hus/2017/046.pdf>.
- 177 Jennifer Dykxhoorn and James B. Kirkbride, “The Epidemiological Burden of Major Psychiatric Disorders,” in *Oxford Textbook of Public Mental Health*, ed. Dinesh Bhugra, Kamaldeep Bhui, Samuel Yeung Shan Wong, and Stephen E. Gilman (Oxford University Press, September 2018), <https://doi.org/10.1093/med/9780198792994.003.0009>.

that is, health insurance for individuals and families with low incomes.¹⁷⁸ Consequently, economic barriers restrict access to quality substance use treatment services accounting for racial differences resulting in people of color entering treatment with a greater severity of substance use issues than white individuals.¹⁷⁹

Housing

Past and current policies have at times institutionalized or enabled discrimination in housing. Discrimination can take on many forms perpetuated by persons and institutions in power, such as landlords, building managers or banks and insurance companies who are ultimately gatekeepers to housing opportunities and housing stability. Housing discrimination affects individuals who are stigmatized because of their race/ethnicity, gender, behavioral health condition (mental health and/or substance use), physical disability, criminal records or sexual orientation.¹⁸⁰¹⁸¹ Individuals experiencing homelessness are also discriminated against in their efforts to secure housing.¹⁸² Individuals who receive a housing voucher, typically through their local housing authority, frequently experience “source of income” discrimination. This occurs when landlords refuse to rent to individuals with Housing Vouchers because of the stereotypes associated with being a voucher holder. While this discriminatory practice is illegal in certain jurisdictions, it is perfectly legal in Arizona.¹⁸³

Housing discrimination also limits equitable opportunities for wealth accumulation and economic mobility for people of color. The process of finding an apartment or home, in and of itself, can be very stressful. Adding to this stress is the fact that housing discrimination isn’t always obvious, yet it is a prevalent societal condition experienced by people of color. It can take the form of:

- “Steering” someone to a particular neighborhood because of their race.
- Being treated differently because of one’s race (e.g., shown fewer housing units).¹⁸⁴
- Denying an individual’s housing application because of their race.

Taken together, these practices also contribute to and perpetuate homelessness.

178 Janet R. Cummings, Hefei Wen, Michelle Ko, and Benjamin G. Druss, “Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the U.S.,” *JAMA Psychiatry* 71, no. 2, February 2014: 190–96, <https://doi.org/10.1001/jamapsychiatry.2013.3575>.

179 Matsuzaka and Knapp, “Anti-Racism and Substance Use.”

180 “The Case for Fair Housing,” Fair Housing Alliance, 2017, <https://nationalfairhousing.org/wp-content/uploads/2017/04/TRENDS-REPORT-4-19-17-FINAL-2.pdf>.

181 “Rental Housing Discrimination on the Basis of Mental Disabilities: Results of Pilot Testing,” U.S. Department of Housing and Urban Development, 2017, <https://www.huduser.gov/portal/sites/default/files/pdf/MentalDisabilities-FinalPaper.pdf>.

182 Susan Sered and Miriam Boeri, “Poor and Homeless Face Discrimination under America’s Flawed Housing Voucher System,” *The Conversation*, January 26, 2016, <https://theconversation.com/poor-and-homeless-face-discrimination-under-americas-flawed-housing-voucher-system-52480>.

183 Antonia K. Fasanelli and Philip Tegeler, “Your Money’s No Good Here: Combatting Source of Income Discrimination in Housing,” *American Bar Association*, November 30, 2019, https://www.americanbar.org/groups/crsi/publications/human_rights_magazine_home/economic-justice/your-money-s-no-good-here--combatting-source-of-income-discrimin/.

184 “Housing Discrimination Against Racial and Ethnic Minorities,” U.S. Department of Housing and Urban Development, 2013, https://www.huduser.gov/portal/publications/fairhsg/hsg_discrimination_2012.html.

185 Evelien P. M. Brouwers, “Social Stigma is an Underestimated Contributing Factor to Unemployment in People with Mental Illness or Mental Health Issues: Position Paper and Future Directions,” *BMC Psychology* 8, no. 36, 2020: 1–7, <https://doi.org/10.1186/s40359-020-00399-0>.

186 National Academies of Sciences, Engineering, and Medicine, *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change* (Washington, DC: National Academies Press, 2016), <https://doi.org/10.17226/23442>.

Employment

Employment discrimination is another form of social inequity that exists in American society. Persons living with severe mental illness are seven times more likely to be unemployed than persons with no mental disorders. Those with common mental health conditions (e.g., Generalized Anxiety Disorder, Major Depressive Disorder) are three times more likely to be unemployed than their counterparts.¹⁸⁵¹⁸⁶ Systemic racism also contributes to workplace discrimination. The work of Bertrand and Mullainathan (2004) highlighted how employers discriminated against “Black sounding names” (i.e., Tanisha, Jamal).¹⁸⁷ They found that after employers reviewed identical resumes with the exception of white or Black names, white names had a 50% higher rate of getting a callback than applicants with Black names. The prejudice towards Black/African American persons simply because of their names coupled with another stigmatizing status—such as criminal history—transcends beyond just discriminatory practices. Black/African American persons with no criminal records still received fewer callbacks compared to whites with criminal records.¹⁸⁸

Extensive research confirms that these trends still exist today. Along with systemic issues like poverty and housing discrimination, hiring discrimination continues to perpetuate inequities in employment for Black/African American persons.¹⁸⁹ Consequently, the disproportion of people of color in low-wage jobs leaves many workers, particularly those who are Black/African American and Latinx, with limited access to health insurance or other benefits compared to whites, including paid sick leave, family leave or retirement benefits.¹⁹⁰ Worsening the inequities in employment, Black/African American persons continue to make less than white persons, earning 82.5 cents for every dollar white persons earn.¹⁹¹ Anti-Black/African American sentiment in the U.S. continues to impede the social and economic advancement of Black/African American persons in the workplace.¹⁹² This, in turn, contributes to poverty and homelessness.

Criminal Justice System and Overcriminalization

A harmful cycle exists between homelessness and involvement with the criminal justice system. Although homelessness may increase an individual's vulnerability to incarceration, research suggests that incarceration leads to homelessness. Approximately 50,000 individuals enter homeless shelters directly from incarceration each year in the U.S. (see Chapter 18 — Focus on Formerly Incarcerated Individuals).¹⁹³ Yet, this is a severe undercount of the number of individuals who are at the nexus of homelessness and incarceration which excludes 1) individuals who are discharged directly to the streets who are homeless immediately upon release from prison;

185 Evelien P. M. Brouwers, “Social Stigma is an Underestimated Contributing Factor to Unemployment in People with Mental Illness or Mental Health Issues: Position Paper and Future Directions,” *BMC Psychology* 8, no. 36, 2020: 1–7, <https://doi.org/10.1186/s40359-020-00399-0>.

186 National Academies of Sciences, Engineering, and Medicine, *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change* (Washington, DC: National Academies Press, 2016), <https://doi.org/10.17226/23442>.

187 Marianne Bertrand and Sendhil Mullainathan, “Are Emily and Greg More Employable than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination,” *American Economic Review* 94, no. 4, 2004: 991–1013, <https://doi.org/10.1257/0002828042002561>.

188 Devah Pager, “The Mark of a Criminal Record,” *American Journal of Sociology* 108, no. 5, 2003: 937–75, <https://doi.org/10.1086/374403>.

189 Lincoln Quillian, Devah Pager, Ole Hexel, and Arnfinn H. Midtbøen, “Meta-Analysis of Field Experiments Shows No Change in Racial Discrimination in Hiring over Time,” *Proceedings of the National Academy of Sciences* 114, no. 41, 2017: 10870–75, <https://doi.org/10.1073/pnas.1706255114>.

190 Danyelle Solomon and Darrick Hamilton, “The Coronavirus Pandemic and the Racial Wealth Gap,” Center for American Progress, March 19, 2020, <https://www.americanprogress.org/issues/race/news/2020/03/19/481962/coronavirus-pandemic-racial-wealth-gap/>.

191 Jones, Schmitt, and Wilson, “50 Years after the Kerner Commission.”

192 Casey Stockstill and Grace Carson, “Are Lighter-Skinned Tanisha and Jamal Worth More Pay? White People’s Gendered Colorism toward Black Job Applicants with Racialized Names,” *Ethnic and Racial Studies* 45, no. 5, 2022: 896–917, <https://doi.org/10.1080/01419870.2021.1900584>.

193 “Connecting People Returning from Incarceration with Housing and Homelessness Assistance,” U.S. Interagency Council on Homelessness, 2016, https://www.usich.gov/resources/uploads/asset_library/Reentry_Housing_Resource_Tipsheet_Final.pdf.

and 2) individuals who experience homelessness shortly after they are released from prison due to temporary housing arrangements (e.g., with family or friends). Individuals living with mental illness, and often co-occurring substance use disorders, experience overcriminalization, particularly since the deinstitutionalization of state hospitals in the 1970s and 1980s.¹⁹⁴ Those who have a low educational status and disabilities, mental health and/or substance use disorders are more likely to be arrested.¹⁹⁵¹⁹⁶ Moreover, the consequences of behavioral health disorders are more significant for people of color who contend with increased odds of incarceration.¹⁹⁷

Overrepresented in the criminal justice system and the homeless population, people of color contend with overcriminalization. Overcriminalization is the overuse or misuse of criminal law to address societal problems that result in harsh enforcement of petty violations and excessive punishment that is incongruent with the seriousness of the crime (see Chapter 7 — Criminalization of the Condition). The rise in incarceration, particularly of Black and Latinx men, was fueled by the not so covert racism inherent in America's "war on drugs." Historically, the illegalization of drugs went far beyond arrests and incarceration of people of color. It became deeply embedded in many aspects of daily life—education, housing, employment and public benefits. The culture of criminalization is acutely rooted in the history of the U.S. This has included targeting and traumatizing Communities of Color with high rates of arrests for misdemeanors and harsh sentencing laws resulting in high rates of incarceration of Black/African American, Hispanic/Latinx and Native American persons.¹⁹⁸¹⁹⁹

Consequently, the share of incarcerated Black/African American persons almost tripled from 1968 to 2016.²⁰⁰ Black/African American persons are incarcerated at more than six times the rate of white persons. Contributing to the inequities in the criminal justice system is the likelihood that police are more prone to use the threat of or use of force against people of color, which leads to higher and more frequent arrest rates in these communities.²⁰¹ As the murder of George Floyd exposed to the world, the excessive force by law enforcement of a Black/African American man suspected of using a counterfeit \$20 bill exemplifies the structural racism—the discrimination and inhumane mistreatment—that people of color, particularly Black/African American men, continue to experience in the U.S.. This is an important factor in explaining why African Americans are overrepresented in the homeless population.

194 Alina Perez, Stephen Leifman, and Ana Estada, "Reversing the Criminalization of Mental Illness," *Crime & Delinquency* 49, no. 1, 2003: 62–78, <https://doi.org/10.1177/001128702239236>.

195 Wendy Sawyer, "Ten Key Facts about Policing: Highlights from Our Work." Prison Policy Initiative, June 5, 2020, <https://www.prisonpolicy.org/blog/2020/06/05/policingfacts/>.

196 Kristin Turney, "Incarceration and Social Inequality: Challenges and Directions for Further Research," *The Annals of the American Academy of Political and Social Sciences* 651, no. 1, 2014: 97–101, <https://doi.org/10.1177/0002716213501273>.

197 Margarita Alegría, Debra Joy Pérez, and Sandra Williams, "The Role of Public Policies in Reducing Mental Health Status Disparities for People of Color," *Health Affairs* 22, no. 5, 2003: 51–64, <https://doi.org/10.1377/hlthaff.22.5.51>.

198 Alexandra Natapoff, *Punishment Without Crime: How Our Massive Misdemeanor System Traps the Innocent and Makes America More Unequal* (Basic Books, 2018).

199 Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2012).

200 Jones, Schmitt, and Wilson, "50 Years after the Kerner Commission."

201 Sawyer, "Ten Key Facts about Policing."

Behavioral and Health Care Systems

Structural stigma is embedded in our health care system, affecting individuals—in particular persons living with mental health and substance use issues—and is exacerbated by systemic racism for people of color.²⁰² Structural stigma perpetuates the exclusion of those stigmatized by mental illness and/or substance use through biased policies, discriminatory practices, limited access to services and barriers to resources or supports.²⁰³ This social exclusion perpetuates mental health conditions and consequently increases individuals' risk for experiencing homelessness, especially for people of color. For example, Black/African American men are more likely to receive a misdiagnosis of schizophrenia when expressing symptoms related to mood disorders or Post-Traumatic Stress Disorder (PTSD).²⁰⁴ These biases and barriers can contribute greatly to self-stigma, which is the negative feelings or self-image of oneself or one's group. In addition, some research findings suggest that ethnic minorities are more likely to talk about their psychological symptoms in the form of physical symptoms when seeking medical care.²⁰⁵ Latinx individuals, for example, may describe physical pain when talking about depression to a medical professional.²⁰⁶²⁰⁷ In both examples, the misdiagnosis of a mental health condition and the self-stigma of having a mental health problem, represent how stigmatization towards mental health and/or substance use issues exist in our society; and the differences that exist in the level and type of care that people of color may receive—contributing to disparities in health outcomes and quality of life. Unfortunately, despite the need for mental health care and/or substance use treatment in Communities of Color, only 1 in 3 Black/African American adults who need mental health care receive it. People of color also face structural challenges (e.g., transportation, health insurance, stigma) accessing the care and treatment they need. Access to mental health care is lowest among Latinxs (7.3%) and other minority groups (11.5%) relative to white persons (16.6%), highlighting significant inequities in mental health care access among people of color.²⁰⁸²⁰⁹ It is clear that “stigma cannot be eradicated without addressing structural stigma” that exists in our policies and laws towards individuals with mental health and/or substance use conditions, in particular among those experiencing homelessness.²¹⁰

202 James D. Livingston, “A Framework for Assessing Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues,” Mental Health Commission of Canada, 2021, https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-05/Structural_Stigma_Assessment_Report_eng.pdf.

203 National Academies of Sciences, Engineering, and Medicine, *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*, (Washington, DC: The National Academies Press, 2016), <https://doi.org/10.17226/23442>.

204 Michael A. Gara et al., “A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic,” *Psychiatric Services* 70, no. 2, 2019: 130–34, <https://doi.org/10.1176/appi.ps.201800223>.

205 John A. Saucedo et al., “Testing for Differences in the Reporting of Somatic Symptoms of Depression in Racial/Ethnic Minorities,” *Health Education & Behavior* 48, no. 3, 2021: 260–64, <https://doi.org/10.1177/10901981211011925>.

206 Jenny Chong, Kerstin M. Reinschmidt, and Francisco A. Moreno, “Symptoms of Depression in a Hispanic Primary Care Population with and without Chronic Medical Illnesses,” *Primary Care Companion to the Journal of Clinical Psychiatry* 12, no. 3, 2010: <https://doi.org/10.4088/PCC.09m00846blu>.

207 Sanam S. Dhaliwal and Theodore A. Stern, “Recognition of Psychiatric Symptoms and Conditions in Latino Patients,” *The Primary Care Companion for CNS Disorders* 13, no. 6, 2011: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3304674/>.

208 Leopoldo J. Cabassa, Luis H. Zayas, and Marissa C. Hansen, “Latino Adults' Access to Mental Health Care: A Review of Epidemiological Studies,” *Administration and Policy in Mental Health and Mental Health Services Research* 33, no. 3, 2006: 316–330, <https://doi.org/10.1007/s10488-006-0040-8>.

209 Margaret Wile and Kristine Goodwin, “The Costs and Consequences of Disparities in Behavioral Health Care,” National Conference of State Legislatures, February 2018, https://www.ncsl.org/Portals/1/Documents/Health/DisparitiesBH_32068.pdf.

210 James D. Livingston, “A Framework for Assessing,” 1.

CLOSING

The experience of homelessness, of not knowing where one will sleep and how one will meet their most basic needs, places a huge burden on one's mental health and wellbeing. The toll of housing instability is exacerbated by structural racism for people of color in their efforts to access services and resources. Individuals who are homeless also face stigmatization because of their housing status, mental health and/or substance use conditions, as well as their other identities (e.g., race, ethnicity, gender, sexual orientation, disability). These conditions result in significant disparities in access to health as well as mental health care and lead to poor health outcomes for the homeless population, with particularly poor outcomes for people of color.

One logical approach to reducing or ending homelessness is to tackle the systemic causes discussed in this chapter. For instance, the detrimental effects of structural racism on the lives of individuals experiencing homelessness, and in particular people of color, can be combatted with policies, programs and services that address social and racial inequities explicitly. Successful policies, institutions and programs often obtain and use feedback from people of color, individuals and families alike, who experience disparities.²¹¹ Similarly, promoting equitable access to quality housing, employment and health care can counteract the complex structural stigma that is a reality for individuals facing the intersection of homelessness, substance use and mental health challenges.

211 Joe Feagin and Zinobia Bennefield, "Systemic Racism and U.S. Health Care," *Social Science & Medicine* 103, 2014: 7-14, <https://doi.org/10.1016/j.socscimed.2013.09.006>.

CHAPTER 10 — GOVERNMENTAL ACTIONS AND PROCESSES

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Acronyms in this Chapter

- AHCCCS—Arizona Health Care Cost Containment System
- ARPA—American Rescue Plan Act
- CCHP—Mercy Care’s Comprehensive Community Health Program
- CMS—Center for Medicare and Medicaid Services
- HHS—Department of Health and Human Services
- HIPAA—Health Insurance Portability and Accountability Act
- HMIS—The Homeless Management Information System
- HUD—United States Department of Housing and Urban Development
- MAG—Maricopa Association of Governments
- USICH—U.S. Interagency Council on Homelessness
- VA—Department of Veteran’s Affairs

INTRODUCTION

This chapter examines the importance of aligning government programs that address homelessness, substance use and mental health issues. Homelessness is a state of crisis. Research shows the longer a person experiences homelessness, the less likely they are to accept housing and other social services. The stress of experiencing homelessness can exacerbate underlying sources of mental health and substance use disorders. While only a subset of persons experiencing homelessness also faces mental health or substance use disorders, the focus of this section is those who face both or all three issues at the same time.

Persons experiencing homelessness and mental health issues and/or substance use disorders face a multiplicity of urgent needs. They need housing/shelter along with various supportive services. Furthermore, co-occurring substance use disorders and/or mental health issues require behavioral and supportive health services, sometimes on a long-term or permanent basis. This is the crux of the matter: the multiplicity of needs of someone who finds themselves at the intersection of homelessness, substance use and/or mental health issues require both a health care response and a coordinated housing response. Further, depending on the severity of individual cases, the services needed may be temporary or permanent. These responses and services are enabled through various funding sources and coordinated governmental action. This chapter discusses the gaps between federal funding and local implementation of health and homelessness crisis services and addresses the need to align them in order to close those gaps.

FEDERAL FUNDING, LOCAL RESPONSE

Federal Funding

Homelessness programs nationally heavily rely on federal funding. The main source of federal funds for addressing homelessness is the Department of Housing and Urban Development (HUD). In contrast, the main source of funding for mental health issues/substance use disorders is the Department of Health and Human Services (HHS). In addition, the Department of Veterans Affairs (VA) administers programs for veterans who are experiencing homelessness and mental health issues and/or substance use disorders, with their own established housing voucher program separate from those funded by HUD.

Beyond the three federal departments mentioned above, some 19 federal entities administer and fund homelessness and health programs at the local level. The U.S. Interagency Council on Homelessness (USICH), a federal coordinating body, works with these agencies and with state and local entities to improve the outcomes of federally funded services and programs.²¹² The funding for programs administered and distributed by federal entities received a historic boost when the American Rescue Plan Act (ARPA) was passed in March 2021.²¹³

HUD funds programs to provide emergency shelter and housing options. It distributes funds for homelessness programs to municipalities that qualify based on their population, to the human services departments of counties, and the Arizona Department of Housing. It also distributes funds through Continua of Care, as described in Chapter 14 – Accessing Services for Recovery and Stabilization. With this funding, these entities fund nonprofit service and emergency housing providers, who supplement their budget through philanthropic and individual donations. An overview of the different sources of funding for housing and shelter is available [here](#) (see Figure 14).

HHS funds several key emergency and longer-term programs for persons experiencing homelessness along with mental illness and substance use disorders. An important HHS responsibility is the distribution of matching federal funds to each state's Medicaid agency through HHS's Center for Medicare and Medicaid Services (CMS). The Arizona Health Care Cost Containment System (AHCCCS) is the state's Medicaid agency. It is jointly funded by the federal government through CMS and the state government. It is a health insurance program for individuals and households who qualify based on income level or need.

212 "About USICH," U.S. Interagency Council on Homelessness, 2021, <https://www.usich.gov/about-usich/>.

213 ARPA was a federal response to speed the recovery from the effects of the COVID pandemic. It bolstered through 2025 many of the measures that were passed in the CARES Act of March 2020 and in the Consolidated Appropriations Act passed in December 2021. See: "Making the Most of the American Rescue Plan: A Guide to the Funding that Impacts People Experiencing Homelessness," U.S. Interagency Council on Homelessness, August 2021, https://www.usich.gov/resources/uploads/asset_library/USICH_American_Rescue_Plan_Guide.pdf.

Temporary Housing		Rental Housing		Ownership Market Rate	
Emergency Shelter	Transitional Housing	Permanent Supportive Housing	Affordable Rental	Affordable Ownership	Rental/ Ownership
Emergency Shelter Grant		Rental Assistance Demonstration		Housing Counseling	
Home Investment Partnership Program					
Community Development Block Grant					
Housing Opportunities for People with AIDS					
Homeless Assistance Grants			Low-Income Housing Tax Credit		
Coordinated Homeless		Housing Opportunity Voucher		Mortgage Interest Deduction	
Project-Based Housing					
Opportunity Zones					
Choice Neighborhoods					
National Housing Trust Fund					
			Private Activity Bonds	HOME Plus Mortgage Program	
Arizona Housing Trust Fund					
State Funding		Federal Funding			

Figure 14. Continuum of housing and funding sources.²¹⁴

AHCCCS reimburses hospitals, mental health clinics and substance use treatment centers and helps pay for the interventions and treatments provided to individuals experiencing homelessness, if they are enrolled. Accordingly, determining eligibility and enrolling persons experiencing homelessness who are dealing with co-occurring health and/or substance use issues is very important. A matrix of HHS programs—many of them administered in Arizona by AHCCCS—by service category for persons experiencing homelessness is available [here](#) (p. 8-10).

Local Response

While a large portion of these programs is funded by the federal government, the nature of homelessness, mental health issues and substance use disorders means they need to be addressed and implemented locally through municipal, nonprofit and clinical programs and entities. Government agencies at the state and local level, nonprofit social service entities, health care providers, religious groups, along with medical organizations such as clinics and hospitals, are at the frontline of funding and delivering services and shelter to those experiencing homelessness, mental health and substance use disorders.

Accordingly, the response to assist a person in need varies by locality and the number of individuals experiencing homelessness. As described in Chapter 3 — The “Revolving Door” in a situation where a person experiencing homelessness is also experiencing a health or mental health crisis, their first point of contact is often first responders.

214 “Understanding the Housing Continuum and Funding Sources,” Vitalyst Health Foundation, 2019, <http://vitalysthealth.org/wp-content/uploads/2019/10/HsngSpectrmFunding-Prf8.pdf>.

In theory, local law enforcement should be able to coordinate effectively with medical and social services providers to offer an individually tailored set of services to those in need. In reality, homelessness assistance and health care treatment are not consistently diagnosed and delivered simultaneously. This is due to several factors:

- **Strings attached to funding.** Funding streams, along with the requirements and intake procedures that determine housing eligibility, do not always align with the procedures and rules to diagnose and identify mental health issues and substance use disorders concurrently. This makes it harder for homelessness agencies to coordinate care when treating an individual experiencing homelessness who is also suffering from mental health issues or substance use challenges. Mental health issues or substance use can make qualifying for Medicaid enrollment more difficult to determine. Further, the transient nature of individuals experiencing homelessness lengthens the Medicaid eligibility process and the housing process because often, they are difficult to find and contact.
- **Specialization-driven silos.** Many institutions specialize in addressing either homelessness or providing mental health treatment or substance use treatment. Intake staff at different housing assistance programs and emergency shelters are not always trained to conduct a whole-person diagnosis where they can identify and/or diagnose mental health or substance use disorders along with the need for housing. The specialization, complexity and friction between the different programs creates and perpetuates silos. Health services providers are not systematically trained to identify whether someone is experiencing homelessness while diagnosing mental health or substance use disorders due to funding and capacity constraints.
- **Imbalance of information.** Even when various service providers have the capacity to reach out to other service providers, the lack of a centralized data source often stymies their efforts. HIPAA requirements can prevent health services providers from sharing data with housing entities. The Homeless Management Information System (HMIS) has extensive information on shelters, but data on mental health issues and substance use disorders is only self-reported. This hinders accurate information on persons experiencing homelessness who are also facing significant mental health issues or substance use disorders and inter-system accountability.
- **Uneven geographical distribution of clinical services.** Not all parts of the state have emergency housing shelters. In addition, many communities do not have domestic violence shelters. Even fewer areas have clinics and facilities that provide substance use and mental health treatment. The availability of services varies greatly even within the Phoenix and Tucson metro areas. This geographic sparsity is important as many individuals experiencing homelessness have limited transportation options.
- **Uneven access to resources.** Assistance that integrates treatment and housing solutions for persons with co-occurring disorders who are experiencing homelessness can result in improved health outcomes when they are able to access and engage in appropriate services.²¹⁵ However, gaps in one service undermine the ability of other services to be effective.
- **A need for statewide coordination.** Policies for providing services for experiencing homelessness, mental health issues and substance use disorders vary by locality. Currently, there is no statewide entity with the responsibility for coordinating, administering and assessing programs for persons who are experiencing homelessness, mental health issues and/or substance use disorders. This makes cross-sector coordination more difficult and could allow persons who qualify for AHCCCS and other assistance programs to fall through the gaps.

215 Donna Fitzpatrick-Lewis et al., "Effectiveness of Interventions to Improve the Health and Housing Status of Homeless People: A Rapid Systematic Review," BMC Public Health 11, August 11, 2011: 1–14, <https://doi.org/10.1186/1471-2458-11-638>.

LINKING HOUSING AND HEALTH CARE THROUGH REGIONAL ACTION

While the aforementioned factors listed result in fragmentation of care and uneven delivery of services at the local level, the passage of ARPA has increased funding and created a renewed push to integrate health care with homelessness services. This has resulted in a greater willingness for federal, state and local agencies to work with service providers and for local communities to work regionally. These conditions present an opportunity to work across sectors and align the delivery of robust health services and stable housing at the same time.

Working Across Sectors

Continuity across housing and health services enhances the efficacy of all services and helps individuals who were homeless and are newly housed to stay housed. Improving coordination of care to treat the whole person would reduce the amount of time someone remains without housing or shelter and lead to health improvements that could reduce the likelihood of individuals returning to homelessness.

Several institutions at the frontlines of homelessness, mental health issues and substance use disorders have launched programs that work together. Their efforts can turn what is currently a patchwork of programs and policies into a more unified social safety net to help people get back on their feet. For example, the cities of Tempe and Chandler employ navigators to guide individuals experiencing homelessness into coordinated entry, one aspect of the region's HUD-funded Continuum of Care process. As described in Chapter 13 – Community Integration, this includes access to housing along with mental health issues and/or substance use treatment. Mercy Care's Comprehensive Community Health Program (CCHP) with the City of Phoenix, in partnership with the Valley of the Sun United Way and AHCCCS, has resulted in improved health outcomes, stable housing and reduced hospitalization for participants.²¹⁶

Regional Action

Ultimately, what is needed is a regional response to homelessness that incorporates the provision of robust health services, including substance use treatment. A regional approach would allow the government, philanthropic funders and service providers to work more closely to leverage funds to provide housing with the needed wraparound social and medical services.

One example of regional collaboration in Arizona is [Pathways Home](#), the Regional Homelessness Action Plan for Local and Tribal Governments unanimously approved by the Regional Council of the Maricopa Association of Governments (MAG) in December 2021.²¹⁷ Over a period of 14 months, MAG staff engaged with cities, towns, counties and tribal governments that make up its membership in Maricopa County and part of Pinal County. They collaborated with nonprofits, funders and service providers to develop the Regional Action Plan. The plan allows the agency to coordinate a regional response in partnership with local governments to develop the following, among other activities noted in the plan:

216 Julia Paradise and Donna Cohen Ross, "Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples," Kaiser Family Foundation, January 27, 2017, <https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/>.

217 "Local Governments Unite to Reduce Homelessness: MAG Regional Council Votes to Implement Regionwide Action Plan," Maricopa Association of Governments, December 8, 2021, <https://azmag.gov/Newsroom/Press-Releases/ArticleId/1281/local-governments-unite-to-reduce-homelessness>.

- Remove barriers by supporting local and tribal governments in forming interdepartmental, cross-sector teams to address homelessness. Review policies and assess resources to ensure effective coordination within local and tribal governments. Work with municipalities and tribal governments to pull limited resources into a bigger network to share resources and coordinate referrals for housing and health care.
- Increase access to local services by adding outreach/navigator specialists by directly supporting teams within the local government, in community locations, within first responder units and/or by contracting or partnering with existing nonprofit providers.
- Help develop a coordinated approach to share data between state, regional, municipal agencies and service providers.
- Coordinate policies, guidelines and protocols for cross-training.

One of the best practices to address the intersection of homelessness with mental illness and/or substance use is to integrate health care with homelessness services and housing. One such approach for mental health treatment that has shown to be effective is the Assertive Community Treatment (ACT) model.²¹⁸ The ACT approach requires twelve behavioral health professionals per 100 clients and is both time- and resource-intensive. This best practice model is used by some behavioral health providers in Arizona. Further public and private investments in this model, along with the provision of supportive housing, would benefit the community at large. This work begins with a willingness by government and community entities to come together in support of regional solutions that address access to housing, supportive services and health care needed by those experiencing homelessness. Through this work, we can begin to address the challenge of homelessness in Arizona.

218 Gary R. Bond and Robert E. Drake, "The Critical Ingredients of Assertive Community Treatment," *World Psychiatry* 14, no. 2, 2015: 240–242, <https://doi.org/10.1002/wps.20234>.

CHAPTER 11 — OVERVIEW OF BEST PRACTICES FOR TREATMENT AND CARE

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Acronyms in this Chapter

CBI—Community Bridges Inc.

MI—Motivational Interviewing

SAMHSA—Substance Abuse and Mental Health Services Administration

TIC—Trauma-Informed Care

TSS—Traumatic-Specific Services

INTRODUCTION

The implementation of effective treatment modalities and evidence-based practices are vital when dealing with highly vulnerable clients, especially those experiencing homelessness, mental health challenges and substance use disorders. As with most human service professions, best practice methodologies in the homeless arena continue to evolve and adapt to effectively meet the needs of those being served. This section will outline some of the core modalities that can be incorporated into practice.

HOUSING FIRST

One theory that is foundational to the integration of mental health, substance use, and homelessness is Housing First. The National Alliance to End Homelessness defines this as a theory that stable housing and basic needs should be the starting point to any intervention.²¹⁹ These basic necessities can be provided prior to securing employment, completing treatment and other milestones. This theory is in contrast to traditional models that require participants to be sober, obtain employment and be stabilized before admittance into a housing program. The Housing First model prioritizes housing and then seeks to establish, maintain or reconnect the client to needed resources within the local area. For the Housing First model to be effective, it must include ongoing supportive services from a case manager or trained staff member based on the needs of the client.

219 "Fact Sheet: Housing First," National Alliance to End Homelessness, April 2016, <http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf>.

IS HOUSING FIRST EFFECTIVE?

There is a wide body of research that continues to grow, showing the overall effectiveness of the Housing First approach. Housing First programs showed substantial increases in housing stability over the short and long term.^{220 221 222 223} In addition, Housing First programs showed positive effects related to reducing the impacts of addiction, increasing quality of life and increasing community involvement.^{224 225} Lastly, Housing First programs provide cost savings to the community. The model decreases use of emergency services, shelters and jails.^{226 227 228 229} Though there is more research to be done, there is growing consensus that Housing First, when implemented correctly, is effective on multiple levels for people experiencing the intersection of mental health, substance use and homelessness. This model is consistent with and incorporates the rest of the modalities described in this section.

KEY NOTES ON HOUSING FIRST

- Housing First starts with stability and meeting basic needs and then addresses other issues, versus traditional models that start with issues and then progress into housing stability.
- It is “housing first,” not “housing only.” Evidence only shows Housing First as effective when appropriate supportive services are provided and paired with housing.
- Research indicates that housing first is effective on many levels, namely: long-term housing retention, decrease in issues related to mental health and substance use (as well as many other things), and cost-effectiveness.

220 Tim Aubry, Geoffrey Nelson, and Sam Tsemberis, “Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the At Home-Chez soi Demonstration Project,” *The Canadian Journal of Psychiatry* 60, no. 11, November 2015: 467–74, <https://doi.org/10.1177/070674371506001102>.

221 Vicky Stergiopoulos et al., “Effectiveness of Housing First with Intensive Case Management in an Ethnically Diverse Sample of Homeless Adults with Mental Illness: A Randomized Controlled Trial,” *PLOS ONE* 10, no. 7, July 2015: <https://doi.org/10.1371/journal.pone.0130281>.

222 Paula N. Goering and David L. Streiner, “Putting Housing First: The Evidence and Impact,” *Canadian Journal of Psychiatry* 60, no. 11, November 2015: 465–66, <https://doi.org/10.1177/070674371506001101>.

223 Danielle Groton, “Are Housing First Programs Effective? A Research Note,” *Journal of Sociology & Social Welfare* 40, no. 1, March 2013: 51–63, <https://scholarworks.wmich.edu/jssw/vol40/iss1/4>.

224 Stergiopoulos et al., “Effectiveness of Housing.”

225 Groton, “Are Housing First Programs.”

226 Eric A. Latimer et al., “Cost-Effectiveness of Housing First Intervention with Intensive Case Management Compared with Treatment as Usual for Homeless Adults with Mental Illness: Secondary Analysis of a Randomized Clinical Trial,” *JAMA Network Open* 2, no. 8, 2019: <https://doi.org/10.1001/jamanetworkopen.2019.9782>.

227 Goering and Streiner, “Putting Housing First.”

228 Julian M. Somers et al., “Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial,” *PLOS ONE* 8, no. 9, 2013: <https://doi.org/10.1371/journal.pone.0072946>. Julian M. Somers et al., “Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial,” *PLOS ONE* 8, no. 9, 2013: <https://doi.org/10.1371/journal.pone.0072946>.

229 “Fact Sheet: Housing First.”

CLIENT-CENTERED CARE, HARM REDUCTION AND INTENSIVE CASE MANAGEMENT

These three models are integrated within the Housing First Model, and all have common tenets. They focus on prioritizing the client's preferences and unique needs in order to provide adequate care. Client-Centered Care is an approach where a case manager provides a structure and support, but the client is directing the process.²³⁰ The case manager assists the client in creating goals, identifying strengths and asking motivating questions. In addition, the case manager provides tools and resources based on the strengths and needs the client presents.

Harm Reduction expands on this model to focus on change, more specifically on any positive change regardless of how small.²³¹ The most common avenue where Harm Reduction is used is to address substance use. As Housing First does not require people to undergo treatment or be sober, it is vital that case managers work with clients through the lens of harm reduction. The emphasis does not focus on sobriety or limiting for philosophical reasons, but practical ones. For example, a case manager may focus on reducing heroin use to reduce the risk of being evicted versus limiting because "it is wrong." However, if the agency's policies are not in alignment with harm reduction principles, implementation will be ineffective.

For this chapter, Intensive Case Management is defined as providing enough support to meet the needs of a client from a staff member who is trained in many of the theories and practices described in this section. Clients experiencing mental health, substance use, and homelessness may experience a vast degree of variability within their expressed and unexpressed needs. For programs to be successful, they need to establish policies, procedures and trainings to ensure staff are equipped to respond effectively to the variation of clients. Agencies should incorporate specific topical trainings on mental health, substance use and homelessness as well as the crossover of these issues.

LOCAL EXAMPLE: COMMUNITY BRIDGES

Community Bridges, Inc. (CBI) provides numerous services to individuals experiencing homelessness, and, in this example, Permanent Support Housing programs will be highlighted (see Chapter 14 — Accessing Services for Recovery and Stabilization). CBI incorporated the Substance Abuse and Mental Health Services Administration's (SAMHSA) Permanent Supportive Housing Evidenced-Based Practice toolkit. The toolkit covers numerous topics related to implementing an effective housing program.²³² In addition to the toolkit, CBI uses an internal tool to identify the needs of each client, outlining the types of services the client needs and how frequently the staff should be meeting or speaking with the client. Lastly, the staff is trained on many of the methods described in this section as well, as additional topics on mental health, substance use and crisis de-escalation. This program works with some of the most vulnerable individuals experiencing homelessness and continues to show high levels of performance and positive outcomes.

230 "Case Management and Coaching," U.S. Department of Housing and Urban Development, 2017, <https://www.hudexchange.info/trainings/fss-program-online-training/3.1-client-centered-approach.html>.

231 Bernadette (Bernie) Pauly, Dan Reist, Lynne Belle-Isle, and Chuck Schactman, "Housing and Harm Reduction: What is the Role of Harm Reduction in Addressing Homelessness?," *International Journal of Drug Policy* 24, no. 4, 2013: 284–290, <https://doi.org/10.1016/j.drugpo.2013.03.008>.

232 "How to Use the Evidence-Based Practices KITS: Permanent Supportive Housing," Substance Abuse and Mental Health Services Administration, 2010, <https://store.samhsa.gov/sites/default/files/d7/priv/howtouseebpkits-psh.pdf>.

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is an evidence-based engagement technique characterized by implementing a communication style that emphasizes focusing on goals and attention to language related to change. The underlying goal of MI is to help the individual identify their own personal motivation for change and establish a sincere commitment to these specific goals. This is accomplished by exploring the individual's personal reasons for and capacity to change in an environment that promotes acceptance and compassion.²³³ MI can be used in a wide range of settings, but it is especially useful when working with individuals that may be experiencing ambivalence toward change or low confidence in their ability to change. MI also encourages practitioners to employ active listening skills, including asking open-ended questions, validating individuals' strengths, using reflective statements, summarizing, attending to change talk and exchanging information in a way that respects that both parties involved have expertise.²³⁴ These combined techniques promote self-efficacy and empower individuals to pursue the positive changes identified within the MI engagements.

TRAUMA-INFORMED CARE AND TRAUMA-SPECIFIC SERVICES

Homelessness is a traumatic experience for a multitude of reasons. Research supports that not only do most individuals experiencing homelessness have past histories of trauma prior to becoming homeless, but experiencing homelessness significantly increases the risk of exposure to additional trauma, including serious physical, psychological and sexual abuse.²³⁵ Trauma-Informed Care (TIC) is an approach to human services that takes into consideration the significant impact trauma has on the individual and places emphasis on the need to acknowledge and understand how an individual's life experiences directly impact their ability to receive assistance. Similarly, Traumatic-Specific Services (TSS) refer to interventions that operate from a TIC framework and address how trauma is impacting the individual. The goal of TSS is to effectively decrease the symptoms resulting from trauma and promote recovery for the impacted individual.²³⁶ Service providers must also be cognizant when working with populations that have significant trauma histories as not to retraumatize them. It is also important for providers to understand that people can become fundamentally changed after experiencing trauma. This means that recovery from trauma must come from a place of self-discovery rather than trying to return to the life that existed prior to the traumatic experiences. This is made possible when service delivery successfully operates from a trauma-informed framework.

231 Bernadette (Bernie) Pauly, Dan Reist, Lynne Belle-Isle, and Chuck Schactman, "Housing and Harm Reduction: What is the Role of Harm Reduction in Addressing Homelessness?," *International Journal of Drug Policy* 24, no. 4, 2013: 284–290, <https://doi.org/10.1016/j.drugpo.2013.03.008>.

232 "How to Use the Evidence-Based Practices KITS: Permanent Supportive Housing," Substance Abuse and Mental Health Services Administration, 2010, <https://store.samhsa.gov/sites/default/files/d7/priv/howtouseebpkits-psh.pdf>.

233 William R. Miller and Stephen Rollnick, *Motivational Interviewing: Helping People Change*, 3rd ed. (New York: Guilford Press, 2013).

234 "Understanding Motivational Interviewing," Motivational Interviewing Network of Trainers, accessed September 29, 2021, <https://motivationalinterviewing.org/understanding-motivational-interviewing>.

235 "Trauma," Substance Abuse and Mental Health Services Administration, October 6, 2020, <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/trauma>.

236 Elizabeth K. Hopper, Ellen L. Bassuk, and Jeffrey Olivet, "Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings," *The Open Health Services and Policy Journal* 3, no. 1, 2010: 80–100, <https://www.homelesshub.ca/sites/default/files/cenfdthy.pdf>.

RACIAL EQUITY LENS

It is no surprise that the substance use, mental health and homeless systems are not exempt from experiencing the impacts of systemic racism. With a long history of racist policies and practices such as redlining, the damaging effects remain present, as evidenced by the racial disparities in the homelessness system (see Chapter 9 — Structural Causes of Homelessness, Mental Illness and Substance Use). This makes providing services from a racial equity lens an increasingly crucial part of disrupting inequity.

One core principle for promoting racial equity is cultural humility. Similar to the long-endorsed cultural competency framework, cultural humility is defined as a “lifelong process of self-reflection and self-critique whereby the individual not only learns about another’s culture but starts with an examination of their own beliefs and cultural identities.”²³⁷ Cultural humility is effective in recognizing and acknowledging the complexities and intricacies of multiculturalism and promotes an antiracist practice. Cultural competence differs from cultural humility by instead placing emphasis on the ability to engage effectively from a place of acceptance and understanding with people of other cultures. Two unintended implications from a cultural competence perspective that often receive criticism are: 1) it suggests that there is attainable general knowledge about an entire group of people, which often perpetuates stereotypes, and 2) it implies there is an endpoint that a person can reach to become fully culturally competent.²³⁸ Cultural competence focuses on the importance of being able to engage knowledgeably with people across numerous cultures; whereas, cultural humility explains a lifelong process centered around reflecting on internal biases to maintain a position of openness and understanding of others. Both theories maintain value toward creating more equitable systems.

Another effective practice derived from racial equity work that has become more widely adopted is the utilization of those with lived experience. Individuals experiencing homelessness, especially those with mental health and substance use disorders, have long remained marginalized. Creating new opportunities that incorporate the voices of those with lived experience in meaningful ways is key to creating more effective services. It is crucial that this be accomplished with intentionality to avoid the perpetuation of exploitation. Consultation with individuals with lived experience should take place at every step of the decision-making process. This process can be solidified through establishing partnerships with consumer advocates, especially those advocacy groups comprised of individuals with lived experience.²³⁹

Implementing these practices can be costly in both time and money. However, in the long run, it is important to follow approaches based on evidence, not only for the individuals suffering but also for the public at large.

237 Katherine A. Yeager and Susan Bauer-Wu, “Cultural Humility: Essential Foundation for Clinical Researchers,” *Applied Nursing Research* 26, no. 4, 2013: 251–56, <https://doi.org/10.1016/j.apnr.2013.06.008>.

238 Shamaila Khan, “Cultural Humility vs. Cultural Competence—and Why Providers Need Both,” *HealthCity Boston Medical Center*, March 09, 2021, <https://healthcity.bmc.org/policy-and-industry/cultural-humility-vs-cultural-competence-providers-need-both>.

239 Shelia White, “The Value of Lived Experience in the Work to End Homelessness,” U.S. Interagency on Homelessness, July 6, 2018, <https://www.usich.gov/news/the-value-of-lived-experience-in-the-work-to-end-homelessness/>.

CHAPTER 12 — THE CROSSROAD OF HOUSING

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Acronyms in this Chapter

AHCCCS—Arizona Health Care Cost Containment System

CLP—Community Living Program

CoC—Continuum of Care

GMH/SU—General Mental Health and Substance Use Disorders

LIHTC—Low-Income Housing Tax Credit

PSH—Permanent Supportive Housing

RBHA—Regional Behavioral Health Authorities

RRH—Rapid Re-housing

SMI—Serious Mental Illness

VI-SPDAT—Vulnerability Index—Service Prioritization Decision Assistance Tool

The intersection of homelessness, mental health and substance use often comes with the lack of stability for an individual. Each, on its own, is a difficult barrier for many, and when combined, can seem insurmountable. Housing is often seen as the main component for overcoming this intersection—providing a safe space and, more importantly, the stability to address the mental health and/or substance use challenges an individual can experience.

Housing is more than a roof over someone's head. It is the security of knowing that you have a place you can go. Persons living with a mental illness are at increased risk of victimization, which is exacerbated by the increased vulnerability of being homeless. Less often considered is that some medications require refrigeration, and the lack of a home with access to a fridge can be detrimental to recovery. Additionally, access to recovery services can suffer significantly without a known stable location; providers may spend many hours simply trying to locate recipients of mental health and substance use services.

Housing is the solution; however, not every housing situation is equivalent or available for those that need it most. The housing spectrum ranges from temporary housing to homeownership with housing opportunities depending on the individual.²⁴⁰ The options that make up temporary housing include emergency shelter and transitional housing. The goal of emergency shelter is to provide temporary respite while connecting the individual with a longer-term housing option.²⁴¹ Each shelter runs slightly differently: varying from no cost to low cost, offering case management support, connecting the individual to different resources, and length of time that individuals can stay. Comparatively, transitional housing can accommodate individuals for up to 24 months but require individuals to move at the end of the program leaving the individual to find new housing, mental health resources and substance use resources depending on their new location. Although these solutions often provide a roof

240 "Understanding the Housing Spectrum and Its Impact on Health," Vitalyst Health Foundation, 2019, <http://vitalysthealth.org/wp-content/uploads/2019/08/HsngSpctrmChrt-FNL-8.19.pdf>.

241 "Understanding the Housing Spectrum."

over someone's head and temporary respite, they lack the ability for individuals to address their mental health and substance use challenges long-term because of the lack of stability. Across Arizona in 2020, there were approximately 4,290 emergency shelter units and 2,040 transitional housing units.^{242,243,244} Despite the number of units, there is still a lack of shelter available due to the number of individuals seeking shelter.

Comparatively, permanent housing options provide greater stability and the ability to address the complete intersection of mental health challenges and substance use. Permanent housing options range from living in a shared housing model with access to 24/7 support services to renting an apartment on your own with no services attached, all depending on insurance, need, availability and cost. Many programs throughout Arizona provide housing and housing-related supportive services to people within this intersection, utilizing an array of funding sources.

In Arizona, services for persons determined to have a Serious Mental Illness (SMI) fall in the purview of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency. SMI is a state determination for people who need extra support as their mental health affects their ability to function.²⁴⁵ A range of services is available to AHCCCS members determined to have an SMI to support the health care and housing costs of an individual.

This range of services is also available to AHCCCS members not determined to have an SMI but who are designated with General Mental Health and Substance Use (GMH/SU) disorders. AHCCCS's legislative funding to support housing for this population is not as significant as for those with SMI and, as such, is generally reserved for those identified as high cost/high need (i.e., those who frequently utilize and have a need for high-cost services).

Within the AHCCCS system, temporary housing is provided through residential flexible care. This level of housing includes an array of services depending on the need of the individual and allows a resident to gain stability and the skills to live independently. The program in Maricopa County serves approximately 400 individuals.²⁴⁶

AHCCCS supports Permanent Supportive Housing through multiple mechanisms, including funding for infrastructure and housing programs. Through the SMI Housing Trust Fund established by the legislature, AHCCCS reviews applications for new construction, acquisition and rehabilitation of properties used to house persons determined to have an SMI. These properties can be designated for other AHCCCS housing programs or be part of larger projects like those funded through the Low-Income Housing Tax Credit (LIHTC) program through the Arizona Department of Housing.

The AHCCCS Housing Program provides subsidized housing for persons determined to have an SMI through two means: the Community Living Program (CLP) and Scattered-Site Housing. While these two programs are essentially the same, the Community Living Program is mostly comprised of properties under deed restriction to serve persons determined to be SMI that were purchased using state funding. These homes range from an individual apartment in a multiplex to sharing a single-family home where individuals have their own bedroom with shared common space. Individuals pay a percentage of their income towards rent, with the remaining rent

242 "Housing Inventory Count Summary, Arizona Balance of State CoC," Solari Crisis and Human Services, 2020, <https://community.solari-inc.org/wp-content/uploads/2021/10/2021-BOS-HIC-Report-Summary.pdf>.

243 "Housing Inventory Count Summary, Phoenix, Mesa/Maricopa County CoC," Solari Crisis and Human Services, 2020, <https://community.solari-inc.org/wp-content/uploads/2021/10/2021-MAR-HIC-Report-Summary.pdf>.

244 "2020 Point-in-Time Presentation," Tucson Pima Collaboration to End Homelessness, 2020, <https://tpch.net/data/hic-pit/>.

245 "SMI Determination," Arizona Complete Health, accessed December 12, 2021, <https://www.azcompletehealth.com/members/medicaid/resources/smi-determination.html>.

246 "Behavioral Health Residential Facility and Supportive Housing Beds Report," Arizona Health Care Cost Containment System, December 5, 2019, https://www.azahcccs.gov/shared/Downloads/Reporting/BHResidentialbeds_report.pdf.

subsidized through AHCCCS. For most, no staff is onsite, and each individual accesses their own service provider for services based on their unique needs. In 2019, there were approximately 1,297 beds across Arizona.²⁴⁷ 103 placements had onsite support for individuals.²⁴⁸

In addition, AHCCCS oversees a scattered-site tenant-based rental assistance program, similar to the Section 8 Housing Choice Voucher program. This program provides a rental subsidy for individuals in the general rental market. The individual signs a lease with a landlord and agrees to pay 30% of their income towards rent. Throughout Arizona, there are approximately 2,000 vouchers, with the majority being in Maricopa County.²⁴⁹ Some housing through the scattered-site program is also available to AHCCCS members determined to be high cost/high need GMH/SU members.

Beyond AHCCCS funding for housing, Arizona receives federal funding to use for persons experiencing homelessness through the Department of Housing and Urban Development (HUD) Continuum of Care (CoC) program. This program provides grants to community agencies that provide housing and housing-related services through various models. The HUD CoC program serves many people who are experiencing homelessness and living with a mental illness and/or substance use issue. The services provided in Arizona, however, are often focused on housing administration (e.g., rental payments, utility payments and move-in costs). Housing agencies often partner with providers of mental health and substance use services to ensure that people in HUD CoC housing have access to services that best support their recovery.

The Continuum of Care coordinates federal grant dollars to support a Coordinated Entry for the homeless services system. The Coordinated Entry system evaluates individuals using the Vulnerability Index–Service Prioritization Decision Assistance Tool (VI-SPDAT), a survey understanding the individual's needs.²⁵⁰ Using the score on the VI-SPDAT, homeless service providers can match individuals experiencing homelessness with the best housing intervention for them whether it is Permanent Supportive Housing (PSH), Rapid Re-housing (RRH), or a lower amount of assistance. Many grants through the CoC provide PSH for persons determined to have an SMI. PSH provides a subsidy for an individual to rent an apartment, and services are provided through the behavioral health system. PSH can be site-based, with individuals living in a complex or block of units in the same location or scattered site rentals in the open market. Individuals still pay 30% of their income towards rent, and the remaining rent is subsidized by the Continuum of Care program. There are 8,634 PSH vouchers in Arizona through the Continuum of Care.^{251 252 253}

242 "Housing Inventory Count Summary, Arizona Balance of State CoC," Solari Crisis and Human Services, 2020, <https://community.solari-inc.org/wp-content/uploads/2021/10/2021-BOS-HIC-Report-Summary.pdf>.

243 "Housing Inventory Count Summary, Phoenix, Mesa/Maricopa County CoC," Solari Crisis and Human Services, 2020, <https://community.solari-inc.org/wp-content/uploads/2021/10/2021-MAR-HIC-Report-Summary.pdf>.

244 "2020 Point-in-Time Presentation," Tucson Pima Collaboration to End Homelessness, 2020, <https://tpch.net/data/hic-pit/>.

245 "SMI Determination," Arizona Complete Health, accessed December 12, 2021, <https://www.azcompletehealth.com/members/medicaid/resources/smi-determination.html>.

246 "Behavioral Health Residential Facility and Supportive Housing Beds Report," Arizona Health Care Cost Containment System, December 5, 2019, https://www.azahcccs.gov/shared/Downloads/Reporting/BHResidentialbeds_report.pdf.

247 "Behavioral Health Residential Facility."

248 "Behavioral Health Residential Facility."

249 "Behavioral Health Residential Facility."

250 "Service Prioritization Decision Assistance Tool (SPDAT): Assessment Tool for Single Adults," OrgCode Consulting, 2015, <http://pehgc.org/wp-content/uploads/2016/09/SPDAT-v4.01-Single-Print.pdf>.

251 "Housing Inventory Count Summary, Arizona."

252 "2020-Point-in-Time Presentation."

253 "Housing Inventory Count Summary, Phoenix."

A shorter housing intervention is Rapid Re-housing (RRH). Aimed to get individuals back on their feet, the program can assist with rent for up to two years. When an individual enters the program, the housing provider assists in finding an apartment and paying the deposits and rent for the first few months. As the individual gets back on their feet, they take over the rent—eventually paying 100% of the rent themselves. The housing provider supports the individual through this transition, providing life training skills as well as keeping them connected to their behavioral health provider. In 2020, there were 2,851 individuals in RRH in Arizona through the Continuum of Care.^{254 255 256}

Both types of permanent housing (the aforementioned PSH and RRH) is tied to supportive services for the individual, but all of these programs follow a Housing First approach (see Chapter 11— Overview of Best Practices for Treatment and Care). When individuals are in housing, all supportive services are optional for the tenant, but it is required for the program to continue to offer services to the tenant. The tenant's lease is not contingent on participation in or compliance with supportive services. Although services are optional, housing retention and success are often greater with participation in these services, whether clinical, housing based or both.

Despite the availability of housing subsidies and support across the state, the system does not have enough housing for all those that need it, where they need it, leading to a mismatch of services, housing units and people.^{257 258} For instance, there are often lotteries to gain access to Section 8 vouchers. The City of Phoenix maintains a lottery to even gain access to the waiting list and wait times on such lists average around three years across the metropolitan area.²⁵⁹ Unfortunately, this leads to individuals being forced to rent a cost-burdening apartment on their own, rely on any support network to assist or continue being homeless.

Not only is there a lack of housing subsidies, but also a lack of housing supply, leading to rising prices. According to the Arizona Department of Housing, there is a shortage of 250,000 housing units across the state.²⁶⁰ Nearly 50% of Arizona renters are cost-burdened, meaning they spend more than 30% of their income on rent.²⁶¹ The unaffordability is not only hindering for individuals but also programs who are assisting individuals. The price growth in the rental market often exceeds increases in grant and legislative funding needed to sustain housing levels. Additionally, individuals at this intersection of homelessness, mental health and substance use often encounter barriers such as past evictions or criminal backgrounds stemming from the criminalization of homelessness and of mental illness. The survival tactics of those experiencing homelessness often clash with the law, for instance, loitering, camping or public intoxication ordinances. These barriers exacerbate the challenges of finding housing in an already saturated and expensive housing market. After finding an affordable unit and overcoming these barriers, the few affordable units that are available aren't always in an ideal location in relation to supportive services and amenities.

254 "Housing Inventory Count Summary, Arizona."

255 "2020-Point-in-Time Presentation."

256 "Housing Inventory Count Summary, Phoenix."

257 Courtney Holmes, "Section 8 Housing Vouchers in Short Supply for Arizona Families," abc15.com, March 3, 2021, <https://www.abc15.com/news/rebound/coronavirus-money-help/section-8-housing-vouchers-in-short-supply-for-arizona-families>.

258 Jill Ryan, Megan Lupo, and Agya K. Aning, "Shelter Crisis," Walter Cronkite School of Journalism and Mass Communication, accessed December 13, 2021, <https://cronkite.zine.asu.edu/bootcamp19/shelter-bed-crisis/>.

259 Holmes, "Section 8 Housing Vouchers."

260 "Five-Year Strategic Plan," Arizona Department of Housing, 2021, <https://housing.az.gov/sites/default/files/documents/files/ADOH%20Five-Year%20Strategic%20Plan%202021-2025.pdf>.

261 "Selected Housing Characteristics, Arizona," U.S. Census Bureau, 2019, <https://data.census.gov/cedsci/table?q=0400000US04&tid=ACSDPIY2019.DP04>.

Additional gaps and barriers include a significant lack of availability of housing and access to services for tribal members, people in the suburban outskirts and rural communities. The lack of services available to assist individuals with housing leaves them grappling with the complications on their own. An individual's behavioral health case manager cannot always help with the nuances of finding an apartment, deposit assistance or challenges communicating with a landlord, leaving the individual to navigate the system on their own.

Although challenges exist, there are some things working within the housing system. The model of Housing First is crucial to the success of individuals because housing isn't tied to an individual enrolling in services and can be accessed when the individual chooses.²⁶² (see Chapter 11 — Overview of Best Practices for Treatment and Care). The system design in Arizona of partnering housing resources with Medicaid services through Regional Behavioral Health Authorities (RBHAs) supports adherence to Housing First while maximizing funding resources for housing. Once an individual is in a safe space, they are able to work on recovery, overcome barriers they are facing, and more readily access the services they need. Beyond Housing First, community partners across Arizona have chosen to invest in community tools that work for individuals. These tools include additional staff to help locate apartments and advocate with landlords on behalf of individuals, technology tools that assist individuals and case managers in locating available housing, flexible funding for move-in costs, and strong public policies that allow for additional support such as damage mitigation.

262 "The Case for Housing First," National Low Income Housing Coalition, January 28, 2020, <https://nlihc.org/sites/default/files/Housing-First-Research.pdf>.

CHAPTER 13 — COMMUNITY INTEGRATION

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Acronyms in this Chapter

AA—Alcoholics Anonymous

MAT—Medication-Assisted Treatment

Rebuilding in a community can feel intimidating and out of reach, and people often need help with integration. Try to imagine moving to a new city—having no vehicle, being far from everyone you know, and not having a cell phone or computer to access directions or other information. This would make anyone feel uncomfortable. Feeling integrated in your community is important. Research has demonstrated the important link between community trust and sense of belonging and better health outcomes.^{263 264 265 266}

People want to trust and remain in their community, and no one likes starting over when it isn't their choice. We all rely on some basic skills and a vast network of connections and resources to successfully live—all of which are impacted or eliminated by homelessness and mental health/substance use challenges. Navigators help rebuild these important community connections and resources. A community navigator is someone who usually has lived experience with mental health, substance use, homelessness or incarceration. They are able to provide peer support to clients with a genuine understanding of what a person may be going through. People are usually connected with a navigator through street outreach or when they enter the homelessness system through a shelter.

Navigators are in charge of case management and pulling together all of the resources that an individual might need when recovering from experiencing the intersection of homelessness, mental health and substance use challenges. The outreach navigator is the first point of contact for a person experiencing homelessness, and this relationship can last for many years. See Chapter 14 — Accessing Services for Recovery and Stabilization for a navigator case study example.

When someone at the intersection of homelessness, mental health and substance use issues overcomes the intimidating process of finding an apartment, they still have the challenge of signing their lease. This process can be difficult for someone who hasn't been on a lease in a while—or possibly ever. The navigator is there to support clients in this process, to explain what the lease states and answer questions about different policies, including guests and pets.

Once the lease is signed, the newly housed individual can move into their apartment. But it certainly isn't home without furniture and personal belongings. While having a roof over your head is a critical first step, clients are still starting from scratch—they have no dishes, no mattress, and no broom or cleaning supplies. They are starting over and require all the basic necessities.

263 "Sense of Community," Robert Wood Johnson Foundation, accessed December 9, 2021, <https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html>.

264 Perry Hystad and Richard M. Carpiano, "Sense of Community—Belonging and Health—Behaviour Change in Canada," *Journal of Epidemiology & Community Health* 66, no. 3, 2012: 277–283, <http://dx.doi.org/10.1136/jech.2009.103556>.

265 Jacinta Francis, "Creating Sense of Community: The Role of Public Space," *Journal of Environmental Psychology* 32, no. 4, December 2012: 401–409, <https://doi.org/10.1016/j.jenvp.2012.07.002>.

266 William B. Davidson and Patrick R. Cotter, "The Relationship between Sense of Community and Subjective Well-Being: A First Look," *Journal of Community Psychology* 19, no. 3, 1991: 246–253, [https://doi.org/10.1002/1520-6629\(199107\)19:3%3C246::AID-JCOP2290190308%3E3.O.CO;2-L](https://doi.org/10.1002/1520-6629(199107)19:3%3C246::AID-JCOP2290190308%3E3.O.CO;2-L).

This is another important role that navigators play. They help clients find furniture and can coordinate with local nonprofits who provide resources like moving boxes, an air mattress, a garage, a mop and dishware. Within a week or so, community donations often help to provide the things necessary for an individual to thrive—a chair for the living room, a permanent mattress, pots and pans, or a TV. However, since resources are all based on available community support, fully furnishing an apartment for a newly housed individual can take up to a month.

For some people, it may have been years since they had their own apartment, and many everyday circumstances look different from when they were experiencing homelessness. The navigator can work with the individual to help them learn everyday skills such as laundry, cleaning, cooking simple recipes and paying the electric bill, among others. This may also include ensuring that the newly housed individual understands what portion of the rent is owed and how to pay that rent.

After moving in and getting settled, individuals must become familiar with their environment. Getting to know a new area is key to becoming integrated and regaining a sense of stability. It is important for individuals to become familiar with the closest grocery store, the nearest public transit stations and their health clinic. Often, they also need help learning how to organize a schedule, when to take medications, where to get mail and what the trash schedule is. The navigator's focus at this stage is to help by coordinating transportation (bus or walking), assisting with finding local stores and even riding the bus with that person, so they know exactly how to get there and back. The navigator can find a primary care doctor and mental health provider for clients if needed, as well as show them where the local pharmacy is. The navigator may help a client obtain a free phone or tablet and find a hobby, like bowling, bingo or church, where there are opportunities to meet new people. Volunteering at a local church or food bank is a great way for people to connect with the community and make friends.

As the individual moves from survival mode to stability, they seek out community integration by visiting a doctor rather than going to the emergency room, preparing meals rather than eating out, getting connected with their clinic, learning how to call the maintenance line at their unit, setting up meal services if they are eligible and using online skills to have food delivered or renew prescriptions. They develop the skills to call the right resource that is appropriate for the situation. Many navigators help clients gather their important information, such as their Social Security Number, passwords for logins and phone numbers they may need in the future (e.g., local food bank, their clinic).

As an individual continues down the path of stability, they start to navigate more complicated relationships and connections and lean on their navigator or case manager for support with developing these skills. One critical relationship is that between landlord and tenant. It is important for the navigator to have a relationship with the landlord so that if something happens at the apartment, the landlord can reach out to the navigator for assistance which can prevent delinquent notices or evictions. Acting as a mediator and advocate for the client, the navigator can provide a buffer until the individual learns to navigate the relationship themselves.

Once stability is achieved, the navigator begins to take a harm reduction approach and plan for the future. For example, a navigator may connect the individual with resources such as outpatient services, Medication-Assisted Treatment (MAT), employment opportunities and other community connections.

Outpatient services are often provided through a “one-stop-shop” approach. Most outpatient service providers offer general mental health services, including individual counseling, group counseling and medication management, all at the same location, making it easier for people to get the support they need. This approach is particularly helpful for persons who are experiencing homelessness or are newly housed as they commonly need multiple interventions at once. Outpatient services with the right treatment plan are shown to be as effective as inpatient services.²⁶⁷ These services can be ongoing, not time-limited, and may help an individual develop the social support needed to stay balanced after leaving services.²⁶⁸

Medication-Assisted Treatment (MAT), which combines the use of medications with counseling and behavioral therapies to provide a “whole-patient” approach to the treatment of substance use disorders, is also offered by some providers.²⁶⁹ Additional services might include family counseling, anger management and basic life skills with each participant having an individualized service plan to meet their unique needs. Furthermore, these services also provide a sense of community that is often lost through the challenges that come with mental illness, addiction and homelessness.

Another big hurdle that navigators can assist with is finding employment. Unfortunately, the stigma around criminal history, homelessness and mental health challenges can be hard to overcome for newly housed individuals.²⁷⁰ Navigators might walk someone through an application, teach them interview skills, help them figure out how to explain their background to an employer and teach them how to advocate for themselves.

As the individual continues to successfully re-integrate into the community, the navigator begins to step away. Reintegration looks different for every client but could include getting involved with a local church, joining an Alcoholics Anonymous (AA) group, volunteering in the community and/or finding hobbies like local sports or crafting. Over time, the navigator begins to see the individual less and less while still remaining available if they are needed.

Despite the benefit of navigators in working one-on-one with clients, there are still gaps and opportunities for improvement within the system. The system is complex and siloed, making it difficult for someone who hasn’t navigated the process to make it through successfully, especially if they are dealing with mental health challenges, substance use and homelessness.

In addition to the complicated process, there is an overall lack of funding and resources. There are not enough shelters, housing programs or affordable housing services for everyone that needs it. Likewise, there are not enough substance use treatment centers or behavioral health clinics in convenient locations. For example, if someone wants to seek treatment, they are put on a waiting list and may not be ready to seek treatment when they are finally next on the list. In addition, they often need to seek approval to be out of their housing unit for treatment if it lasts for more than a few days and they are in some form of public housing, or they risk losing their housing altogether. These types of challenges make it difficult to get help, keep help and stay on track.

267 Dennis McCarty et al., “Substance Abuse Intensive Outpatient Programs: Assessing the Evidence,” *Psychiatric Services* 65, no.6, June 2014: 718–26, <https://doi.org/10.1176/APPI.PS.201300249>.

268 “Comparing Inpatient & Outpatient Alcohol Treatment Options,” American Addiction Centers, November 17, 2021, <https://www.alcohol.org/inpatient/or-outpatient/>.

269 “Medication-Assisted Treatment (MAT),” Substance Abuse and Mental Health Services Administration, accessed July 21, 2021, <https://www.samhsa.gov/medication-assisted-treatment>.

270 “Homelessness and Employment,” Homelessness Policy Research Institute, August 24, 2020, <https://socialinnovation.usc.edu/wp-content/uploads/2020/08/Homelessness-and-Employment.pdf>.

Another challenge is the high staff turnover among community providers. Turnover affects community integration because clients' belief and trust in the system is diminished when they have to tell their story over and over every few months to a new service provider. They become resistant to engaging with services when their biggest confidant and supporter has a new face every few months. Something that we do as a navigator is to make sure that clients are connected to other resources so that if/when someone leaves their job, they will still have a large circle of support.

There are many reasons why people have such a hard time with reintegration into a new community. It is our job as navigators to continue to help the clients build trust in their new community with multiple resources so that they feel connected and at home. Once an individual feels confident and connected in their community, they can begin to thrive.

CHAPTER 14 — ACCESSING SERVICES FOR RECOVERY AND STABILIZATION

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Acronyms in this Chapter

CBI—Community Bridges Inc.

CoC—Continuum of Care

SNAP—Supplemental Nutrition Assistance Program

SOAR—Social Security Outreach and Recovery

INTRODUCTION

The “system” utilized to provide services to individuals experiencing homelessness with mental health and substance use issues is complex and hard to navigate, especially for an individual suffering from such conditions.²⁷¹ Local or regional Continua of Care (CoC) centralize the application for federal and state dollars to end homelessness and coordinate various providers like state and city agencies, non-profits, contractors and private businesses.²⁷² Continua of Care might also link with separate but related systems, like the behavioral health system, the criminal justice system and the medical system. They might also have dedicated programs to connect individuals experiencing homelessness to other mainstream programs, such as food stamps (SNAP), social security benefits or publicly funded health insurance. Despite these efforts, the system confronts individuals experiencing homelessness often as opaque and inaccessible. Even experts describe the systems as “silos” that are hard to navigate. Community Bridges, Inc. (CBI) presents an example of an Arizona organization that works to break down those silos, helping individuals receive behavioral health, physical health and housing services.²⁷³

OUTREACH AND ENGAGEMENT

Ask yourself this question, “If I experienced poverty, trauma, abuse, inequality, mental illness or substance use as a coping tool, how am I going to navigate through the plethora of evidence-based programs to end my homelessness and enter recovery for mental illness and/or substance use?” The answer is that finding, entering and committing to the appropriate services is increasingly difficult, especially for individuals that have experienced these conditions for long periods of time. As a result, many community-based services begin with outreach and engagement. Outreach and engagement are tools used by staff traveling in the community to meet people emotionally, physically and mentally in their current environment. Outreach and engagement begin by building trusting relationships with individuals out in the field and empowering them to engage in services. This is the first step in recovery and stabilization.

271 Kevin Martone, Francine Arienti, Rachel Post, and Ashley Mann-McLellan, “Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness,” National Association of State Mental Health Program Directors, 2020, <https://www.nasmhpd.org/sites/default/files/2020paper2.pdf>.

272 “What is a Continuum of Care,” National Alliance to End Homelessness, January 14, 2020, <https://endhomelessness.org/resource/what-is-a-continuum-of-care/>.

273 “Supportive Housing,” Community Bridges, Inc., <https://communitybridgesaz.org/families-patients/housing-3/>.

Outreach and engagement at Community Bridges, Inc. (CBI) are led by a peer support specialist (navigator) and a credentialed behavioral health technician, who has a personal history in recovery from substance use, mental health disorders and/or homelessness. All of CBI's navigators complete a peer support certification program that includes 106 hours of training to develop skills such as motivational interviewing, assessment and triage, suicide prevention, cultural competency, boundaries and ethics, blood-borne pathogens, mental illness, substance use, and patient care planning. The education of CBI navigators is enhanced through monthly clinical oversight and weekly team meetings. Navigators also attend community-based trainings on topics related to homelessness and recovery such as Housing First, Case Management, Coordinated Entry, Social Determinants of Health, as well as accessing Social Security Disability Benefits (SOAR—Social Security Outreach and Recovery). Each navigator is responsible for completing continuing education and clinical supervision regardless of professional level or certification.

Navigators collaborate in a team of emergency medical technicians, nurses, clinicians and doctors, striving to develop a culture of dignity and respect. CBI has a culture of honoring lived experience by employing the expertise of peer support specialists to inform the implementation of interventions. There is no "us" and "them." Instead, CBI provides an atmosphere that enables people to take their strengths and mold them together in the service of others.

The first step to addressing homelessness, physical health, mental health and substance use is a proper assessment to identify the individual's needs. Once there is a proper assessment of a person's needs, and trust is built with that person, then it is time to consider and decide what interventions would provide the most benefit. The most important aspect in understanding what health care interventions work best for the unhoused population is accepting that each person has individualized needs that can change quickly. The job of health care providers is to develop diverse resources and make them accessible to the community.

The CBI peer support specialist and the individual work together to empower the individual to access the resources available. As a team, they identify the individual's needs and how to access services within the complex system. The navigator has personally utilized the Continuum of Care services and uses that knowledge and their training to guide the individual. At CBI, we believe recovery and stabilization are improved through the support of a navigator with lived experience to help the individual stay engaged during the hard and long journey towards recovery.

After an individual chooses to engage in services, we start to use the various resources in our toolbox to identify solutions. Crisis and medical services are typically used initially to treat immediate issues. These resources include a continuum of services that are intended to stabilize immediate crisis concerns that include Access Point (23-Hour Crisis Observation), Inpatient Behavioral Health, Transition Point (short term/crisis residential), Residential, Crisis Mobile Teams and application for court-ordered evaluation and treatment (see Chapter 2 — Background). These facilities specialize in crisis stabilization, which must happen before a client can move into another level of care.

While initial stabilization is underway, we begin looking for a temporary housing option. For example, while someone is in Access Point undergoing a safe 24-hour detox, we are working on obtaining a shelter bed for the individual. As the individual's needs change, the organization must work with them to adapt and find the right pathway to their stabilization, moving them as quickly as possible into stable preventative care, with housing being a major component of the health care continuum.

CASE STUDY: AN INDIVIDUAL'S EXPERIENCE WITH THE INTEGRATED HEALTH CARE CONTINUUM OF CARE SERVICES

An extraordinary young adult entered a CBI shelter at the age of 20 in 2021. The young adult had utilized CBI crisis services since 2018, including detox and inpatient to address mental health and substance use issues. The young adult experienced homelessness for most of his childhood and young adulthood because both his parents were chronically homeless. In the three months that the young adult lived at the shelter, he has shown great strides towards stabilization, but his journey showcases challenges and growth during recovery. There are three main areas of his recovery that demonstrate the benefits of an integrated health care continuum of care services.

First, the health care system identified the young adult as a “familiar face” or high utilizer of crisis services and emergency rooms. After being recognized as a familiar face, we focused attention on stabilizing the individual by connecting him to a specialized care team. The specialized team was able to build enough trust with him to persuade him to enter the shelter. At the same time, the specialized team was collaborating with the health plan and another provider to coordinate care. However, the first barrier noticed by the shelter staff was that he was unable to identify his needs simply because he was unaware of the choices he had. The shelter supervisor initially observed that the young adult could speak but had no voice. Some essential skills, such as showering and talking to peers, are skills he had to learn from the staff, who encouraged him to participate. The staff explained that it was not the young adult being defiant or not wanting to shower—rather, it was that he didn't even think about showering because this normally isn't an option for him or a choice he gets to make. One trait of poverty is that it doesn't let individuals grow into themselves because it doesn't give you choices. Without the knowledge that we have choices, we are unable to hope that life can be better.

Second, during his stay at the shelter, he has been doing well and learning basic skills, including communicating with staff and other shelter residents. While at the shelter, he expressed suicidal ideation twice and was admitted to inpatient care. Both times, the staff said he never changed his emotional range other than to tell them he was having thoughts about harming himself. CBI quickly moved the individual from the shelter, the lowest level intervention on the continuum, into psychiatric stabilization, the highest level of intervention. After he was stabilized, he was transitioned back to the shelter.

Third, after being at the shelter for about eight weeks, the young adult voiced his desire to be employed. The young man will be attending his first job interview during his fourth month at the shelter. The specialized support team believes this is his voice trying to end his homelessness, mental health and substance use suffering. The young adult has also been matched to a housing subsidy. CBI does not have the expectation that he will resolve his homelessness with employment and housing immediately. However, we expect that he is learning that he has choices and hope for the first time in his life.

Anti-Poverty Business Model

At CBI, we use an anti-poverty business model. The CBI navigators are certified peer support specialists that are examples of people in recovery that are now employed. The CBI culture is to hire peer support specialists and promote them as their skills grow and opportunities arise in the agency. For example, the CBI Phoenix Rise senior manager joined the CBI team nearly ten years ago as a peer support specialist. Due to their excellent performance over the years, the staff promoted them internally. The manager also completed a bachelor's degree while employed with CBI. This is an example of the CBI anti-poverty business model that uses employment as a tool to break the cycle of poverty by creating an equitable and sustainable job promotion pool of opportunity.

Another successful example of this model is the Toole Shelter manager. She joined the CBI team three years ago as a receptionist. Due to her great performance as a receptionist, she was promoted to Housing Navigator II in Rapid Re-Housing, then promoted to Lead Navigator of Outreach. From this position, she was promoted soon after to the Supervisor of Outreach and recently received a promotion to Manager of Outreach and Shelter Programming. While being employed with CBI, she completed a bachelor's degree from the University of Arizona. She purchased a home in 2020 and has expressed interest in being promoted to a senior manager at CBI and/or seeking an advanced degree. The cycle of anti-poverty now goes full circle because both employees now use their lived experiences as peer support specialists to encourage the participants that ending their poverty is possible.

CONCLUSION

Homelessness is a complex social issue nestled deeply in the roots of inequality and poverty. Recovery and stabilization require a health care system that combines cutting-edge interventions to serve individuals at specific moments in their recovery path. Successful health care providers welcome creativity and diversity when developing an individual's unique treatment plan. Diverse voices can also improve policy development, at both the agency and state levels. The most critical aspect of recovery and stabilization is that clients can be seamlessly and constantly moved between crisis-level care and regular support. There is no one formula for all people to be successful in their recovery journey, but the trusting relationship between a peer support specialist and community member has been shown to work well for people experiencing homelessness, mental health and substance use issues. See Chapter 13—Community Integration for more about the important role that navigators play in helping those in recovery to integrate into their community and learn to thrive.

CHAPTER 15 — CREATING CONNECTIONS, IMPROVING LIVES: HEALTH INFORMATION EXCHANGE IN ARIZONA

Melissa Kotrys, MPH, CEO, Health Current/Contexture

Acronyms in this Chapter

ACT—Assertive Community Treatment
ADTs—Admissions, Transfers, Discharges
AHCCCS—Arizona Health Care Cost Containment System
AzHeC—Arizona Health-e Connection
CBO—Community-Based Organization
CHA—Community Health Associates
CORHIO—Colorado Regional Health Information Organization
COT—Court-Ordered Treatment
ED—Emergency Department
EHR—Electronic Health Record
HIE—Health Information Exchange
HIO—Health Information Organization
HINAz—Health Information Network of Arizona
OPCS—Old Pueblo Community Services
PHI—Personal Health Information
SDOH—Social Determinants of Health
SMI—Serious Mental Illness
SUD—Substance Use Disorder
WPCI—Whole Person Care Initiative

WHAT IS HIE?

A 2019 survey identified more than 100 disparate health information exchange (HIE) networks at the local, regional and national levels, with 89 health information organizations (HIOs) supporting HIE in the U.S. In Arizona, Health Current is fortunate to serve one of the most collaborative and supportive HIE communities in the nation.²⁷⁴

HIE in Arizona got its start in 2005 with the signing of a gubernatorial executive order and subsequent community efforts to develop a statewide health information technology (IT) strategy. The strategic plan called for the creation of Arizona Health-e Connection (AzHeC) in 2007. Over the next decade, AzHeC merged with the statewide HIE, the Health Information Network of Arizona (HINAz), and the HIE rebranded as Health Current in 2017 (healthcurrent.org). In 2021, Health Current joined forces with CORHIO, the largest HIE in Colorado, to form Contexture (contexture.org), a new organization positioned to serve the western region.²⁷⁵

274 Julia Adler-Milstein et al., "A Survey of Health Information Exchange Organizations in Advance of a Nationwide Connectivity Framework," *Health Affairs* 40, no. 5, 2021: 736–744, <https://doi.org/10.1377/hlthaff.2020.01497>.

275 "CORHIO and Health Current Introduce New Regional Organization—Contexture," *Health Current*, August 3, 2021, <https://healthcurrent.org/corhio-health-current-contexture/>.

Today in Arizona, roughly 1,000 health care organizations participate in the statewide HIE that connects electronic health records (EHRs) and other IT systems across the continuum of care, from first responders, hospitals and health systems, labs, community behavioral health and physical health providers to post-acute care and hospice providers. Through the secure sharing of both physical and behavioral health data, the HIE empowers providers with more complete patient health records that lead to better clinical decisions and improved health outcomes. (See Sidebars 1 and 2 for Arizona HIE Efforts to Ensure Patient Privacy and Information Security).

Security: HIE Protections to Safeguard Patient Health Information

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to ensure patients have rights over their own health information, no matter what form it is in. The government also created the HIPAA Security Rule to require specific protections to safeguard patients' electronic health information. As Arizona's trusted steward of patient data, Health Current adheres to HIPAA security rules, such as:

Access control—tools like passwords and PIN numbers to help limit access to patient information to authorized individuals.

Encrypting—patient health information cannot be read or understood except by those using a system that can decrypt it with a key.

Audit trail—records who accessed a particular patient's information, what changes were made, and when.

Notification of a breach—requirement by federal law that doctors, hospitals and other health care providers notify a patient of a breach of their health information. The law also requires the health care provider to notify the Secretary of Health and Human Services. If a breach affects more than 500 residents of a state or jurisdiction, the health care provider must also notify prominent media outlets serving the state or jurisdiction. This requirement helps patients know if something has gone wrong with the protection of their information and helps keep providers accountable for EHR protection.

In addition, Health Current security measures are certified by HITRUST.

The HITRUST Common Security Framework (CSF) Certified status demonstrates that an organization's information systems and technical processes meet key regulations and industry-defined requirements and are appropriately managing risk to prevent security breaches. The rigorous certification process involves 19 assessment domains, including third-party management, password management, access control and physical security. By including federal and state regulations, standards and frameworks, and incorporating a risk-based approach, the HITRUST CSF helps organizations address security and privacy challenges through a comprehensive and flexible framework of prescriptive and scalable security controls.

HIE IMPACT: BY THE NUMBERS

The Arizona HIE positively impacts the lives of millions of patients who engage with our state's health care system. Health Current coordinates the exchange of health information of roughly 15 million patients comprised of Arizona residents, out-of-state visitors who receive care in Arizona (aka "snowbirds") and deceased Arizona patients. To support this volume, the HIE processes 26 million monthly data transfers statewide and distributes millions of alerts to health care providers and organizations monthly, arming them with information to better treat patients receiving care in Arizona.²⁷⁶

INTEGRATED DATA, INTEGRATED CARE SUCCESS

The secure sharing of robust physical and behavioral health data in the HIE helps providers save time, money, and, most importantly, lives. It also demonstrates the interconnectedness of mental health, substance use, and homelessness in Arizona. Below are a few HIE success stories that highlight those connections.

HIE DATA IN ACTION

Community Health Associates (CHA) is an integrated health care provider that offers psychiatric health, recovery support, physical health and individual and family services across southern Arizona. With over 4,500 patients, CHA works with a variety of populations, including children, adults, patients determined as having a serious mental illness (SMI), court-ordered treatment (COT) patients, and patients enrolled in the Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid agency.

After joining Health Current and incorporating HIE alerts into their daily workflow, CHA staff learned something new about the high-needs patients they serve. "We were surprised at the volume of ED (emergency department) use by these patients, and we recognized that we needed to take steps to assure more appropriate ED utilization," said Jessica Gleeson, population health administrator for CHA. New insight gained from HIE alerts allowed CHA to identify inappropriate uses of ED services, such as patients seeking care that could be addressed in more suitable settings (i.e., urgent care clinic or a physician office); someone trying to illegally obtain opioids; or someone with SDOH needs like social isolation, in need of air-conditioning during summer months and limited access to food. Armed with this information, the team was able to intervene more quickly and address the root causes of ED use.

Empowered by HIE alerts, CHA closed gaps in care and improved ED utilization. It launched a program that identified patients who had visited the ED more than four times in the past six months and reached out to help them understand the appropriate places to seek care. "The connection with the HIE has shown a big improvement on patient care," Gleeson said. "We are able to identify the frequent users and then develop strategies to intervene, so they are using the ED more appropriately."²⁷⁷ Most importantly, proper ED utilization leads to better patient outcomes. For example, studies show that ED crowding can have adverse consequences, such as longer wait times and higher mortality.²⁷⁸

276 "Arizona Health Information Exchange (HIE) Monthly Utilization Report," Health Current, December 2021.

277 "Closing Gaps in Care and Improving Utilization," Health Current, August 9, 2018, <https://healthcurrent.org/closing-gaps-in-care-and-improving-utilization/>.

278 "Report to Congress: Trends in the Utilization of Emergency Department Services, 2009-2018," U.S. Department of Health and Human Services, March 2, 2021, <https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf>.

Privacy: The Patient Rights Process

The Arizona HIE makes patients' health information electronically available to participants. State and federal law give patients certain rights and protections concerning this information. Personal health information (PHI) of deceased individuals is protected just like the PHI of living individuals—it can only be accessed, used or disclosed in accordance with applicable law and policies.

Providers who actively participate in the HIE must do the following to comply with these laws:

1. Distribute the Notice of Health Information Practices (Notice) to patients. Obtain a signature from each patient acknowledging receipt of the Notice. This signature can be obtained on any form (physical or electronic), including the health care provider's HIPAA Notice of Privacy Practices or conditions of admission or treatment form. The form must reference the health care provider's participation in the HIE and must state that the patient has received, read and understands the Notice.

2. Provide the HIE Opt-Out Form to any patient who wants to opt out or the opt-back-in form to change a previous opt-out decision. A patient can opt out or opt back in at any time.

3. Provide the HIE Health Information Request Form to any patient who wants to request a copy of their health information that's available through the HIE or who wants a list of persons who have accessed their health information through the HIE in the last three years.

To learn more about the HIE Patient Rights Process, visit: healthcurrent.org/rights.

INTEGRATING HIE SERVICES INTO A LARGE BEHAVIORAL HEALTH NETWORK

Southwest Network is a nonprofit integrated care organization that provides behavioral health services to infants, children, adolescents and adults across Maricopa County. When Southwest Network first connected to Health Current, they gained valuable insight into the care history of their patients deemed SMI, including past medications and previous lab work that often helped avoid unnecessary blood draws.

The Southwest Network team also created multiple patient panels focused on two population segments: a children's group selected for acute needs and adult groups consisting of patients with SMI who receive services 24/7 from their assigned Assertive Community Treatment (ACT) team and are deemed most likely to go to the hospital.

The effort realized two key benefits: 1) locating members through an Alert who aren't currently engaged and re-engaging them in their behavioral health services; and 2) finding members with new or existing medical conditions, like pregnancy, and tailoring services to support the health of the whole individual.

"As soon as we know we have a member who has been hospitalized, we can contact the hospital and any involved family members to initiate discharge planning, which helps prevent re-hospitalization," said Danielle Griffith, corporate compliance director for Southwest Network. Griffith further recognized the value of information from the HIE in treating the "whole individual and working with a member's entire health care team."²⁷⁹

HIE ALERTS HELP EASE TRANSITIONS BACK INTO THE COMMUNITY

The journey can be difficult for someone returning from time in jail, time in active military service or time living on the street. It's even more difficult when facing serious health issues. Old Pueblo Community Services (OPCS) provides behavioral health services and housing in southern Arizona to over 430 clients, including veterans, post-incarceration patients, individuals experiencing homelessness and substance users.

OPCS assigns a recovery coach to each client who guides them throughout their transition. The coaches utilize three different types of HIE alerts: outpatient, inpatient and ED alerts. "The number one benefit of receiving alerts from the HIE is the reduction in time for coordination of care and direct services," said Phillip Pierce, data integrity specialist at OPCS. "The HIE eases the process of understanding the client's history in order to identify a level of need and care."

One service in great demand among OPCS clients is housing. Clients and patients are placed into one of four housing options based upon their needs:

- Emergency Shelter (less than 90 days).
- Transitional Housing for those re-integrating into the community from incarceration (less than 90 days).
- Rapid Re-housing for clients who have already been identified to receive housing (less than 60 days).
- Supportive Housing that lasts a year or so as the client secures their own housing.

One innovative use of the HIE by OPCS is utilizing alerts for "bed checks." People in emergency and transitional housing are often in grant programs that pay for the cost of their bed each day. If an emergency or transitional housing client is admitted to a hospital or clinic overnight, OPCS conducts a bed check to ensure the client isn't charged by both the housing facility and the inpatient facility. Receiving an alert of inpatient admission, rather than just relying on a 10 p.m. physical bed check, increases accuracy in reporting. "Since being connected with the HIE, we now know what is going on with the client as it happens," Pierce said. "Not only does it save money, it's the best way to coordinate care on the client's behalf."²⁸⁰

279 "Southwest Network: Integrating HIE Services Into a Large Behavioral Health Network," Health Current, February 28, 2018, <https://healthcurrent.org/integrating-hie-services-large-behavioral-health-network/>.

280 "Alerts Help Ease the Transition Back Into the Community," Health Current, October 22, 2018, <https://healthcurrent.org/alerts-help-ease-the-transition-back-into-the-community/>.

MENTAL ILLNESS HOSPITALIZATION ALERTS

There are over two million hospitalizations each year for mental illness in the U.S. Patients hospitalized for mental health issues are vulnerable after discharge, and follow-up care by trained mental health clinicians is critical for their health and well-being.

In 2021, Health Current introduced Mental Illness Hospitalization Alerts—notifications for admissions, transfers and discharges (ADTs) of patients from level-1 psychiatric hospitals. The new service supports rapid coordination of care and assists with discharge planning upon admission to a psychiatric hospital, a key factor in reducing inpatient lengths of stay and supporting seamless transition, medication continuity and stability in community settings post-discharge.

OUR COMMUNITYCARES

In 2019, AHCCCS launched its Whole Person Care Initiative (WPCI) to focus on the social determinants of health (SDOH) factors that impact individual health and well-being, such as housing, employment, criminal justice, non-emergency transportation and home and community-based service interventions (see Chapter 4 — Integrated Treatment and Care in Arizona).

AHCCCS partnered with Health Current to implement a technology solution to support providers, health plans, community-based organizations (CBOs) and community stakeholders in meeting the SDOH needs of Arizonans.

In collaboration with AHCCCS, 2-1-1 Arizona/Solari Crisis & Human Services, and NowPow/Unite Us, Health Current developed and launched CommunityCares in 2021. The new initiative connects health care and community service providers on a single statewide technology solution that streamlines the referral process, fosters easier access to vital services and provides confirmation when social services are delivered.

One example of the closed-loop referral process is when a patient has an appointment with a primary care physician (PCP), who then refers the patient to see a specialist. Utilizing an SDOH needs screening assessment tool, the PCP might discover that there are barriers that could potentially prevent the patient from seeing the specialist, such as a lack of transportation or the need for childcare. Utilizing the CommunityCares platform, the PCP could then refer the patient to social service providers to help meet those needs. After the patient completes the appointment with the specialist, the PCP receives notification that the referral appointment was completed and that the social service needs for transportation and childcare were met as well. Thus, “closing the loop” with the PCP on all the referrals.

CommunityCares “is foundational to our Whole Person Care Initiative,” AHCCCS Director Jami Snyder said. “We see this as a real opportunity to link current community resources with individuals’ social needs, ultimately resulting in improved member health and wellness.”²⁸¹

Health Current is now actively signing up organizations for the SDOH referral program and onboarding health care providers and CBOs onto the CommunityCares platform. The functionality for patients to independently seek and obtain social services through CommunityCares will be added in late 2022.

281 “Health Current Selects NowPow as Technology Partner to Implement a Statewide SDOH Closed Loop Referral System in Arizona,” Health Current, February 17, 2021, <https://healthcurrent.org/health-current-selects-nowpow-as-technology-partner-to-implement-a-statewide-social-determinants-of-health-closed-loop-referral-system-in-arizona/>.

CONCLUSION

The Arizona HIE is all about creating connections—connecting providers to real-time information to better serve patients, connecting the health care community with one another to share best practices, and connecting the dots through data to demonstrate the complexities of human health and how it's impacted by the ways in which we engage with our health care system.

One such complexity is the interconnectedness of mental health, substance use, and homelessness in Arizona. The secure sharing of robust physical and behavioral health data helps to minimize that complexity and, ultimately, helps others improve lives. That's the power of accessing real-time, accurate patient information—that's the power of HIE.

CHAPTER 16 — FOCUS ON AFRICAN AMERICAN COMMUNITIES

Samantha Jackson, Downtown Mesa Association

Acronyms in this Chapter

B/AA—Black/African American

CoC—Continuum of Care

MAG—Maricopa Association of Governments

SAMHSA—Substance Abuse Mental Services Administration

Things you take for granted when you have a home: (1) the ability to take a shower whenever you want, (2) sheets that haven't been slept on by hundreds of other people, (3) a real kitchen, (4) the ability to store your things away in a safe place, (5) the sound of your keys when you pull them out of your pocket to unlock your very own door.

Things you take for granted when you are not a person of color: (1) trust—people don't automatically assume you are doing something wrong and call the police, (2) opportunity—people really want to help you, they believe in your ability, (3) belonging—nobody sees you as "other." When you're Black, they don't want to recognize you. When you're Black and homeless, they flat out ignore you, don't want to see you. Like you're invisible.

The words above are experiences that have been shared by those who have survived living without a house. Those people who some complain, "just need to get sober" and/or "pull themselves up by the bootstraps and get a job." Those whose trauma has regularly been ignored and overlooked.

In March 2020, the Maricopa Regional Continuum of Care (CoC), in partnership with the Maricopa Association of Governments (MAG) and Race Equity Partners, began to research racial disparities in relation to homelessness around Maricopa County. To the service providers working within the system, it seemed as though more people of color were experiencing homelessness. Even worse, the tool used to assess someone's eligibility for housing seemed to skew in favor of white people. But for change to happen, there needed to be data to determine to what degree the disparity existed.

The study evaluated the racial disparity within the homelessness system in Maricopa County.²⁸² Here are the highlights of the study conducted by Racial Equity Partners, specifically as it relates to Maricopa County's Black/African American (B/AA) population:

- African Americans experience homelessness at a rate 3.9 times greater than their share of the general population.
- Racial discrimination in housing and criminal justice drives high rates of homelessness among people of color.

282 Jeff Olivet and Donald Whitehead, "Race and Homelessness in Maricopa County, Arizona: Examining the Intersections," Maricopa Regional Continuum of Care, Racial Equity Partners, February 2021, <https://azmag.gov/Portals/0/Documents/Homelessness/Maricopa-Racial-Equity-Report.pdf>.

- African American people experience homelessness for 105 days on average, seven days longer than other races in Maricopa County.
- People of color are more likely than their white peers to return to homelessness from permanent supportive housing and rapid re-housing interventions.
- Many clients and providers perceive racial bias in the current assessment and prioritization process (“Coordinated Entry”).
- The homelessness workforce in Maricopa County is racially diverse. Out of 240 respondents to a survey of the homeless services field, 47% of the total workforce and 40% of executive leaders/board members identified as people of color.
- 36% of the homeless services workforce has personal lived experience of homelessness.

Find the study [here](#).

In Arizona, B/AA make up 21% of individuals experiencing homelessness but only 5.7% of the state population (see Figure 15).^{283 284} Two other considerations that likely exacerbate challenges for African Americans experiencing homelessness in Arizona are (1) mental health conditions, including substance use disorders, and (2) intellectual and developmental disabilities. Analysis of census data from 2019 shows that nearly 47 million people, or 14% of the population in the U.S., identify as B/AA.²⁸⁵ Figure 16 shows the prevalence of mental illness and substance use among the B/AA population. Four out of nine African American individuals with a substance use disorder struggle with illicit drugs, 2 out of 3 struggle with alcohol, and 1 in 9 struggle with both alcohol and illicit drugs.²⁸⁶ In addition, 14% of African Americans are living with a disability in the U.S. compared to 13.1% of non-Hispanic whites.²⁸⁷

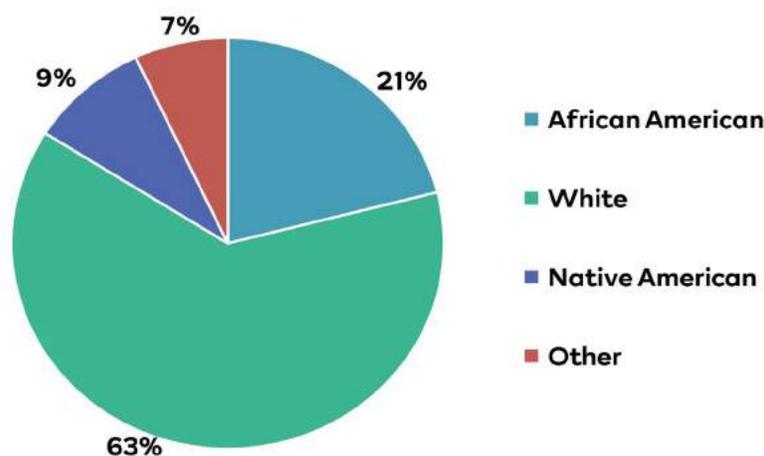


Figure 15. Racial characteristics of the Arizona homeless population (PIT Count) in 2020.²⁸⁸

283 “2020 CoC Homeless Populations and Subpopulations Report – Arizona,” U.S. Department of Housing and Urban Development, December 15, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_State_AZ_2020.pdf.

284 “ACS Demographic and Housing Estimates,” U.S. Census Bureau, 2019, <https://data.census.gov/cedsci/table?q=race%20and%20ethnicity&q=0400000US04&tid=ACSDPIY2019.DP05&hidePreview=true>.

285 Christine Tamir, “The Growing Diversity of Black America,” Pew Research Center, March 25, 2021, <https://www.pewresearch.org/social-trends/2021/03/25/the-growing-diversity-of-black-america/>.

286 “2019 National Survey on Drug Use and Health.”

287 “Disability Characteristics,” American Community Survey, U.S. Census Bureau, 2019, <https://data.census.gov/cedsci/table?q=ACSST5Y2019.S1810>.

288 “2020 CoC Homeless Populations.”

Prevalence of Mental Illness and Substance Use among the African American Population, U.S. 2019

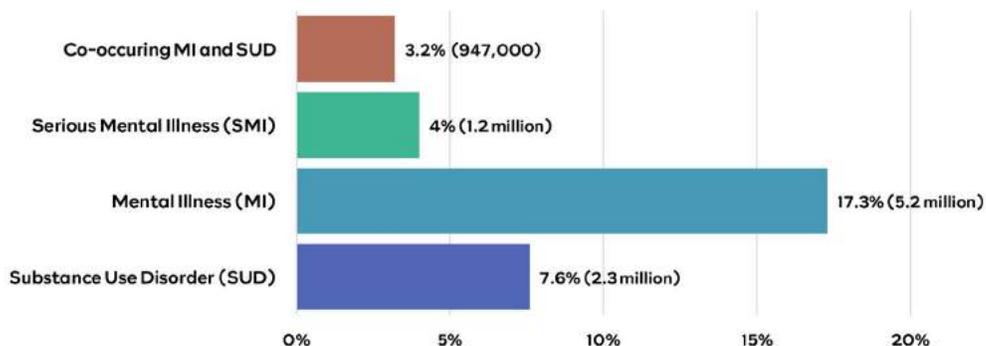


Figure 16. Prevalence of mental illness and substance use among African Americans in the U.S. in 2019.²⁸⁹

While numbers certainly help tell the story, what remains critical to this conversation is the examination of the incredible disparities that continue to exist within the B/AA community. At the core of this conversation, we must acknowledge the centuries of dehumanization, oppression and violence that Black people in the U.S. have experienced. We must be willing to examine our own biases. In very valid ways, it is not as simple as “pull yourself up” when much of what is needed to do just that remains inaccessible because of the bias and discrimination that exist. If the sort of housing a Black person qualifies for is only rapid re-housing, which has greater returns to homelessness, versus permanent supportive housing, how can one find the needed stability to remain housed with access to regular care? Without a home, where is someone supposed to keep their important documents and items that may help end their homelessness? Without a stable place to live, how is one supposed to eat? Visit a doctor to treat chronic health ailments? Get the sort of education that may lead to a better-paying job that can stabilize their housing?

When contemplating solutions, it is important to distinguish “equality,” which signifies that everyone should get the exact same resources, and “equity,” where resources are distributed based on the needs of the individual. In Maricopa County, the CoC is currently (1) redesigning the coordinated entry system to develop and utilize a more equitable assessment tool, (2) including the voices of people with lived experiences with homelessness in decision-making roles to create more equitable policies and practices, (3) building organizational capacity to collect and use data to create equity-based systems change, and (4) conducting training and organizational change activities with service providers to decrease bias and implement equity.

Change in other analogous, complicated systems that interact with individuals experiencing homelessness (i.e., education, justice, housing, health care, etc.) could be contemplated by the Arizona community as well. Are there actions that can be taken to increase the prevention of homelessness by growing cross-sector collaboration? Could coalitions be built to advance important initiatives?

While there is important work to do at the policy level, the most impactful change in homelessness is giving someone a key that opens the door to their new home. Because in truth, that key opens up so much more than a door for the person who holds it.

289 “2019 National Survey on Drug Use and Health: African Americans,” Substance Abuse and Mental Health Services Administration, September 2020, <https://www.samhsa.gov/data/report/2019-nsduh-african-americans>.

CHAPTER 17 — FOCUS ON HISPANIC/LATINO COMMUNITIES

Max Gonzales, Chicanos Por La Causa Inc.

Erin Garcia, Chicanos Por La Causa Inc.

Acronyms in this Chapter

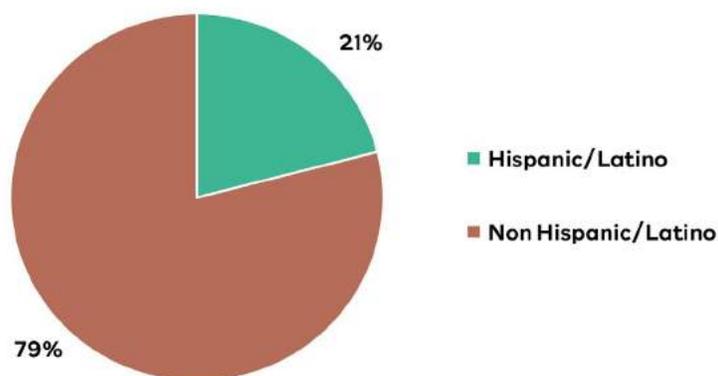
AHCCCS—Arizona Health Care Cost Containment System

CPLC—Chicanos Por La Causa

HUD—U.S. Department of Housing and Urban Development

WIC—Women, Infants, and Children

Hispanics/Latinos have higher rates of homelessness than non-Hispanic whites (21.5 per 10,000 compared to 11.8 per 10,000, respectively). However, given comparable poverty rates, Hispanics/Latinos experience homelessness much less frequently than African Americans (55.2 per 10,000). In 2020, 21% of the unhoused community who was surveyed in Arizona identified as Hispanic/Latino (see Figure 17).²⁹¹



*Figure 17. Hispanic/Latino unhoused population (PIT Count) in Arizona in 2020.*²⁹²

Researchers have hypothesized that Hispanic/Latino families have culturally-based resilience factors, like stronger extended family networks, that can help prevent someone from experiencing homelessness.²⁹³ In a national study of 2,282 families with children who entered homeless shelters between late 2010 and early 2012, Latino/Hispanic families had the most favorable outcomes in a two year follow up.²⁹⁴ However, this was only true in the Northeast; in the West, Hispanic/Latino families were more likely to continue to experience homelessness than non-Hispanic whites.

290 Meghan Henry et al., "The 2020 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness," U.S. Department of Housing and Urban Development, January 2021, <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>, own calculation.

291 "Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations – Arizona," U.S. Department of Housing and Urban Development, December 15, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_State_AZ_2020.pdf, own calculation.

292 "Continuum of Care Homeless Assistance Programs."

293 Jill Khadduri et al., "How Do Hispanic Families Experience Homelessness? Evidence from the Family Options Study," Center for Evidence-Based Solutions to Homelessness, February 2018, <http://www.evidenceonhomelessness.com/wp-content/uploads/2018/03/HOW-DO-HISPANIC-FAMILIES-EXPERIENCE-HOMELESSNESS.pdf>.

294 Khadduri et al., "How Do Hispanic Families."

Additionally, Hispanics/Latinos may be undercounted when using official definitions of homelessness, which do not consider “doubled-up” individuals as homeless. In other words, if someone is staying with family or friends because they do not have a home, they would not be counted under the HUD definition as experiencing homelessness.²⁹⁵ Additionally, people staying with family or friends or in vehicles are rarely captured in the Point-in-Time Count. Consider findings from Chicanos Por La Causa’s (CPLC) 2020 COVID-19 Community Needs Assessment with over 1,000 CPLC clients responding: Housing instability due to COVID affected 37% of Hispanic respondents.²⁹⁶ Of this sample, Hispanic clients were making room for family significantly more than white families. 67% of Hispanics reported moving in with a relative or having a relative move in with them compared to 14% of white individuals. Additionally, 41% of Hispanic clients mentioned paying rent as a daily stressor.²⁹⁷

At the same time, another study among individuals experiencing homelessness in Los Angeles County found that Hispanics/Latinos were much less likely to receive social services than other populations.²⁹⁸ The author attributed this to cultural and language barriers. Additionally, it is also thought that Hispanics/Latinos, especially men, are comparatively more reluctant to accept help from social service providers.²⁹⁹ Taken together, national data suggests that there are risk and protective factors that impact this demographic group.

Housing instability exists as a spectrum from individuals experiencing street homelessness to renters who are rent-burdened or doubled-up and at imminent risk of eviction to homeowners at risk of foreclosure. There is a need for various levels of support throughout that spectrum, and the pandemic has amplified those needs.

In March of 2020, CPLC assumed operations of a low-barrier homeless shelter in Las Vegas, NV. CPLC interviewed 154 clients living in the shelter for its COVID-19 needs assessment study. Findings suggest that those who reported a recent housing change due to the pandemic have different perceptions of their housing situation than those who experienced homelessness prior to the pandemic. Over 45% self-identify as being “temporarily displaced,” not homeless, while the remaining guests classify themselves as experiencing homelessness.³⁰⁰ This highlights a growing number of people that are experiencing homelessness by the HUD definition but may not be self-identifying as such. How an individual self-identifies will guide their decision-making in how they look for resources, what resources they look for, what agencies they turn to, or even how they respond to intake or application questions. From July 2020 to July 2021, there has been a 10% average rent increase in Phoenix, which has led to the housing affordability issues that have exacerbated low-income families’ ability to survive the COVID-19 economic crisis.³⁰¹ CPLC’s Navigation efforts among all of our programs, Keogh Health Connections (health insurance enrollment), Parenting Arizona (family support services), Centro De La Familia (behavioral health services), and Workforce Solutions (career services), have been working to increase access to rental and utility support but it has not been enough. From March 2020 to April 2021, total evictions in Maricopa County saw a 55% decline, but rising again after the end of the moratorium at the end of 2021.³⁰² However, despite the

295 “Criteria and Recordkeeping Requirements for Definition of Homelessness,” U.S. Department of Housing and Urban Development, January 2012, https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf.

296 Karen Armknecht, Victoria Iwinski, and Amanda Douglas, “The Burden of the Pandemic: CPLC COVID-19 Client Impact and Needs Assessment,” Chicanos Por La Causa, CPLC Research & Evaluation, December 10, 2020, <https://cplc.org/assets/files/covid-report.pdf>.

297 Armknecht, Iwinski, and Douglas, “Burden of the Pandemic.”

298 Melissa Chinchilla, “Stemming the Rise of Latino Homelessness,” Latino Policy & Politics Initiative, University of California Los Angeles, January 1, 2019, <https://latino.ucla.edu/research/stemming-the-rise-of-latino-homelessness-lessons-from-los-angeles-county/>.

299 Amanda Machado, “Why Many Latinos Dread Going to the Doctor,” The Atlantic, May 7, 2014, <https://www.theatlantic.com/health/archive/2014/05/why-many-latinos-dread-going-to-the-doctor/361547/>.

300 Armknecht, Iwinski, and Douglas, “Burden of the Pandemic,” 67.

301 Joe Dana, “It’s Becoming Out of Reach: Phoenix–Area Housing Rentals Becoming Too Costly for Tenants,” 12News.com, July 7, 2021, <https://www.12news.com/article/news/local/valley/phoenix-area-housing-rentals-becoming-too-costly-for-tenants/75-d5280aa9-04fc-4flc-aaaf-3ca9fd28f66c>.

302 “More Evictions Filed in Maricopa County Last Month than in any Month of the Pandemic,” 12News.com, October 1, 2021, <https://www.12news.com/article/news/local/arizona/maricopa-county-evictions-september-more-pandemic-month/75-2b694047-09d7-4aac-a026-6ba4a700ec93>.

moratorium, evictions did not come to a complete halt. Evictions that were not covered by the federal and state mandates, such as a breach of contract excluding inability to pay, were still present within the county, and as a result, over 26,000 evictions were filed in Maricopa County from March–December of 2020.³⁰³ During this period, two of the top ten ZIP codes for evictions were in the predominantly Hispanic neighborhood of Maryvale–85035 and 85033.³⁰⁴ As of September of 2021, Alhambra and Maryvale remain in the top ten ZIP codes for evictions (85015 and 85035).³⁰⁵

Hispanics/Latinos have lower rates of mental health issues than the general population, on average (see Figure 18). For instance, Hispanics/Latinos reported about half the rate of illicit substance use within the past year compared with non-Hispanic whites.³⁰⁶ However, this is not true of specific subgroups. For example, U.S.-born Hispanics/Latinos have much higher rates of mental health issues than those born outside the U.S. (coined the “immigration paradox”).³⁰⁷ Hispanic/Latino children report worse mental health than their white peers and Hispanics/Latinos over 60 years old report worse mental health than the general population. Worse mental health outcomes in these groups have been shown to be related to immigration experiences, discrimination and challenges in acculturation.^{308 309}

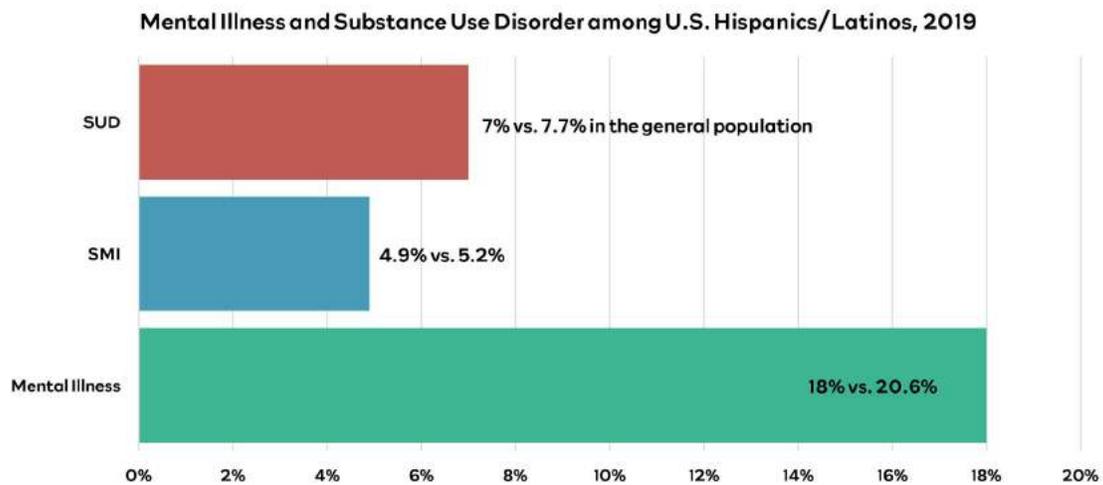


Figure 18. Mental illness and SUD among adult Hispanics/Latinos in the U.S. in 2019.³¹⁰

Arizona numbers are slightly distinct from these national trends. In 2010, 30% of Hispanics/Latinos reported mild to severe psychological distress, while only 24% of non-Hispanic whites did.³¹¹ However, controlling for income showed lower rates of distress among Hispanics/Latinos, pointing at the protective factors discussed.

303 “More Evictions Filed.”

304 “Eviction Filings from 2015-2021,” Maricopa County Justice Court System, accessed September 2021.

305 “Eviction Filings.”

306 Luis Arturo Valdez and Brent A. Langellier, “Racial/Ethnic and Socioeconomic Disparities in Mental Health in Arizona,” *Frontiers in Public Health* 3, July 3, 2015: 170, <https://doi.org/10.3389/fpubh.2015.00170>.

307 Margarita Alegria et al., “Prevalence of Mental Illness in Immigrant and Non-Immigrant U.S. Latino Groups,” *The American Journal of Psychiatry* 165, no. 3, March 2008: 359–69, <https://doi.org/10.1176/appi.ajp.2007.07040704>.

308 Tania Maria Caballero et al., “Addressing the Mental Health Needs of Latino Children in Immigrant Families,” *Clinical Pediatrics* 56, no. 7, June 1, 2017: 648–58, <https://doi.org/10.1177/0009922816679509>.

309 Daniel E Jimenez et al., “Older Latino Mental Health: A Complicated Picture,” *Innovation in Aging* 4, no. 5, August 18, 2020: 1–12, <https://doi.org/10.1093/geron/igaa033>.

310 “Results from the 2019 National Survey on Drug Use and Health: Detailed Tables,” Substance Abuse and Mental Health Services Administration, August 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

311 Valdez and Langellier, “Racial/Ethnic and Socioeconomic Disparities.”

Nationally, members of the Hispanic/Latino community are much less likely than the general population (10 percentage points) to seek or receive treatment for mental illness and substance use.³¹² This is also true in Arizona, where Hispanics/Latinos are much less likely to be diagnosed with a mental health condition given a set level of psychological distress.³¹³ Hispanic/Latino men are much more likely than non-Hispanic whites to die of alcoholic liver disease, suggesting poor access to treatment and low treatment completion.³¹⁴ These outcomes are due to unique barriers to treatment in this community.³¹⁵ For example, mental illness is often seen as a stigma in Hispanic/Latino communities, resulting in less health literacy and behavioral health service use.³¹⁶ Various cultural factors, such as a stronger reliance on family and traditional ideas of masculinity, are thought to contribute to underutilization of treatment. Additionally, there are not enough culturally competent mental health professionals that can understand the needs of the Hispanic/Latino community and provide services in Spanish. According to a study by the American Psychological Association in 2015, 4.4% of psychologists identify as Hispanic/Latino, and 5.5% speak Spanish.³¹⁷ In Arizona, where Hispanics/Latinos make up 31% of the population, only 7% of therapists speak Spanish.³¹⁸ Immigration-related concerns, real and perceived, also play a role. In states that treat immigrants more restrictively, like Arizona, Hispanics/Latinos tend to report worse mental health and decreased service utilization.³¹⁹ In recent interviews with frontline staff from CPLC's Centro de La Familia and Esperanza behavioral health services for an Integrated Health and Human Services community needs assessment, key themes about care were: 1) clients not having the technology necessary for telehealth services, 2) increased need for trauma-centric therapies, 3) need for immigration services, 4) increased need for Spanish-speaking staff.³²⁰

CPLC operates one of the few clinics that has bilingual therapists and case managers. They receive many referrals from other agencies that lack Spanish-speaking staff. Undocumented Hispanic/Latino individuals, in particular, are often hesitant to seek services due to fear and lack of financial resources. Moreover, undocumented Hispanics/Latinos do not qualify for most federal funding programs, such as Medicaid and WIC.³²¹ The impact of COVID-19 underscores the importance of these services. In CPLC's community-level COVID needs assessment, a quarter (23%) of clients noted their mental health had been impacted by COVID-19, a number that is higher than that of their white counterparts (19%).³²²

312 "Results from the 2019 National Survey on Drug Use and Health: Mental Health Detailed Tables. Table 8.17B," Substance Use and Mental Health Services Administration, August 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

313 Valdez and Langellier, "Racial/Ethnic and Socioeconomic Disparities."

314 Robert E. Levy et al., "Ethnic Differences in Presentation and Severity of Alcoholic Liver Disease," *Alcoholism: Clinical and Experimental Research* 39, no. 3, 2015: 566–574, <https://doi.org/10.1111/acer.12660>.

315 Josefina Alvarez et al., "Substance Abuse Prevalence and Treatment Among Latinos and Latinas," *Journal of Ethnicity in Substance Abuse* 6, no. 2, 2007: 115–141, https://doi.org/10.1300/J233v06n02_08.

316 Lorraine T. Benuto, Fraces Gonzalez, Francisco Reinoso-Segovia, and Melanie Duckworth, "Mental Health Literacy, Stigma, and Behavioral Health Service Use: The Case of Latinx and Non-Latinx Whites," *Journal of Racial and Ethnic Health Disparities* 6, no. 6, December 2019: 1122–1130, <https://doi.org/10.1007/s40615-019-00614-8>.

317 Aunré Hamp, Karen Stamm, Luona Lin, and Peggy Christidis, "2015 APA Survey of Psychology Health Service Providers," American Psychological Association, September 2016, <https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf>.

318 Deborah Bailey and Bruce Hogan, "Hispanic American Mental Health Care Gap to Reach Almost \$500 Million by 2030," SimplePractice (blog), November 26, 2019, <https://www.simplepractice.com/blog/hispanic-american-mental-health-care-gap>.

319 Mark L. Hatzenbuehler et al., "Immigration Policies and Mental Health Morbidity among Latinos: A State-Level Analysis," *Social Science & Medicine* 174, February 2017: 169–178, <https://doi.org/10.1016/j.socscimed.2016.11.040>.

320 Romero, et al. "IHHS Community Needs Assessment: Corazon, Esperanza, & Centro de la Familia," CPLC Research & Evaluation.

321 Tanya Broder, Gabrielle Lessard, and Avidah Moussavian, "Overview of Immigrant Eligibility for Federal Programs," National Immigration Law Center (blog), accessed September 27, 2021, <https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/>.

322 Armknecht, Iwinski, and Douglas, "Burden of the Pandemic."

In addition to the unique barriers discussed above, Hispanics/Latinos also face other general barriers related to low income and poverty. Hispanics/Latinos in Arizona live in poverty and are uninsured or underinsured at higher rates than non-Hispanic whites.³²³³²⁴ Eighty percent of Centro de La Familia clients utilize public health insurance (Medicaid/AHCCCS); 96% use Medicaid at the Corazon substance use treatment center; 94% use Medicaid at the Esperanza facility; 91% of Integrated Health and Human Services clients are below the federal poverty line. Many prospective clients can't afford to pay for services themselves or take time off work to attend services. Transportation to appointments often poses a challenge. Parents often cannot attend appointments because they do not have access to reliable childcare. The COVID-19 needs assessment found that 25% of Hispanic individuals left or reduced their work hours to take care of their children due to the pandemic—again, a significant difference when compared to the general population surveyed.³²⁵

Hispanic/Latino families have some culturally based resilience factors leading to lower rates of homelessness, mental illness and substance use. However, they do face unique barriers when accessing services and treatment, many related to poverty and inequality. The COVID-19 pandemic has exacerbated these issues. We discussed CPLC as one innovative organization that provides culturally sensitive services.

323 John Creamer, "Poverty Rates for Blacks and Hispanics Reached Historic Lows in 2019," U.S. Census Bureau, September 15, 2020, <https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html>.

324 Katherine Keisler-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the U.S.: 2019," U.S. Census Bureau, September 2020, <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>.

325 Armknecht, Iwinski, and Douglas, "Burden of the Pandemic."

CHAPTER 18 — FOCUS ON FORMERLY INCARCERATED INDIVIDUALS

Beya Thayer, Yavapai Justice and Mental Health Coalition

Acronyms in this Chapter

- AHCCCS—Arizona Health Care Cost Containment System
- DOC—Department of Corrections, Rehabilitation, and Reentry
- HUD—U.S. Department of Housing and Urban Development
- SMI—Serious Mental Illness

The U.S. incarcerates more people per capita than any other country.³²⁶ Arizona has the 5th highest imprisonment per capita rate in the nation.³²⁷ In November 2021, there were 34,330 individuals incarcerated in Arizona's 16 state or privately-owned Department of Corrections, Rehabilitation and Reentry (DOC) prisons.³²⁸ In 2019, county and city jails in Arizona housed on average 13,540 individuals daily with 189,100 unique annual bookings.³²⁹ Incarceration increased 58% in prisons between 2000 and 2018 and 29% in jails between 2000 and 2015—even more, the prison population increased 507% since 1983 and the jail population increased 695% since 1970.³³⁰

People living with a mental illness and/or substance use are overrepresented in prisons and jails (see Figure 19). Compounding mental health and substance use issues, formerly incarcerated individuals are also much more likely to experience homelessness when compared to the public.³³¹

National trends align with data from Arizona showing that experiencing homelessness and living with unmet behavioral health needs are prevalent characteristics of individuals revolving through our detention systems (see Figure 20).

326 "Countries with the Largest Number of Prisoners per 100,000 of the National Population, as of May 2021," Statista, June 2, 2021, <https://www.statista.com/statistics/262962/countries-with-the-most-prisoners-per-100-000-inhabitants/>.

327 "Prison Population by State 2021," World Population Review, 2021, <https://worldpopulationreview.com/state-rankings/prison-population-by-state>.

328 "Committed Population," Arizona Department of Corrections, Rehabilitation, and Reentry, November, 26, 2021, https://corrections.az.gov/sites/default/files/DAILY_COUNT/Nov2021/11262021_count_sheet.pdf.

329 Zhen Zeng and Todd D. Minton, "Census of Jails, 2005–2019 – Statistical Tables," U.S. Department of Justice, 2021, <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cj0519st.pdf>.

330 "Incarceration Trends in Arizona," Vera, December 2019, <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-arizona.pdf>.

331 Lucius Couloute, "Nowhere to Go: Homelessness among Formerly Incarcerated People," Prison Policy Initiative, August 2018, <https://www.prisonpolicy.org/reports/housing.html>.

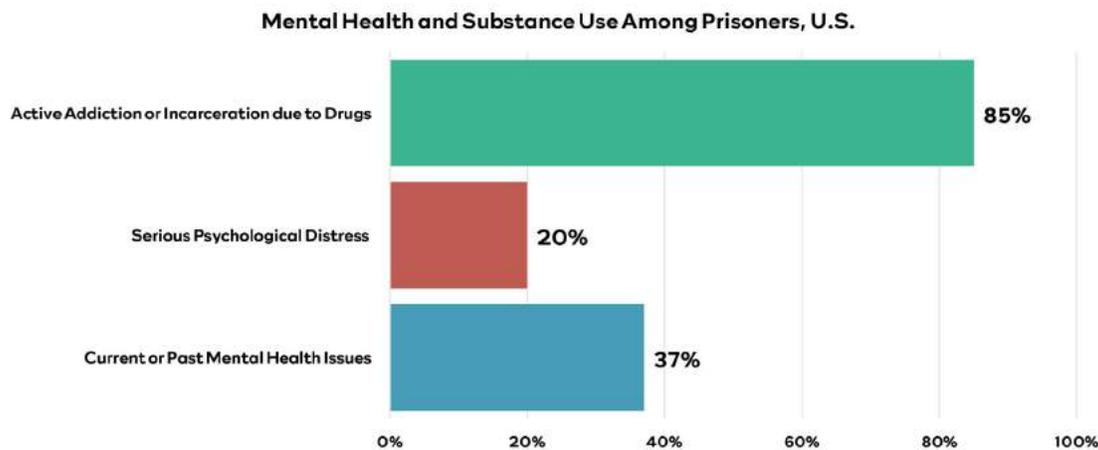


Figure 19. Mental health and substance use among U.S. prisoners.^{322,333}

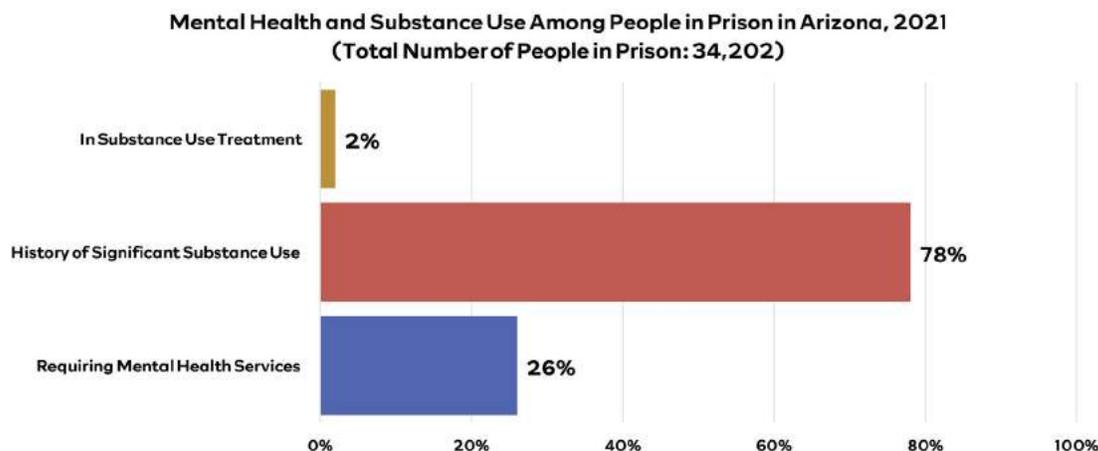


Figure 20. Mental health and substance use among people in Arizona prisons 2021.³³⁴

Officials estimate that 1,100 individuals with Serious Mental Illness (SMI) are housed in Maricopa County jails—20% of the total population.³³⁵ More than 50% of arrestees were classified as having either moderate (30.1%) or substantial (23.8%) risk of substance use or dependence in 2012.³³⁶ In Yavapai County, 44% of the incarcerated population disclosed moderate or high risk for mental health concerns, 36% disclosed moderate or high risk for Substance Use Disorders, and 22% disclosed that they were experiencing homelessness at their time of arrest among 13,753 inmates between 2018 and 2020. These risk factors directly impact recidivism rates. Those with moderate to high behavioral health risk factors returned to jail at rates between 21% and 23% compared to an overall recidivism rate of 18.5%. Unfortunately, those who experience homelessness return to jail on a new charge at a rate of almost 26%. To counteract this trend, the Reach Out program meets with all inmates

332 Jennifer Bronson and Marcus Berzofsky, "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12," U.S. Department of Justice, June 2017, <https://bjs.ojp.gov/content/pub/pdf/imhprpii112.pdf>.

333 "Criminal Justice DrugFacts," National Institute on Drug Abuse, June 2020, <https://www.drugabuse.gov/download/23025/criminal-justice-drugfacts.pdf?v=25dde14276b2fa252318f2c573407966>.

334 "Corrections at a Glance," Arizona Department of Corrections, Rehabilitation and Reentry, November 2021, <https://corrections.az.gov/sites/default/files/REPORTS/CAG/2021/cagnov-21.pdf>.

335 Roger A. Hughes, Carol A. Lockhart, Stephen L. Day, and Ann O'Hara, "Gray Land: Housing for People with Serious Mental Illness in Maricopa County," St. Luke's Health Initiatives, January 2008, <http://vitalysthealth.org/wp-content/uploads/2014/02/ib-2008-January.pdf>.

336 Michael D. White, "Arizona Arrestee Reporting Information Network: 2012 Maricopa County Office of the Public Defender Report on Co-Occurring Disorders among Arrestees," Center for Violence Prevention & Community Safety, Arizona State University, October 2012, https://cvpcs.asu.edu/sites/default/files/content/products/AARIN_Public_Defender_final.pdf.

and offers mental health screening and connection opportunities.³³⁷ At the same time, a class-action lawsuit currently on trial in federal court alleges that Arizona has provided insufficient medical services, including mental health treatment, to its DOC prisoners.³³⁸

Incarceration, unmet behavioral health needs and homelessness uniquely intersect in such a way that can perpetuate each of these conditions. Research has found that incarcerated “individuals with mental and substance use disorders are less likely to make bail” and more likely to be victimized or exploited, subjected to segregation during incarceration, and have longer jail stays compared to those without mental health and substance use issues.³³⁹ Additionally, people who have been incarcerated experience homelessness at far greater rates (7–13 times higher) than those of the general population.³⁴⁰ Studies by the Urban Institute describe the cycle of people rotating in and out of jails, emergency shelters, emergency rooms, and psychiatric and detox facilities, which prevent any true engagement in housing and behavioral health services.³⁴¹ Losing housing and/or employment during incarceration, lack of/burden of public transportation, poor credit, policies allowing the exclusion of renters with criminal backgrounds on housing applications, probation/parole regulations, minimal family reunification, and lack of accessible and affordable housing are all issues that individuals who have been incarcerated face upon release.³⁴² These factors are compounded with jurisdictional policies that add a layer of criminalization to homelessness, such as loitering, camping in city limits, disorderly conduct, panhandling, public urination, etc. (see Chapter 7 – Criminalization of the Condition).³⁴⁵ For those living with a mental illness, securing steady employment and carrying out daily activities are difficult due to cognitive or behavioral barriers brought on by the illness, which decreases access to stable housing. Alcohol and drug use, along with violent victimization, can also reinforce the impact that homelessness and mental illness have on one another.³⁴⁶

In-depth release coordination pre-release is imperative to mitigating homelessness for those who are formerly incarcerated. “When it comes to housing for men and women that are returning to our communities after a period of incarceration, we’re finding that having a comprehensive reentry plan, including connecting individuals with health care and treatment services prior to release, is paramount to one’s success. Designing a plan that takes into account factors such as proximity to employer, supportive family, resources and services helps eliminate barriers before they become issues.”³⁴⁷ Arizona has multiple peer-run agencies with certified peer support specialists who are breaking barriers and stigma by providing enhanced pre-release coordination plans and hope for individuals post-release.³⁴⁸

337 George Pro and Ricky Camplain, “Yavapai County Detention Center Reach Out Program,” Northern Arizona University, 2021, <https://justicementalhealth.com/wp-content/uploads/2021/08/Yavapai-Reach-Out-Fact-Sheet-July-2021.pdf>.

338 Jimmy Jenkins, “Centurion VP Makes ‘Damning Admission’ on Last Day of Arizona Prison Health Care Trial,” Arizona Republic, December 14, 2021, <https://www.azcentral.com/story/news/local/arizona/2021/12/14/damning-admission-last-day-arizona-prison-health-care-trial/8898911002/>.

339 “Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide,” Substance Abuse and Mental Health Services Administration, 2017, <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4998.pdf>.

340 Couloute, “Nowhere to Go.”

341 Emily Peiffer et al., “Five Charts that Explain the Homelessness-Jail Cycle—and How to Break it,” Urban Institute, September 16, 2020, <https://www.urban.org/features/five-charts-explain-homelessness-jail-cycle-and-how-break-it>.

342 Katharine H. Bradley, R. B. Michael Oliver, Noel C. Richardson, and Elspeth M. Slayter, “No Place like Home: Housing and the Ex-Prisoner,” Community Resources for Justice, November 2001, https://www.researchgate.net/publication/239616156_No_Place_Like_Home_Housing_and_the_Ex-Prisoner.

343 “Employment and Income: Barriers to Employment,” National Coalition for the Homeless, <https://nationalhomeless.org/issues/economic-justice/>.

344 Couloute, “Nowhere to Go.”

345 Eric S. Tars, “Criminalization of Homelessness,” National Homelessness Law Center, 2021, https://nlihc.org/sites/default/files/AG-2021/06-08_Criminalization-of-Homelessness.pdf.

346 Peter Tarr, “Homelessness and Mental Illness: A Challenge to Our Society,” New Horizons Behavioral Health, <http://nhbh.org/press.cms/2020/68/homelessness-and-mental-illness--a-challenge-to-our-society>.

347 Personal Communication with Brett Matossian, CEO, ReEntry by Design, Inc.

348 “How to Become a Peer Recovery Support Specialist,” Arizona Health Care Cost Containment System, 2021, <https://www.azahcccs.gov/AHCCCS/Downloads/PeerRecoverySupportSpecialist.pdf>.

All of these barriers are exacerbated by the increasing cost of housing and limited supply in our communities. A housing expert stated, "Finding housing that is sustainable, close to resources/work and is dignified is very difficult in the current housing climate. Attempting to do so with a criminal record is almost impossible. Rental companies are looking at long lists of applicants, creating the opportunity to select what they consider to be the most stable or lowest risk tenants—this often excludes those previously incarcerated."³⁴⁹

"Fair housing" is the right to choose housing free from unlawful discrimination. Fair housing laws protect people from discrimination in housing based on race, color, religion, sex, national origin, familial status and disability (see also Fair Housing Act). Depending on where you live in Arizona, additional local protections may apply. Discrimination is illegal in housing transactions such as rentals, sales, lending and insurance. Individuals with a criminal record are not a protected class under the Fair Housing Act. The law does not prohibit housing providers from considering criminal records when screening applicants or making other housing decisions. The law does prohibit housing providers from using criminal records: (1) As a pretext for intentional discrimination; or (2) in a manner that causes an unjustified discriminatory effect on a protected class."³⁵⁰

Although the federal Fair Housing Act does not prevent a landlord from using a potential renter's criminal history in the decision to rent to the individual, it is important for landlords to understand that per the Fair Housing Act, these decisions must be made on an individualized, case-by-case basis. HUD regulations emphasize that policies are to be established and need to not only take into consideration the criminal history—noting that an arrest is not proof of criminal conduct—but also the individual's rehabilitation, community ties and support, and employment history. HUD's best practices for housing providers include the consideration of mitigating factors such as letters from parole/probation officers, caseworkers/counselors, family members, employers and/or teachers; certifications of various treatment/rehab programs and/or trainings/education completed; proof of employment; and a statement from the applicant. The Fair Housing Act accentuates the need to eliminate blanket policies and utilize individual assessments.

Re-entry housing, also called transitional housing or sober living homes, is an intervention that may help former inmates avoid homelessness. Re-entry housing offers placement to individuals directly after release for a limited amount of time. Transitional housing incorporates some form of supervision over residents, along with rules and requirements to maintain their placement, such as curfews, participating in substance use treatment and seeking or maintaining employment. If residents do not comply with the rules and regulations, often including sobriety, they can be discharged and possibly reincarcerated.

Some transitional houses can be accessed voluntarily, while others are reserved for those who are required to live there as a condition of their parole or probation. Private or non-profit operators are able to utilize various local, state and federal funding sources, allowing them to serve clients at low or no cost. Re-entry housing has been embraced by some jurisdictions because it holds the promise of reduced costs and reduced recidivism.³⁵¹

349 Personal Communication with Jessi Hans, Executive Director Coalition for Compassion and Justice (providing emergency and transitional housing options in western Yavapai County).

350 "Guide Sheet: HUD Guidance on Criminal Background and Resources for Reentry," Southwest Fair Housing Council, 2016, <http://swfhc.com/criminal-background-and-resources-for-reentry-housing>.

351 Christopher T. Lowenkamp and Edward J. Latessa, "Evaluation of Ohio's Community Based Correctional Facilities and Halfway House Programs," University of Cincinnati, 2002, https://www.uc.edu/content/dam/uc/ccir/docs/reports/project_reports/HH_CBCF_Report1.pdf.

Unfortunately, service delivery models and regulations for these facilities vary widely across the U.S. As a result, many reports find poor conditions, resident mistreatment, corruption and worse outcomes for society.^{352 353} The Arizona Recovery Housing Association is dedicated to providing quality residential recovery services through their standards and certification program.³⁵⁴ Recent research suggests that offering quality housing with supportive services for persons re-entering from prison or county jails holds the promise of improving their lives and reducing recidivism.³⁵⁵

The state of Arizona has introduced several initiatives to reduce recidivism, support reintegration into society and avoid homelessness for those who have been incarcerated. Beginning in 2017, the Second Chance re-entry program offers inmates eight weeks of training, including job and life skills development. Many graduates leave prison with a job.³⁵⁶ According to the Arizona Supreme Court, formal release planning facilitated by probation for persons leaving the Arizona DOC system beginning 90 days prior to release, to be followed up by intensive supervision for at least 90 days post-release is required. The Arizona State Legislature put into statute the ability for counties to formalize Coordinated Re-entry Planning Services. Through this statute, sheriff's offices are able to begin screening and service coordination immediately upon booking. Some counties are building re-entry centers for those exiting the jails, in which multiple service agencies will be available to support engagement in wrap-around services, including coordinated-entry applications for housing. Due to unknown release dates and shorter lengths of stays for county inmates, immediate screening and collaboration with service providers upon release are imperative in supporting this population.

Another Arizona initiative concerns bridging gaps in behavioral health treatment for inmates exiting incarceration. Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, started a pilot program in 2005 that has since been expanded to the whole state to better coordinate care for individuals released from jail and prison.³⁵⁷ A data exchange system tracks admissions and releases which allows automatic re-enrollment of benefits upon release. Additionally, the Department of Economic Security has designated staff members who help previously un-enrolled individuals to apply for Medicaid, which can be done up to 30 days before release. Maricopa County has placed health insurance navigators in its probation assessment centers to provide enrollment assistance to people eligible for release. As part of AHCCCS's Targeted Investments Program, individuals with significant mental health needs can meet with their parole or probation officer and receive health care services in the same visit in some jurisdictions. AHCCCS also requires Managed Care Organizations to provide reach-in care coordination for individuals with complex health needs, including serious mental illness. In practice, this means inmates are contacted pre-release to create a care plan and schedule doctor's visits.

352 "Halfway Back to Society," The New York Times, March 29, 2014, <https://www.nytimes.com/2014/03/30/opinion/sunday/halfway-back-to-society.html>.

353 Anat Rubin, "A Record of Trouble," The Marshall Project, 2015, <https://www.themarshallproject.org/2015/04/11/a-record-of-trouble>.

354 "About Us," Arizona Recovery Housing Association, 2022, <https://myazrha.org/about-us>.

355 Kimberly Burrowes, "Can Housing Interventions Reduce Incarceration and Recidivism?," Urban Institute, 2019, <https://housingmatters.urban.org/articles/can-housing-interventions-reduce-incarceration-and-recidivism>.

356 Maria Polletta, "Ducey, Arizona Cardinals Players Visit 'Second Chance' Program for Prisoners," The Arizona Republic, October 24, 2018, <https://www.azcentral.com/story/news/local/southwest-valley/2018/10/24/arizona-prison-program-curb-recidivism-sees-positive-effect-ducey-cardinals/1732869002/>.

357 Jane B. Wishner and Jesse Jannetta, "Connecting Criminal Justice-Involved People with Medicaid Coverage and Services: Innovative Strategies from Arizona," Urban Institute, March 2018, https://www.urban.org/sites/default/files/publication/97036/connecting_criminal_justice_involved_people_with_medicaid_coverage_and_services_innovative_strategies_from_arizona.pdf.

These practices allow immediate access to medical and behavioral health services upon release. Due to the average length of stay in the DOC system, most people have their Medicaid completely terminated and require assistance prior to release in ensuring that enrollment benefit is in place. With the shorter lengths of stay in county jails, AHCCCS's program to suspend and then immediately re-instate enrollment has had a major impact on engagement in immediate support services. Justice involved individuals are much more likely than the general population to suffer from chronic illnesses or mental health issues.³⁵⁸ Non-treatment, especially for mental disorders, in turn, is an obstacle to re-integration and a factor in recidivism.³⁵⁹

This chapter provided an overview of the association between incarceration and the intersection of homelessness, mental health and substance use. Imprisonment often exacerbates these issues rather than providing effective treatment and rehabilitation. Homelessness is not uncommon after incarceration—which, in turn, increases the likelihood of reincarceration (see Chapter 7 — Criminalization of the Condition). Arizona has implemented innovative ways to meet the unique challenges associated with reentry and recidivism, and yet, additional efforts are needed to support former inmates who experience homelessness, mental illness and substance use and help them thrive.

358 Andrew P. Wilper et al., "The Health and Health Care of U.S. Prisoners: Results of a Nationwide Survey," *American Journal of Public Health* 99, no. 4, April 2009: 666–72, <https://doi.org/10.2105/AJPH.2008.144279>.

359 Steve Aos, Marna Miller, and Elizabeth Drake, "Evidence-Based Adult Corrections Programs: What Works and What Does Not," Washington State Institute for Public Policy, 2006, http://www.wsipp.wa.gov/ReportFile/924/Wsipp_Evidence-Based-Adult-Corrections-Programs-What-Works-and-What-Does-Not_Preliminary-Report.pdf.

CHAPTER 19 — FOCUS ON YOUTHS AND YOUNG ADULTS, INCLUDING THE LGBTQ POPULATION

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Acronyms in this Chapter

ACE—Adverse Childhood Experiences

CoC—Continuum of Care

HIC—Housing Inventory Count

HMIS—Homeless Management Information System

HUD—U.S. Department of Housing and Urban Development

LGBTQ—Lesbian, Gay, Bisexual, Transgender, Queer

PIT—Point-in-Time Count

PSH—Permanent Supportive Housing

RRH—Rapid Re-Housing

SOGI—Sexual Orientation/Gender Identity

TPCH—Tucson Pima Collaboration to End Homelessness

YHCP—Youth Homelessness Demonstration Program

UNIQUE CONSIDERATIONS RELATED TO MENTAL HEALTH, SUBSTANCE USE AND YOUTH HOMELESSNESS

Youth homelessness is a national concern, which has been exacerbated by the nation's racial inequities and the COVID-19 pandemic. Previous research suggests that youth who experience homelessness are at higher risk than their housed peers of developing mental illness,³⁶⁰ substance use problems,³⁶¹ and health conditions,³⁶² all of which can contribute to early death.³⁶³ Over two-thirds of youth experiencing homelessness report mental health problems, including depression, anxiety and Post-Traumatic Stress Disorder, and one-third report substance misuse problems, including non-medical use of prescription drugs.³⁶⁴

Disparities also exist for youth of color and sexual orientation/gender identity (SOGI) minority youth. Youth of color, and in particular Black/African American youth, are at higher risk than white youth of experiencing homelessness and are overrepresented in both the overall population of youth experiencing homelessness and in the subpopulation of lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) youth experiencing homelessness.³⁶⁵ Likewise, LGBTQ youth have a 120% increased risk of experiencing homelessness compared with their cisgender and heterosexual peers.³⁶⁶ It is important to note that even though reported figures indicate overrepresentation of youth of color and SOGI minority youth in the population experiencing homelessness, these figures are likely underreporting accurate numbers of these youth. Research suggests that race also influences how youth identify with the label "homeless," with white youth more favorably identifying as "homeless" than African American youth. As a result, African American youth experiencing homelessness are much less likely than white youth to access and utilize services.³⁶⁷

Figure 21 shows the lifetime prevalence of homelessness among young people in the U.S. in 2017. The U.S. Department of Housing and Urban Development's (HUD) 2020 report demonstrates a 7% increase between 2019-2020 in the overall number of unsheltered individuals, including youth/young adults.³⁶⁸ Figure 22 shows a similar trend in Arizona.

Given the broad impact of the COVID-19 virus and pandemic on individuals' health, mental health and well-being, it is expected that mental health and substance use challenges among youth and young adults experiencing homelessness also have increased following the pandemic.

360 Sarah Carter Narendorf et al., "Relations between Mental Health Diagnoses, Mental Health Treatment, and Substance Use in Homeless Youth," *Drug and Alcohol Dependence* 175, 2017: 1-8, <https://doi.org/10.1016/j.drugalcdep.2017.01.028>.

361 Anamika Barman-Adhikari et al., "Prevalence and Correlates of Nonmedical Use of Prescription Drugs (NMUPD) among Young Adults Experiencing Homelessness in Seven Cities across the U.S.," *Drug and Alcohol Dependence* 200, 2019: 153-60, <https://doi.org/10.1016/j.drugalcdep.2019.03.015>.

362 Sharon Medlow, Emily Klineberg, and Kate Steinbeck, "The Health Diagnoses of Homeless Adolescents: A Systematic Review of the Literature," *Journal of Adolescence* 37, no. 5, 2014: 531-42, <http://dx.doi.org/10.1016/j.adolescence.2014.04.003>.

363 Colette L. Auerswald, Jessica S. Lin, and Andrea Parriott, "Six-Year Mortality in a Street-Recruited Cohort of Homeless Youth in San Francisco, California," *PeerJ* 4, April 14, 2016: <https://doi.org/10.7717/peerj.1909>.

364 Matthew Morton, Amy Dworsky, Gina Miranda Samuels, and Sonali Patel, "Voices of Youth Count Comprehensive Report: Youth Homelessness in America," U.S. Department of Housing and Urban Development, September 2018, <https://www.huduser.gov/portal/sites/default/files/pdf/Voices-of-Youth-Report.pdf>.

365 Eliane M. Maccio and Kristin M. Ferguson, "Services to LGBTQ Runaway and Homeless Youth: Gaps and Recommendations," *Children and Youth Services Review* 63, 2016: 47-57, <https://doi.org/10.1016/j.childyouth.2016.02.008>.

366 Morton, Dworsky, Samuels, and Patel, "Voices of Youth Count."

367 Benjamin Hickler and Colette L. Auerswald, "The Worlds of Homeless White and African American Youth in San Francisco, California: A Cultural Epidemiological Comparison," *Social Science & Medicine* 68, no. 5, 2009: 824-31, <https://doi.org/10.1016/j.socscimed.2008.12.030>.

368 Meghan Henry et al., "The 2020 Annual Homeless Assessment Report (AHAR) to Congress," U.S. Department of Housing and Urban Development, January 2021, <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>.



Figure 21. Lifetime prevalence of homelessness among young people in the U.S. in 2017.³⁶⁹

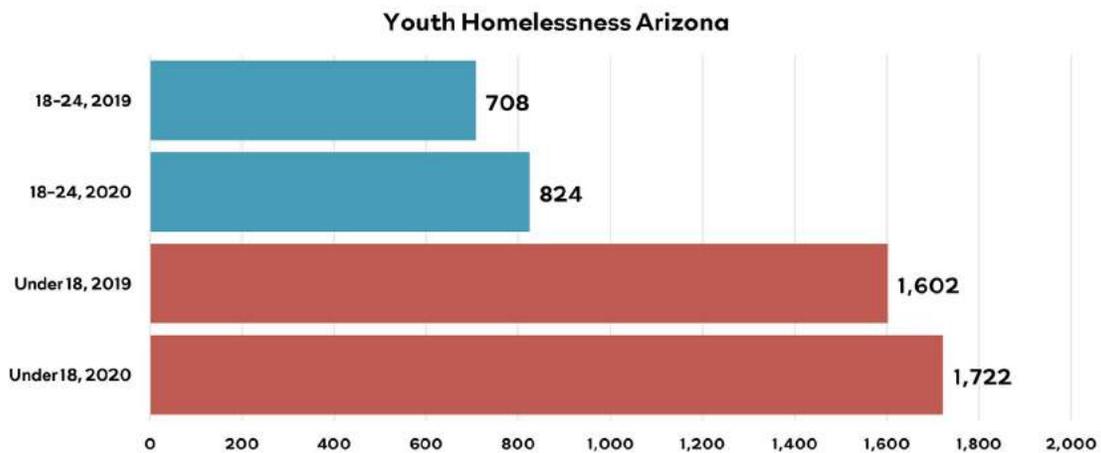


Figure 22. Youth homelessness in Arizona.³⁷⁰

UNIQUE NEEDS OF YOUTH/YOUNG ADULTS EXPERIENCING HOMELESSNESS

Youth and young adults experiencing homelessness have unique needs and challenges. Given their developmental stage in transition to adulthood, they also encounter multisystem factors (i.e., individual, peer, family and structural) that shape both their entry into and exit from homelessness. First, with respect to defining youth/young adults experiencing homelessness, there currently are three definitions used within different youth-serving systems such as The Runaway and Homeless Youth Act, the U.S. Department of Housing and Urban Development, and the U.S. Department of Education.³⁷¹ The lack of one common definition that encompasses youth and young adults through the age of 24 makes it difficult to serve youth and young adults consistently within and across systems.

369 Matthew H. Morton et al., "Prevalence and Correlates of Youth Homelessness in the U.S.," *Journal of Adolescent Health* 62, no. 1, 2018: 14–21, <https://doi.org/10.1016/j.jadohealth.2017.10.006>.

370 Henry et al., "The 2020 AHAR."

371 "Federal Definitions of Runaway and Homeless Youth," Interagency Working Group on Youth Programs, 2021, <https://youth.gov/youth-topics/runaway-and-homeless-youth/federal-definitions>.

Second, given these young people's developmental stage in transition to adulthood, various interrelated multisystem factors—often outside their control—also affect them.³⁷² These multisystem factors can be related to the youth themselves (e.g., mental illness and substance use), to their peer groups (e.g., gang involvement, negative peer influences), to their families (e.g., high levels of Adverse Childhood Experiences [ACEs] and family dysfunction), and to systemic barriers (e.g., substandard neighborhood conditions, lack of housing, unemployment, racism, sexism and heterosexism; See Box 1).³⁷³ Many times, these factors are interrelated and difficult to disentangle and address, leaving many youth feeling overwhelmed with how hard it is to successfully exit homelessness.³⁷⁴ Further, these factors take place during a developmental stage—young adulthood—in which experimentation with substances/substance use is high, the onset of mental health challenges and mental illness is common, and engagement in treatment of mental illness and/or substance use disorder is low.^{375 376 377} Arizona has the highest rate in the nation for the percentage of children birth to 17 years who have experienced two or more ACEs. ACEs are correlated with the development of mental illness, substance use disorder and homelessness (See: 2019 Town Hall Report—[Strong Families, Thriving Children](#)).

Successful efforts to prevent and intervene in youth homelessness thus emerge from both systems-informed and developmentally appropriate frameworks that recognize the influence of interrelated multisystem factors and behaviors that are developmentally appropriate among young adults.

Youths' Illustrations of Barriers to Exiting Homelessness

Individual

I got out of jail when I was 18, so I think to cope with my problems, I was drinking. – Male youth, age 20, Phoenix

Peer Influences

About six months ago, I got into my own apartment through [agency name], and I thought I was like ready and just go for it. But my roommate was not. And we both—we both started drinking, you know, doing all the drinking and bad things. Hanging out with lots of people. Being very disruptive. You know, not being focused. And so, one day, I thought I was ready, but I guess I was not. –Transgender female youth, age 25, Phoenix

Family

My mom stole my credit cards... she took all my money. She took everything from my bank account. I lost my job. Lost my apartment. –Transgender female youth, age 21, Phoenix

Systemic

Most jobs don't take unstable people because, you know, for you to get the job, you have to be in a stable place. And if you want the—if you want the apartment and, you know, you have to have some source of income. –Female youth, age 20, Phoenix

372 Katie Sample and Kristin M. Ferguson, "It Shouldn't Be This Hard: Systemic, Situational, and Intrapersonal Barriers to Exiting Homelessness among Homeless Young Adults," *Qualitative Social Work* 19, no. 4, 2020: 580–98, <https://doi.org/10.1177/1473325019836280>.

373 Morton et al., "Prevalence and Correlates of Youth Homelessness."

374 Sample and Ferguson, "It Shouldn't Be This Hard."

375 Jeffery Jensen Arnett, *Emerging Adulthood: The Winding Road from the Late Teens through the Twenties* (Oxford University Press, 2014), <https://doi.org/10.1093/acprof:oso/9780199929382.001.0001>.

376 Kristin Ferguson and Bin Xie, "Adult Support and Substance Use among Homeless Youths Who Attend High School," *Child & Youth Care Forum* 41, 2012: 427–45, <https://doi.org/10.1007/s10566-012-9175-9>.

377 Les B. Whitbeck, *Mental Health and Emerging Adulthood among Homeless Young People* (New York: Psychology Press, 2009).

Third, across the country, many of the communities in which youth reside prior to and during their homeless episodes lack sufficient institutional and adult mentoring supports to prevent homelessness as well as navigate and successfully exit homelessness. For example, among all 50 states, Arizona ranks 40th—faring worse than national averages on 9 of 12 Casey Foundation Kids Count indicators, which are correlated with youth homelessness, from economic well-being and education to health, family and community.³⁸⁰ Efforts to support families and communities in preventing and intervening early in youth homelessness are vital, in particular in states with rapidly growing youth populations such as Arizona, where youth ages 10–24 comprise 20.5% of the population.³⁸¹

Fourth, foster care and/or justice involvement produce a difficult set of circumstances for young people in achieving housing stability, self-sufficiency and economic independence.³⁸² Approximately one-third of youths who are unhoused report a history in foster care, and one-half report prior involvement in juvenile detention, jail or prison.³⁸³ Each year over 23,000 youth and young adults “age-out” of the U.S. foster care system.³⁸⁴ Similarly, on any given day, over 48,000 in the U.S. are confined in facilities away from home as a result of juvenile or criminal justice involvement.³⁸⁵ Neither the child welfare nor the juvenile or adult criminal justice systems were designed to support children and youths’ economic self-sufficiency by young adulthood. As a result, many youths leaving these systems face immediate and imminent housing instability and homelessness.

Youth and young adults with system involvement face a host of challenges, including housing instability, interruptions in education, limited workforce participation, exposure to trauma, mental and behavioral health challenges, and early pregnancy and parenthood.³⁸⁶ In the 2020 Youth Experiences Survey in Arizona, 49.4% of youth experiencing homelessness ages 18 to 25 surveyed reported they had dropped out of school before completing high school. The primary reasons included moving around a lot and being homeless. The average age of first homelessness was 16.6 years old, and on average, youth reported they had been homeless 3.5 times.³⁸⁷ Figure 23 shows additional findings from the 2020 Youth Experiences Survey. Many respondents reported sex trafficking, labor trafficking, trauma and other Adverse Childhood Experiences (ACE). More than four ACEs have been found to lead to long-term health and mental health problems.³⁸⁸ As a further example, in a 2019–2020 survey of 466 youth aged 17 in foster care in Arizona, 40% indicated that they had been homeless, and 24% had been referred for alcohol or drug use assessment or counseling in their lifetimes.³⁸⁹

380 “2020 Kids Count Data Book: State Trends in Child Well-Being,” The Annie E. Casey Foundation, 2020, <https://www.aecf.org/resources/2020-kids-count-data-book>.

381 “2020 Kids Count Data Book.”

382 Sarah C. Narendorf et al., “System Involvement among Young Adults Experiencing Homelessness: Characteristics of Four System-Involved Subgroups and Relationship to Risk Outcomes,” *Children and Youth Services Review* 108, 2020: <https://doi.org/10.1016/j.childyouth.2019.104609>.

383 Morton et al., “Prevalence and Correlates of Youth Homelessness.”

384 “National Youth in Transition Database Data Briefs,” Administration for Children and Families, 2019, <https://www.acf.hhs.gov/cb/report/national-youth-transition-database-data-briefs>.

385 Wendy Sawyer, “Youth Confinement: The Whole Pie 2019,” Prison Policy Initiative, 2019, <https://www.prisonpolicy.org/reports/youth2019.html>.

386 Narendorf et al., “System Involvement.”

387 Dominique Roe-Sepowitz and Kristen Bracy, “2020 Youth Experiences Survey,” Office of Sex Trafficking Intervention Research, Arizona State University, October 2020, https://socialwork.asu.edu/sites/default/files/stir/2020_youth_experiences_survey_report_final.pdf.

388 Vincent J. Felitti et al., “Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study,” *American Journal of Preventive Medicine* 14, no. 4, 1998: 245–58, [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8).

389 “Summary of NYTD Baseline Survey Results,” Center for Child Well-Being, Arizona State University, unpublished data, 2021.

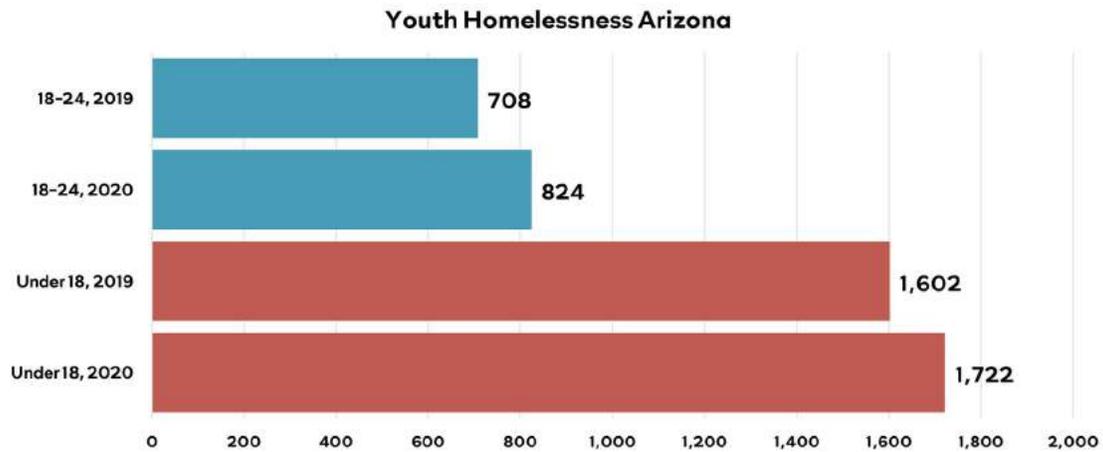


Figure 23. 2020 Youth Experiences Survey of 18–25-year-olds experiencing homelessness in Arizona.³⁹⁰

BARRIERS AND CHALLENGES TO TREATMENT FOR YOUTH/ YOUNG ADULTS EXPERIENCING HOMELESSNESS

A host of barriers—often interactive—prevent youth and young adults experiencing homelessness from seeking and accessing treatment. Foremost, Arizona’s decreasing supply of Permanent Supportive Housing (PSH) and Rapid Re-housing (RRH) units combined with increasing rent prices that do not keep pace with incomes make it difficult for youth to have the housing stability and safety necessary for effective mental health and/or substance use treatment. For instance, the 2020 Housing Inventory Count (HIC) in Maricopa County reported 157 PSH and RRH beds for youth operated by four providers in Maricopa County. By 2021, the number of PSH and RRH beds among these four providers had dropped to 115 beds, despite the growing population of youth experiencing homelessness in Maricopa County ages 18–24 years as reported in HMIS data (i.e., 1,402 youths in 2019 and 1,926 youths in 2020).³⁹¹ Further, Phoenix is experiencing the interrelated effects of population growth, low apartment vacancies and rising rent prices, all of which limit available housing options for youth and young adults who are navigating and attempting to exit homelessness.³⁹²

Second, the state lacks effective and coordinated outreach strategies to locate youth and young adults experiencing homelessness who are not connected to traditional youth-serving systems (e.g., education, child welfare, workforce, etc.). Similarly, existing outreach efforts are largely limited to meeting youths’ basic and immediate needs (e.g., food, clothing, shelter) and focus less on screening, diagnosis and brief interventions for mental illness and substance use disorder. Early intervention with youth and young adults could, in turn, reduce the risk of them being chronically homeless during adulthood.

Third, it is complicated to address the root issues impacting homelessness among youth, including relationship dysfunction, experiences of childhood trauma, exploitation, mental illness and substance use. Addressing these issues requires more than cursory information collection and necessitates trained clinical personnel and the use of evidence-based programs that support change and healing (see Chapter 11 — Overview of Best Practices for Treatment and Care). Additionally, providing training and support to deliver trauma-informed care for youth who are unhoused to all service providers is expensive and generally not included in federal funding provided to address youth homelessness.

390 Roe-Sepowitz and Bracy, “2020 Youth Experiences Survey.”

391 Personal Communication, Crisis Response Network, September 20, 2021.

392 Catherine Reagor, “Phoenix Home Prices: How Population Growth Spurs Record Home Prices, Rents,” Arizona Republic, August 22, 2021, <https://www.azcentral.com/story/money/real-estate/catherine-reagor/2021/08/22/how-metro-phoenix-population-growth-spurs-record-home-prices-rents/8158797002/>.

Fourth, the COVID-19 pandemic has contributed to an increase in homelessness among youth and young adults as well as increases in un/under-diagnosed and untreated mental health and substance use problems.³⁹³ Youth who have remained connected to youth-serving systems during the pandemic (e.g., schools, child welfare, justice, behavioral health) likely have benefitted from telehealth/mental health services as organizations adapted services to virtual formats. Yet youth who are disengaged from these systems or who lack technology or access to virtual services remain highly vulnerable. To illustrate, as early as six months into the COVID-19 pandemic in August 2020, many youths experiencing homelessness reported increased obstacles to meeting their basic human needs (e.g., food, clothing, hygiene, health care and safe and stable housing) as well as increased job losses and interruptions in their educational/vocational trajectories.³⁹⁴

INNOVATIONS IN ARIZONA TO ADDRESS YOUTH HOMELESSNESS

Arizona has various noteworthy approaches to addressing youth homelessness that could be strengthened and scaled with additional funding, political support and regional coordination. For instance, in 2019, the Tucson/Pima County Continuum of Care was awarded a Youth Homelessness Demonstration Program (YHDP) grant by the U.S. Department of Housing and Urban Development in the amount of \$4.558 million to accelerate community efforts to prevent and end youth homelessness. To accomplish this goal, the [Tucson Pima Collaboration to End Homelessness \(TPCH\)](#) is working to elevate youth power in decision-making at the individual, organizational and system levels. Likewise, TPCH is partnering with [A Way Home America Grand Challenge](#) and nine other communities across the nation to end homelessness among youth of color and LGBTQ+ youth by 2022. These efforts are the first in the state to coordinate a cross-system response to youth homelessness centered on the voices and lived experiences of youth—primarily youth of color and SOGI youth—experiencing homelessness.

Additionally, data dashboards operated by Continuum of Care (CoC) workgroups across the state and informed by technical assistance and resources from the [Built for Zero](#) movement have enabled service providers to work more effectively together via case-conferencing approaches informed by their local data. Related, the three statewide CoC Programs (i.e., Maricopa County Regional, Tucson/Pima County, and Balance of State) are collaborating to create a statewide data warehouse/data lake for a single repository of data on homelessness across the state. This statewide data source will allow the policy, practice and research communities to identify patterns in youth homelessness, the services available and the interventions that are most effective in addressing youth homelessness.

Finally, Arizona service provider agencies such as [Homeless Youth Connection \(HYC\)](#) continue to implement and expand innovative community-based housing solutions that are integrated with wrap-around support services to address youth homelessness among high school-age students, such as the Host Family Program. Host homes are a community-based alternative to the shelter system for youth experiencing homelessness through which volunteer families are trained and supported in housing them in their homes so that young people can complete their secondary education and pursue their postsecondary and/or career goals.

393 Colette L. Auerswald, Sherilyn Adams, and Marguerita Lightfoot, "The Urgent and Growing Needs of Youths Experiencing Homelessness During the COVID-19 Pandemic," *Journal of Adolescent Health* 67, no. 4, 2020: 461–62, <https://doi.org/10.1016/j.jadohealth.2020.07.026>.

394 Joan S. Tucker et al., "Behavioral Health and Service Usage during the COVID-19 Pandemic among Emerging Adults Currently or Recently Experiencing Homelessness," *Journal of Adolescent Health* 67, no. 4, 2020: 603–605, <https://doi.org/10.1016/j.jadohealth.2020.07.013>.

Youth homelessness is a national concern because it puts children at risk of developing mental illnesses, substance use problems, other health conditions and experiencing homelessness repeatedly throughout their lifetime. Youth of color and SOGI minority youth are at disproportionate risk. We discussed four specific barriers: a lack of affordable and supportive housing for families; a lack of coordination among youth-serving systems; root causes, like the environment a child grows up in, which are hard to address by public policy; and impacts of the COVID-19 pandemic. We have highlighted efforts by several organizations that are actively addressing these issues. Below, we provide six ideas that could help better address youth homelessness in the future.

ADDRESSING GAPS

The authors suggest six steps that could enable Arizona to better prevent, intervene in and address youth homelessness.

1. Adopt a racial equity lens to view and intervene in youth homelessness, including a statewide racial equity framework and a culturally responsive environment. Key elements of a racial equity lens include expanding sustainable solutions for homelessness prevention, increasing federal and local funding, creating safe, affordable, and stable housing for all, and monitoring data across systems and programs to identify and eliminate racial disparities in how services are provided and outcomes are achieved.
2. Better coordination across youth-serving systems, including the education, health, behavioral health, child welfare, justice and workforce systems to provide holistic care to youth. Coordinated service planning across systems would benefit from a focus on prevention of and early intervention in youth homelessness to avoid contributing further to the population of adults experiencing chronic homelessness. Use of a collective impact approach with a common agenda and shared measures (e.g., youth scorecard) could help guide this process.
3. Develop an integrated and linked dataset across the state to understand and address youth homelessness. At present, there are multiple limited data sources (e.g., HMIS, PIT counts, Arizona Department of Education, National Youth Transition Database), and datasets are not linked, so duplicate counts cannot be eliminated. As such, the field currently relies on incomplete incidence and prevalence rates of youth experiencing homelessness, largely drawn from national empirical samples of youth experiencing homelessness outside of the state of Arizona. Knowing how to intervene in youth homelessness requires a more nuanced understanding of who is homeless, where they are located, and what factors contribute both to their homeless episodes and exits from homelessness.
4. Further integrate the voices and experiences of youth and young adults with lived experience to address youth homelessness. Given the developmental stage of youth and young adults, interventions to prevent and intervene early in youth homelessness need to be youth-centered and customized to their needs to keep youth engaged.³⁹⁵

395 Kristy Muir, Abigail Powell, and Shannon McDermott, "They Don't Treat You like a Virus': Youth-Friendly Lessons from the Australian National Youth Mental Health Foundation," *Health & Social Care in the Community* 20, no. 2, 2012: 181–89, <https://doi.org/10.1111/j.1365-2524.2011.01029.x>.

5. Fund long-term sustainable solutions to address youth homelessness through policy change and increased access to specialized youth-serving resources. Evidence-based supportive housing (Housing First),³⁹⁶ employment (Supported Employment),³⁹⁷ education (Supported Education),³⁹⁸ case-management (Critical Time Intervention),³⁹⁹ and clinical interventions (Trauma-focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Motivational Interviewing, harm-reduction approaches),⁴⁰⁰ have demonstrated success with samples of youth experiencing homelessness. Yet large-scale replications of effective interventions and the necessary political will to institutionalize them in policy are needed.
6. Integrate a trauma-informed care perspective to the delivery of services to youth experiencing homelessness. This includes recognizing that they have experienced complex trauma both prior to becoming homeless and during their homeless episode(s).⁴⁰¹ A trauma-informed care perspective includes training all staff serving youth experiencing homelessness about the impact of trauma on them and assisting them in addressing trauma symptoms through mental health and substance use treatment.

396 Angela Ly and Eric Latimer, "Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature," *The Canadian Journal of Psychiatry* 60, no. 11, 2015: 475–87.

397 Robert E. Drake et al., "Individual Placement and Support Services Boost Employment for People with Serious Mental Illnesses, but Funding Is Lacking," *Health Affairs* 35, no. 6, 2016: 1098–105, <https://doi.org/10.1377/hlthaff.2016.0001>.

398 Kristin Ferguson, Bin Xie, and Shirley Glynn, "Adapting the Individual Placement and Support Model with Homeless Young Adults," *Child & Youth Care Forum* 41, 2012: 277–94, <https://doi.org/10.1007/s10566-011-9163-5>.

399 Kristine Jones et al., "Cost-Effectiveness of Critical Time Intervention to Reduce Homelessness among Persons with Mental Illness," *Psychiatric Services* 54, no. 6, 2003: 884–90, <https://doi.org/10.1176/appi.ps.54.6.884>.

400 Nina Vitopoulos et al., "Developing a Trauma-Informed Mental Health Group Intervention for Youth Transitioning from Homelessness," *Professional Psychology: Research and Practice* 48, no. 6, 2017: 499–509, <https://doi.org/10.1037/pro0000168>.

401 Elizabeth K. Hopper, Ellen L. Bassuk, and Jeffrey Olivet, "Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings," *The Open Health Services and Policy Journal* 3, no. 1, 2010: 80–100, <https://www.homelesshub.ca/sites/default/files/cenfdthy.pdf>.

CHAPTER 20 — FOCUS ON RURAL COMMUNITIES

Amanda Aguirre, President & CEO, Regional Center for Border Health, Inc.

Acronyms in this Chapter

- CRIT—Colorado River Indian Tribe
- HUD—U.S. Department of Housing and Urban Development
- RCBH—Regional Center for Border Health
- TLC—Transitional Living Care
- WACOG—Western Council of Governments

Homelessness exists in rural areas but is often less evident than in urban environments. Unhoused people in rural areas are out of view, in the woods, on campgrounds, in old cars or in abandoned buildings. For example, so-called “desert nomads” live in their cars in remote desert areas without access to any services. In Gila County, where there are no homeless shelters, people sleep in Walmart parking lots or stay in the forest.⁴⁰² There are a few distinct characteristics associated with rural homelessness. Specifically, people experiencing homelessness in rural areas are:

- More likely to live in sub-standard housing or live “doubled up.”
- More likely to be employed.
- Likely unhoused for the first time.
- Less likely to receive government assistance.⁴⁰³

Rural homelessness is a hard problem to measure because many people experiencing homelessness are not included in official homeless counts.⁴⁰⁴ This is due to a lack of capability to count this population, finding them is too difficult or they do not fall under the HUD definition of homelessness, for instance, when living in abandoned buildings that have not been officially condemned, which is often common in rural areas.^{405 406}

While the root causes of homelessness are similar across areas and populations, a number of factors are specific to rural areas. These factors include the prevalence of low-wage service occupations and seasonal work, a lack of services such as childcare and public transportation that support employment, insufficient treatment to address medical and behavioral health problems, and inadequate responses to natural disasters.⁴⁰⁷

402 Alden Woods, “Into the Trees: Rural Housing Shortages Push Some into Forests, Parking Lots,” *The Arizona Republic*, December 3, 2017, <https://www.azcentral.com/story/news/local/arizona-best-reads/2017/12/03/rural-housing-shortages-pushing-people-into-forests-parking-lots-few-options/849754001/>.

403 “Homelessness in Rural America,” National Advisory Committee on Rural Health and Human Services, 2014, <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2014-homelessness.pdf>.

404 Mary Meehan, “Unsheltered and Uncounted: Rural America’s Hidden Homeless,” NPR, July 4, 2019, <https://www.npr.org/sections/health-shots/2019/07/04/736240349/in-rural-areas-homeless-people-are-harder-to-find-and-to-help>.

405 Mark Evan Edwards, Melissa Torgerson, and Jennifer Sattem, “Paradoxes of Providing Rural Social Services: The Case of Homeless Youth,” *Rural Sociology* 74, no. 3, 2009: 330–55, <https://doi.org/10.1526/003601109789037204>.

406 Marjorie Robertson et al., “Rural Homelessness,” U.S. Department of Health and Human Services, 2007, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/139171/report.pdf.

407 Sarah Knopf-Amelung, “Rural Homelessness: Identifying and Understanding the ‘Hidden Homeless,’” National Health Care for the Homeless Council, June 2013, http://councilbackup.flywheelsites.com/wp-content/uploads/2013/06/InFocus_June2013.pdf.

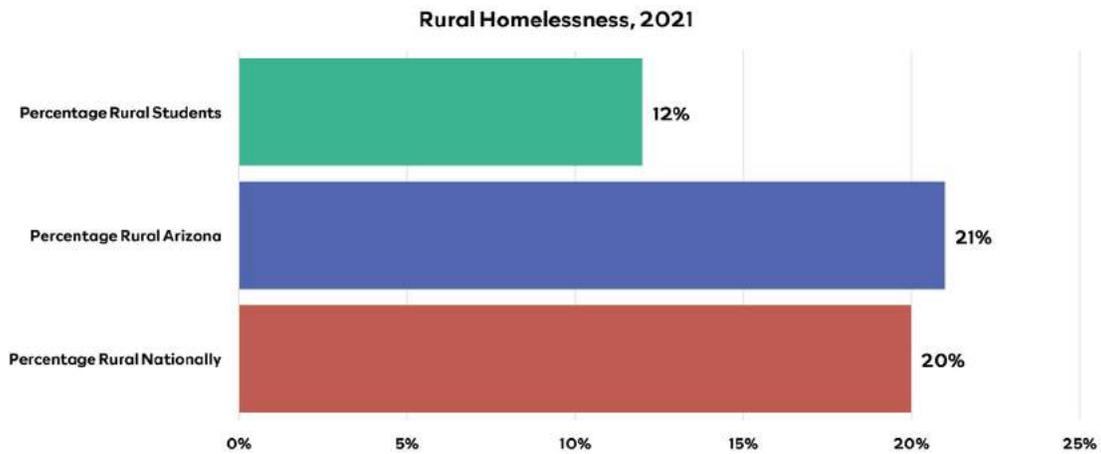


Figure 24. Rural homelessness as a percentage of total homelessness (PIT Count) in 2020.^{408 409 410 411}

Mental illness and substance use disorders occur at similar rates in urban and rural environments.⁴¹² In 2018, residents of rural counties reported 4.6 poor mental health days per month compared to 4.0 days per month for all of Arizona.⁴¹³ Furthermore, alcohol use and deaths from drug overdoses are more common in some, but not all rural Arizona counties.⁴¹⁴

Although national rates of mental illness and substance use are similar in urban and rural areas, large health disparities are evident when it comes to physical and mental health outcomes. For example, rural populations have a lower life expectancy, and higher rates of death from “heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.”⁴¹⁵ Death from suicide and drug overdose is much more common in rural areas.⁴¹⁶ One important reason for these disparate outcomes is that residents of rural areas are much less likely to seek and to receive treatment for mental health issues.⁴¹⁷ This is due to several unique barriers:

- **Accessibility:** Accessing services in rural areas is challenging because it often requires transportation due to unhoused families and individuals being much more physically and socially isolated.⁴¹⁸ Rural residents need to travel farther distances to receive mental health care, are less likely to be insured for mental health services and are less likely to recognize a mental illness.⁴¹⁹

408 Meghan Henry et al., “The 2020 Annual Homeless Assessment Report (AHAR) to Congress,” U.S. Department of Housing and Urban Development, January 2021, <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-I.pdf>.

409 “Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations—Arizona” U.S. Department of Housing and Urban Development, 2020, https://files.hudexchange.info/reports/published/CoC_PopSub_State_AZ_2020.pdf.

410 “State of the Homeless 2020,” Arizona Department of Economic Security, December 1, 2020, <https://des.az.gov/sites/default/files/dl/Homelessness-Annual-Report-2020.pdf?time=1615214499188>.

411 “Student Homelessness Growing Fastest in Rural America,” Institute for Children, Poverty & Homelessness, February 27, 2019, <https://www.icphusa.org/reports/ruralreport/>.

412 Joshua Breslau, Grant N. Marshall, Harold A. Pincus, and Ryan A. Brown, “Are Mental Disorders More Common in Urban than Rural Areas of the U.S.?,” *Journal of Psychiatric Research*, 56, 2014: 50–55, <https://doi.org/10.1016/j.jpsychires.2014.05.004>.

413 “Poor Mental Health Days,” Population Health Institute, University of Wisconsin, 2018, <https://www.countyhealthrankings.org/app/arizona/2021/measure/outcomes/42/data?sort=sc-2>.

414 “Excessive Drinking,” Population Health Institute, University of Wisconsin, 2018, <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/alcohol-drug-use/excessive-drinking>.

415 Ernest Moy et al., “Leading Causes of Death in Nonmetropolitan and Metropolitan Areas—U.S., 1999, 2014,” *MMWR Surveillance Summaries* 66, no. 1, 2017: 1–8, <http://dx.doi.org/10.15585/mmwr.ss6601a1>.

416 Deborah M. Stone, Christopher M. Jones, and Karin A. Mack, “Changes in Suicide Rates—U.S., 2018–2019,” *Morbidity and Mortality Weekly Report* 70, no. 8, 2021: 261–268, <http://dx.doi.org/10.15585/mmwr.mm7008a1>.

417 Steven Peterson et al., “Race and Ethnicity and Rural Mental Health Treatment,” *Journal of Health Care for the Poor and Underserved* 20, no.3, 2009: 662–77, <https://doi.org/10.1353/hpu.0.0186>.

418 Mark Evan Edwards, Melissa Torgerson, and Jennifer Sattem, “Paradoxes of Providing Rural Social Services: The Case of Homeless Youth,” *Rural Sociology* 74, no. 3, 2009: 330–55, <https://doi.org/10.1526/003601109789037204>.

419 John Gale, Jaclyn Janis, Andrew Coburn, and Hanna Rochford, “Behavioral Health in Rural America: Challenges and Opportunities,” *Rural Policy Research Institute*, December 2019, <https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf>.

- **Availability:** There are shortages of mental health professionals in rural areas and specialty providers often do not exist.⁴²⁰ For instance, there are no methadone clinics in rural areas.⁴²¹ In urban areas, the rate of behavioral health providers—psychiatrists, counselors, social workers—per 100,000 people is 209, while large rural areas have 86 providers per 100,000 people and isolated rural areas have 61.⁴²² Similarly, the rate of physicians in urban areas is 257 per 100,000 while rural areas sit at 129 per 100,000, and isolated areas at 20 per 100,000.⁴²³
- **Acceptability:** There is a stronger stigma of needing or receiving mental health care in rural areas, and professionals are often not trained to work in such areas.⁴²⁴

Furthermore, other health and human services, such as food pantries, for example, are either nonexistent or much harder to access in rural areas.⁴²⁵ Additionally, there is little rural infrastructure to assist unhoused people. Small towns cannot afford to hire staff to apply for grants and offer services.⁴²⁶ Service providers are often separated by hundreds of miles, making it hard to submit federal funding applications together or transfer clients and coordinate care. These factors all contribute to a much less robust provider network in rural Arizona than in more urban counties like Maricopa and Pima.⁴²⁷

In the following pages, we highlight two programs that serve rural communities. One is a transitional living program in Yuma County for people recovering from substance use issues. The other program is an expansion of the model to tribal communities in La Paz County and the Colorado River Reservation.

REGIONAL CENTER FOR BORDER HEALTH, INC.— TRANSITIONAL LIVING CARE PROGRAM

The [Regional Center for Border Health \(RCBH\)](#) is a non-profit organization established in 1987 to provide integrated, comprehensive primary/behavioral health care throughout Yuma, La Paz and Mohave counties. RCBH and its subsidiary, San Luis Walk-In Clinic, operate clinics in San Luis, Somerton, Yuma, Parker and Lake Havasu for medically underserved and disadvantaged rural communities.

Beginning in 2018, the Regional Center for Border Health operates a Transitional Living Care (TLC) program. The TLC program offers men and women transitioning from substance use rehabilitation a safe, transitional housing structure in a professional and community-based model. The program is six months long and can house 12 people at a time. TLC includes specific activities such as work assignments and counseling in one-on-one and group settings. At the end of the program, members are expected to secure independent housing and employment. 70% of previous clients found employment, and 65% secured independent housing. The program is free of charge for participants, who are usually either referred by local rehab centers or probation officers.

420 Kathleen Thomas et al., "County-Level Estimates of Mental Health Professional Shortage in the U.S.," *Psychiatric Services* 60, no. 10, 2009: 1323–28, <https://doi.org/10.1176/ps.2009.60.10.1323>.

421 Lurissa Carbajal, "Methadone Clinics Centered in Phoenix," *Cronkite News – Arizona PBS*, April 3, 2019, <https://cronkitenews.azpbs.org/2019/04/03/rural-methadone/>.

422 Bryna Koch et al., "The Arizona Behavioral Health Workforce," Center for Rural Health, The University of Arizona, November 2020, https://crh.arizona.edu/sites/default/files/publications/20201117_AZ_BH_Workforce_FINAL.pdf.

423 Bryna Koch et al., "Arizona Primary Care Physician Workforce Report," Center for Rural Health, The University of Arizona, October 2019, https://crh.arizona.edu/sites/default/files/publications/20191010_AZ_PCP_Workforce_Report_Final.pdf.

424 Kathryn Rost, Richard Smith, and Lynn Taylor, "Rural-Urban Differences in Stigma and the Use of Care for Depressive Disorders," *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association* 9, no. 1, 1993: 57–62, <https://doi.org/10.1111/j.1748-0361.1993.tb00495.x>.

425 Joy Rayanne Piontak and Michael D. Schulman, "Food Insecurity in Rural America," *Contexts* 13, no. 3, 2014: 75–77, <https://doi.org/10.1177/1536504214545766>.

426 "Homelessness in Rural America," National Advisory Committee on Rural Health and Human Services, July 2014, <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2014-homelessness.pdf>.

427 Woods, "Into the Trees."

The TLC program is designed to teach members the skills necessary to transition back into the community. With intensive case management, members learn daily living and self-care skills, practice socialization, recreation and community living, receive vocational job training, and work on their recovery. Members can also receive services at the clinics offered by RCBH. Transportation is provided. After completion of the program, RCBH offers rental assistance.

Currently, the TLC program is operating in San Luis and Somerton. This program helps fill a gap in services and acts as the first transitional housing program in the area. So far, it has served 23 men and three women between the ages of 23 and 69.

REGIONAL CENTER FOR BORDER HEALTH, INC. — EXPANSION OF THE TRANSITIONAL LIVING CARE PROGRAM IN PARKER, ARIZONA

A collaboration between the Western Council of Governments (WACOG) and the Regional Center for Border Health (RCBH) brought two AmeriCorps VISTA members to La Paz County to establish the La Paz County Homeless Continuum of Care. RCBH houses the VISTA members at its Parker office and provides day-to-day supervision as they bring together homeless service providers in La Paz County. The main goal was for the VISTA members to create a fully functioning homeless coalition, better coordinate resources, identify needs and provide improved access to services to the homeless population in La Paz County. The lack of coordination between agencies led to a lack of service integration and duplication of efforts. In September 2017, the La Paz County Coalition to End Homelessness was established.

In 2020, there were 178 individuals experiencing homelessness surveyed in La Paz County during the annual Point-in-Time Count, twice as many as in 2017. Transportation is a major barrier to alleviating the suffering of individuals and families experiencing homelessness or those about to become homeless in La Paz County. Although services may be available in neighboring counties, the rural and dispersed terrain of La Paz County prevents people from reaching those services. The veteran and homeless needs in La Paz County are not fully addressed due to a lack of resources and organizational capacity. While there are a number of programs assisting these populations, they are small and often operate with volunteers or limited staff. These programs are focused on the immediate needs at hand, which limits their ability to work at a structural level across organizations.

RCBC is working to expand its TLC program to La Paz County in collaboration with the Colorado River Indian Tribe (CRIT) to serve all residents in need of transitional housing after completing substance use rehabilitation. The proposed TLC-La Paz County Program will establish a comprehensive integrated transitional living center that will serve the residents of the Colorado River Indian Tribe and surrounding communities of Parker, Quartzsite, Salome and Wenden.

Program participants will be living in a "Tiny Home" during the six-month program while participating in a variety of life and job skill development training, one-to-one and group substance use counseling, and behavioral and primary care health care service. A total of six "Tiny Homes" and a multipurpose facility are being proposed to be constructed in a 10-acre piece on the CRIT Reservation.

Individuals at the intersection of homelessness, mental health and substance use face unique barriers in rural areas. Even when they are related to low population density and long distances, they can be overcome with innovative solutions. We highlighted two projects by the Regional Center for Border Health, Inc, which try to fill in some of the gaps. However, impacting the larger factors of availability, accessibility and acceptability might require systems-level change.

CHAPTER 21 — FOCUS ON NATIVE AMERICAN HEALTH CARE IN RURAL AREAS

Dr. Rose Weahkee, Director, Office of Urban Indian Health Programs, Indian Health Service

Dr. Glorinda Segay, Director, Division of Behavioral Health, Indian Health Service

Acronyms in this Chapter

AI/AN—American Indian/Alaska Native

HHS—U.S. Department of Health and Human Services

IHS—Indian Health Service

BACKGROUND

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for American Indians and Alaska Natives.

In the ongoing effort to meet behavioral health challenges in Indian Country, there is a trend toward tribal management and delivery of behavioral health services in American Indian and Alaska Native (AI/AN) communities. Tribes have increasingly contracted or compacted via the Indian Self Determination and Education Assistance Act, Public Law 93-638, to provide these services themselves. Currently, more than 50% of the mental health programs and more than 90% of the alcohol and substance use programs are tribally operated. This evolution in behavioral health care delivery and management is changing the face of behavioral health services in Indian Country. Where IHS was previously the principal behavioral health care delivery system for AI/AN people, there is now a less centralized and more diverse network of care provided by federal, tribal and urban Indian health programs.

CHALLENGES FOR RURAL TRIBAL COMMUNITIES

American Indians and Alaska Natives are at high risk for many of the conditions that lead to and sustain homelessness, including disproportionately high rates of poverty, exposure to domestic and other violence, housing instability, and health and behavioral health disorders, as well as low levels of education and literacy. Current and historical trauma among Indian people also factors into the prevalence and risk of homelessness. Displacement, genocide, forced assimilation, culture, language, spiritual suppression and oppression all contribute to a sense of powerlessness and hopelessness.

Serious behavioral health issues such as substance use disorders, mental health disorders, suicide, violence and behavior-related chronic diseases have a profound impact on the health of AI/AN individuals, families and communities. Alcohol and substance use and addiction are among the most severe public health and safety problems facing AI/AN communities. In general, AI/AN populations suffer disproportionately from substance use disorders compared with other racial groups in the U.S.—10.8% vs. 8.1% of white adults.⁴²⁸ Domestic violence rates are also alarming, as AI/AN women are reported as having among the highest rates of sexual assault and intimate partner violence victimization.⁴²⁹ Suicide rates among American Indians and Alaska Natives are historically higher than those of the total U.S. population. In 2019, suicide was the second leading cause of death for American Indians and Alaska Natives between the ages of 10 and 34.⁴³⁰

Rural and remote tribal communities face significant challenges accessing health care services, which leads to negative health status. Attracting health professionals to rural and remote locations is an ongoing challenge. Recruitment and retention challenges are attributable to a variety of factors that include, but are not limited to, the remoteness of some IHS and tribal facilities, rural reservation communities, housing shortages, limited access to schools and basic amenities including childcare and shopping areas, limited spousal employment opportunities, and competition with higher-paying public and private health care systems. Behavioral health service utilization rates for American Indians and Alaska Natives are also low, which is likely due to a combination of factors, including stigmatization of mental health, lack of culturally trained providers and lack of available services in rural and remote locations.⁴³¹

ADDRESSING THE CHALLENGES

Eliminating the health disparities experienced by American Indians and Alaska Natives and ensuring that their access to critical health services is maximized requires tribal consultation. It is essential Indian tribes and federal and state governments engage in open, continuous and meaningful consultation. True consultation is an ongoing process that leads to information exchange, respectful dialogue, mutual understanding and informed decision-making. Tribes are in the best position to understand their own health care needs and priorities. With the majority of behavioral health programs being tribally operated, tribes have the ability to develop innovative solutions that address the health care delivery challenges facing their communities with the support of federal and state governments.

Social determinants of health play a significant role in the health disparities experienced by AI/AN populations. American Indians and Alaska Natives experience health inequities due to a number of social determinants of health such as inadequate access to health care, substandard housing, homelessness, lack of education, unemployment and a lack of food security. When developing programs, a range of factors are relevant and underscore the need for holistic and integrated solutions that contribute to improved health outcomes. Finding solutions will require sustained collaboration between tribes and policymaking bodies, as well as a willingness to thoughtfully engage in deep issues such as historical trauma and cultural renewal and a readiness to include entire communities in

428 "Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, Table 5.5b," Substance Abuse and Mental Health Services Administration, August 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

429 André B. Rosay, "Violence against American Indian and Alaska Native Women and Men: 2010 Findings from the National Intimate Partner and Sexual Violence Survey," National Institute of Justice, May 2016, <https://www.ojp.gov/pdffiles1/nij/249736.pdf>.

430 "Web-based Injury Statistics Query and Reporting System (WISQARS): Leading Causes of Death Visualization Tool," Centers for Disease Control and Prevention, December 2, 2021, <https://wisqars.cdc.gov/data/lcd/home>.

431 "The National Tribal Behavioral Health Agenda," Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, December 2016, <https://store.samhsa.gov/sites/default/files/d7/priv/pep16-ntbh-agenda.pdf>.

healing work. The importance of integrated perspectives that include cultural and traditional practices and community-wide healing and wellness should not be underestimated.

Strategies to address behavioral and mental health, alcohol, substance use disorder and suicide prevention require comprehensive clinical strategies and approaches. Integration of behavioral health treatment into primary care and acute care services offers immediate and same-day opportunities for health care providers to identify patients with behavioral and mental health disorders, provide them with medical advice, help them communicate the health risks and consequences, obtain consultations, and refer patients with severe behavioral and health problems for appropriate treatment, including community resources. For too long, the role of behavioral health has been largely overlooked when it is actually a strength of primary care. Behavioral health integration within primary care helps to ensure people have access to the effective behavioral and mental health care they need. When it becomes a routine part of primary health care, it can help to minimize stigma and discrimination. With integrated care practices, there must also be respect and understanding for the cultures and languages of the people served. This includes having culturally competent staff and approaches while respecting and incorporating indigenous healing practices.

Implementing the principles of trauma-informed care ensures the systems that serve American Indians and Alaska Natives understand the prevalence and impact of trauma, facilitate healing, avoid re-traumatization, and focus on strength and resilience. Developing and implementing a trauma-informed care approach to address various trauma, including historical trauma, is necessary to comprehensively address the root causes of violence, suicide, depression, anxiety, self-harm and chronic physical diseases. Equally important is to provide training for health care providers on topics such as compassion fatigue, promoting self-care to prevent secondary traumatic stress, cultural resilience and supporting the mental health of health care providers.

CONCLUSION

American Indians and Alaska Natives have traditions that can support resilience and recovery. Among American Indians, coping strategies and keys to survival include the supportive role of the extended family and close friendships, as well as spirituality, culture and language. Our work is grounded in the cultures of the communities and the people we serve. We must honor traditions and the resiliency and strength of Indian people. This work requires the recognition of traditional practices and the integration of cultural and spiritual perspectives on mental health and well-being. It is important to recognize the power of the cultural practices and beliefs with Native families and communities that have contributed to their survival, recovery and resiliency over thousands of years. Without the tireless efforts of our health care heroes to do this work, commitment to serve, and vision for a better place to work and to provide care, we would not be able to provide our relatives, families and tribal communities the quality health care they need and deserve.

CHAPTER 22 — FOCUS ON NATIVE AMERICAN HEALTH CARE IN URBAN AREAS

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Margot Córdova, MPA-URP, Grants Manager, Native American Connections

Acronyms in this Chapter

AHEC—Area Health Education Center

AI / AN—American Indian / Alaska Native

HUD—U.S. Department of Housing and Urban Development

ITCA—Inter-Tribal Council of Arizona

NAC—Native American Connections

PTSD—Post-Traumatic Stress Disorder

UIO—Urban Indian Organization

Native Americans feel the negative impact of a wide array of health and economic disparities resulting from forced relocation, inadequate funding of the Indian Health Service and systemic racism. The disparities show up in high rates of homelessness, poverty, mental health issues, death by suicide and substance use.⁴³² Historical and inter-generational trauma contributes to coping strategies and outcomes in the Native American community. Psychological wounding, especially when caused by a group trauma experience, can reverberate across generations. According to some researchers, historical trauma is a culturally specific and clinically recognizable condition that cannot be adequately captured by diagnoses like PTSD, complicated bereavement or survivor syndrome.⁴³³ The concept of historical trauma tasks behavioral health providers with developing treatments specific to Native Americans, incorporating traditional ways of healing and confronting historical inequities. Historical trauma can also be understood as a life stressor that negatively impacts Native American communities, suggesting public health interventions.

A good illustration of how historical injustice translates into poor health outcomes today is the unequal effects of the COVID-19 pandemic (see Figure 25). An analysis by APM Research Lab indicates one in 390 AI/ANs has died from COVID-19, compared to one in 665 for white Americans.⁴³⁴

432 "Mental Health Disparities: American Indians and Alaska Natives," American Psychiatric Association, 2017, <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf>.

433 William E. Hartmann et al., "American Indian Historical Trauma: Anti-Colonial Prescriptions for Healing, Resilience, and Survivance," *The American Psychologist* 74, no. 1, January 2019: 6–19, <https://doi.org/10.1037/amp0000326>.

434 "The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.," American Public Media, March 5, 2021, <https://www.apmresearchlab.org/covid/deaths-by-race>.

U.S. COVID-19 Incidence Rate, Native Americans Compared to White Population, 2021

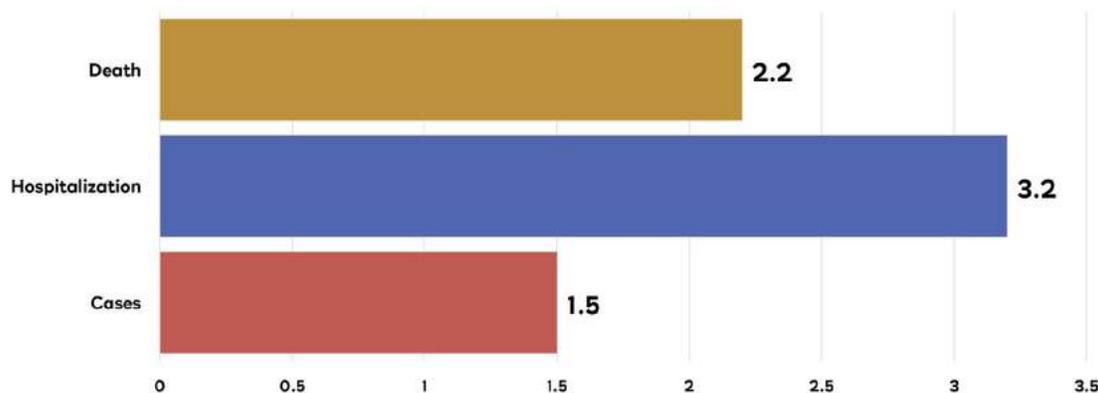


Figure 25. COVID-19 incidence among Native Americans compared to the white population in the U.S. in 2021.⁴³⁵

In the Navajo Nation, which spans parts of Arizona, New Mexico and Utah, 1,542 residents have lost their lives to COVID-19 from March 2020 to December 1, 2021. Despite all of this, Native American community members, tribal leadership and community-based organizations are making progress in fostering resilience and creating healthy tribal communities.

NATIVE AMERICANS AND HOMELESSNESS

U.S. Census data indicates 5.5 million Native Americans reside in the U.S. with 317,400 Native Americans living in Arizona. Nationally, about 71% of the 5.5 million Native Americans live in urban areas, a trend also seen in Arizona. Maricopa County has a population of about 88,900 Native Americans, and Pima County has an additional 139,700 Native Americans, adding up to approximately 72% of the total Native American population in Arizona. Both Maricopa County and Pima County are adjacent to large tribal communities, offering tribal members the opportunity to remain living in their tribal community but with close access to jobs and schools located off-reservation.

435 "COVID-19: Hospitalization and Death by Race/Ethnicity," Center for Disease Control and Prevention, updated November 22, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.

436 "Situation Report #629: Navajo Nation Dikos Ntsaaígíí-19 (COVID-19)," Navajo Nation Department of Health, updated December 1, 2021, <https://www.ndoh.navajo-nsn.gov/COVID-19/Data>.

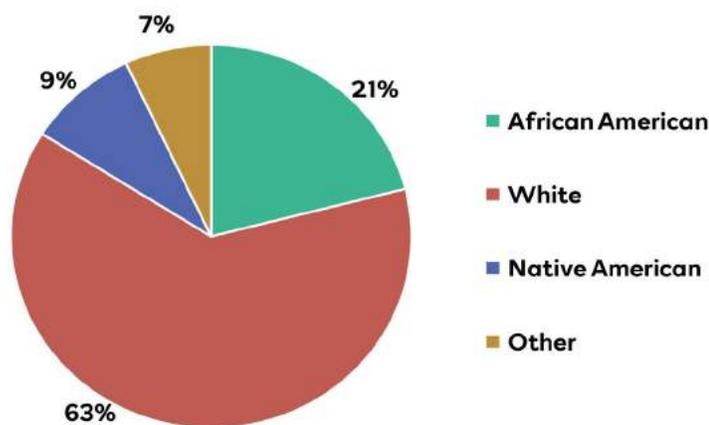


Figure 26. Racial characteristics of the Arizona homeless population (PIT Count) in 2020.⁴³⁷

Arizona aligns with national data highlighting the disparate percentage of Native Americans experiencing homelessness (see Figure 26). Just 2.8% of the general population living in Maricopa County is Native American. However, 7% of individuals experiencing homelessness are Native American.⁴³⁸ In Pima County, 4.4% of the population is Native American; however, 9% of people experiencing homelessness are Native American.⁴³⁹ A 2017 study by the Department of Housing and Urban Development (HUD) and the Urban Institute conducted in 24 cities across the U.S., including Phoenix and Flagstaff, identified homelessness among Native Americans as a serious problem. The causes of homelessness most often cited included a lack of affordable housing, health-related issues and domestic violence. The study reported an increase in homelessness among families, youth and the elderly.⁴⁴⁰

CONTRIBUTING FACTORS: HEALTH, SUBSTANCE USE AND BEHAVIORAL HEALTH

Health issues contribute to homelessness and are often exacerbated by periods of living unhoused. Native Americans are disproportionately affected by chronic health conditions and die earlier than non-Natives. The Health Status Profile of American Indians in the Arizona, 2019 Data Book indicates American Indian residents of Arizona:

- Ranked worse than the statewide average on 53 of 65 health indicators.
- Were 16 years younger at time of death, on average, compared to all racial/ethnic groups.
- Had higher than average mortality rates from alcohol-induced causes, chronic liver disease and cirrhosis, diabetes, motor vehicle accidents, unintentional injuries, and influenza and pneumonia.⁴⁴¹

437 "2020 CoC Homeless Populations."

438 "2020 Point-in-Time (PIT) Count Report," Maricopa Regional Continuum of Care, 2020, <https://www.azmag.gov/Portals/0/Documents/MagContent/PIT-Count-Report-2020.pdf?ver=2020-07-27-155257-657>.

439 "TPCH-2020 Point-in-Time Report," Tucson Pima Collaboration to End Homelessness, August 20, 2020, <https://tpch.net/data/hic-pit/>.

440 Diane K. Levy et al., "Housing Needs of American Indians and Alaska Natives Living in Urban Areas: A Report from the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs," U.S. Department of Housing and Urban Development, January 2017, <https://www.huduser.gov/portal/sites/default/files/pdf/NAHSG-UrbanStudy.pdf>.

441 "Health Status Profile of American Indians in Arizona," Arizona Department of Health Services, March 2021, <https://pub.azdhs.gov/health-stats/report/hspam/2019/indian2019.pdf>.

Mental Illness and Substance Use Among Native Americans, 2019

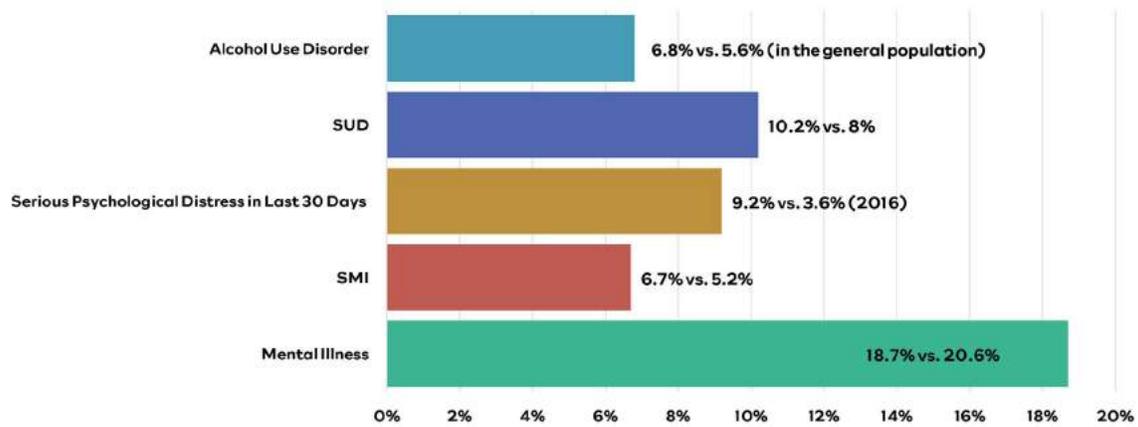


Figure 27. Mental illness and substance use among Native Americans in the U.S. in 2019.^{442,443,444,445}

Figure 27 compares mental illness and substance use among Native Americans to the general population. The impacts of alcohol use in Native American communities particularly are well documented. In the Morrison Institute 2013 survey of persons experiencing homelessness, alcohol use was cited as a cause of homelessness by 36% of Native American respondents, compared to 14% of white respondents.⁴⁴⁶ Additionally, Native American children are exposed more to violence and trauma compared to their non-Native peers, leading to much higher rates of PTSD and suicide.

SOLUTIONS

Native American Connections (NAC), an Urban Indian Organization (UIO) located in Phoenix (one of four UIOs in Arizona), has been supporting Native Americans and persons experiencing homelessness for close to fifty years. Since inception, NAC recognized the connection between health and housing, along with the need to foster a whole health model, one that is focused on physical, mental and spiritual health. Anchored in traditional healing, NAC offers a continuum of care with a culturally specific response and services, including substance use treatment, emergency shelter, supportive housing, affordable housing communities for families with low incomes and employment opportunities within the agency for people with lived experience.

Addressing the Issues

NAC, the Inter-Tribal Council of Arizona (ITCA), and the Arizona Advisory Council on Indian Health Care developed policy considerations to better address the needs of Native Americans experiencing homelessness, mental illness and substance use:

- 1. Identify funding to pay for room and board for families bringing young children into residential treatment programs. This approach keeps families together and lets staff work with young children to identify issues and connect to resources.*

442 "Results from the 2019 National Survey on Drug Use and Health: Detailed Tables," Substance Abuse and Mental Health Services Administration, September 11, 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

443 "Health U.S., 2017, Table 46," Centers for Disease Control and Prevention, 2018, <http://www.cdc.gov/nchs/data/abus/abus17.pdf>.

444 Byron L. Dorgan et al., "Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence So Children Can Thrive," U.S. Department of Justice, November 2014, https://www.justice.gov/sites/default/files/defendingchildhood/pages/attachments/2015/03/23/ending_violence_so_children_can_thrive.pdf.

445 "Results from the 2019 National Survey on Drug Use and Health: Detailed Tables," Substance Abuse and Mental Health Services Administration, September 11, 2020, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

446 E.C. Hedberg and Bill Hart, "A New Look: A Survey of Arizona's Homeless Population," Morrison Institute for Public Policy, June 2013, <https://morrisoninstitute.asu.edu/sites/default/files/newlook-homelessurvey.pdf>.

2. Mandate health plans to authorize length of stay based upon clinical diagnosis and social determinants of health. Frequently, the length of stay is too short for a client to begin recovery while also working on housing, employment and family reunification. Exiting individuals from treatment that do not have adequate housing contributes to recidivism and homelessness.
3. Create a more equitable workforce by supporting the development of a 6th Area Health Education Center (AHEC) that focuses on the Indian Health System. AHECs are non-profit organizations that work to improve the supply and quality of health care providers in underserved areas. Passed by the Arizona Legislature in 2021, the 6th AHEC will improve the Indian Health Care Delivery System in Arizona, increase access to care in rural areas, generate economic opportunities and create new jobs, all while strengthening Arizona's health care workforce. Providers that are from the community will help to expand the number of clinicians overall while also increasing the level of trust between provider and client.⁴⁴⁷
4. Encourage adoption of the "Elements of a Health Tribal Community" model developed by ITCA and the Vitalyst Health Foundation. Corresponding to the "Four Directions," the model supports the creation of opportunities "to live in balance from birth to an elderly age, within environments that are clean, safe and promote wellness."⁴⁴⁸
5. Implement Native American (American Indian) specific "Specialty Coordinated Entry" for the HUD Continuum of Care. Collect and analyze homeless data by race to determine disparities and the strategies to ensure equity to access, to services and to the most effective interventions.
6. Determine more culturally responsive tools for deciding who and what services a person receives. Create innovative regional and local practice-based strategies with measured benefits and outcomes serving local communities.
7. Re-define "homelessness." Many tribal communities have extreme shortages of housing and, as a result, live in overcrowded and sometimes substandard housing conditions without running water. Many families have members who "couch surf" from family to family for years because of the housing shortage. COVID-19 illuminates these issues with some tribal communities showing the highest COVID-19 positivity rates, hospitalization and death rates nationally, in part due to the inability to isolate or distance with little or no access to water.
8. Allocate Urban Indian-specific funding for American Indian housing and homelessness similar to funding received by Urban Indian Health Organizations under the Indian Health Care Improvement Act PL 94-437 to serve tribal members living off-reservation/tribal land.
9. Consider legal approaches to ensure housing for homeless tribal members living in urban centers. State governments have a trust obligation to tribes as sovereign political nations regardless of their federal recognition status. This trust responsibility brings Native-specific housing development well within the confines of the law. While the narrative has focused on individual deficits resulting in homelessness, modern indigenous homelessness is a direct extension of colonialism and structural racism.

447 "Creation of a 6th Area Health Education Center that Focuses on the Indian Health System," Arizona Center for Economic Progress, Arizona Advisory Council on Indian Health Care, February 2, 2021, http://azeconcenter.org/wp-content/uploads/2021/02/6th-AHEC_-FACTSHEET_Collab-1_0.pdf.

448 "Elements of a Healthy Tribal Community," Vitalyst Health Foundation, Inter-Tribal Council of Arizona, August 2021, <http://vitalysthealth.org/wp-content/uploads/2021/08/TribalComm-FULL.pdf>.

CHAPTER 23 — FOCUS ON SENIORS

Morrison Institute for Public Policy with consultation from Deborah Arteaga, MA, Chief Executive Officer, Tempe Community Action Agency

Acronyms in this Chapter

SSI—Supplemental Security Income

Adults experiencing homelessness develop geriatric symptoms like frequent falls, urinary incontinence, vision and hearing difficulties, weight loss, depression, and poor memory much earlier than the general population.⁴⁴⁹ Moreover, these conditions are much more difficult to manage without stable housing. New York City, which happens to publish data on this issue, reports that adults experiencing homelessness above the age of 50 cost the state on average over \$25,000 annually for shelter, emergency room care, inpatient care and nursing home care.⁴⁵⁰ Many people experiencing homelessness die in their 40s and 50s.⁴⁵¹ For these reasons, adults experiencing homelessness above 50 are often considered “seniors” or “old,” with higher service needs.⁴⁵²

The average age of individuals experiencing homelessness has been increasing for the last 30 years. In 1990, 11% of single male sheltered individuals experiencing homelessness were over the age of 50; in 2010, it was 50% (see Figure 28).⁴⁵³ In New York City, the number of homeless shelter residents over the age of 50 tripled between 2014 and 2017.⁴⁵⁴ In the next decade, the sheltered population above the age of 65 is expected to double.⁴⁵⁵ In Arizona, over half of the unhoused population is over 50.⁴⁵⁶



Figure 28. Individuals over 50 among NYC homeless population in 2010.⁴⁵⁷

449 Rebecca T. Brown et al., “Geriatric Syndromes in Older Homeless Adults,” *Journal of General Internal Medicine* 27, no. 1, January 2012: 16–22, <https://doi.org/10.1007/s11606-011-1848-9>.

450 Dennis Culhane et al., “The Emerging Crisis of Aged Homelessness: Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs?,” *Actionable Intelligence for Social Policy*, University of Pennsylvania, 2019, <https://aisp.upenn.edu/aginghomelessness/>.

451 “National Homeless Mortality Overview,” *National Health care for the Homeless Council*, 2020 <https://nhchc.org/wp-content/uploads/2020/12/Section-1-Toolkit.pdf>.

452 Rebecca T. Brown et al., “Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study,” *PLOS ONE* 11, no. 5, May 10, 2016: <https://doi.org/10.1371/journal.pone.0155065>.

453 Dennis P. Culhane et al., “The Age Structure of Contemporary Homelessness: Evidence and Implications for Public Policy,” *Analyses of Social Issues and Public Policy* 13, no. 1, 2013: 228–44, <https://doi.org/10.1111/asap.12004>.

454 Dennis Culhane et al., “The Emerging Crisis of Aged Homelessness: Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs?,” *Actionable Intelligence for Social Policy*, University of Pennsylvania, 2019, <https://aisp.upenn.edu/aginghomelessness/>.

455 Culhane, “The Emerging Crisis.”

456 “State of Homelessness 2020,” *Arizona Department of Economic Security*, 2020, <https://des.az.gov/sites/default/files/dl/Homelessness-Annual-Report-2020.pdf?time=1615214499188>.

457 Culhane, “The Age Structure of Contemporary Homelessness.”

Some researchers argue that these trends are due to cohort effects that make individuals born after the peak of the baby boom (1954–1963) uniquely vulnerable to homelessness because of economic conditions present when they entered the labor market.⁴⁵⁸ This does not, however, imply that this population tends to be homeless for longer periods of their life. Instead, members of this generation have a higher likelihood of entering homelessness at any age. Studies suggest that at least half of older unhoused people have not experienced homelessness earlier in life.⁴⁵⁹⁴⁶⁰ Many led relatively normal lives previously, often in low-income professions.

Homelessness at an older age is often preceded by loss of a spouse or a relationship breakdown, the death of a parent, stopping work, the loss of housing, onset or increased severity of a mental illness, or disability.⁴⁶¹⁴⁶² Rising housing costs make stable housing unattainable for people that cannot work anymore due to disability or age. Individuals who worked low-income jobs often do not have savings or pensions that can pay for today's rent prices. Federal support programs, like Supplemental Security Income (SSI) or Social Security's special minimum benefit, are not sufficient alone to afford housing in many markets. Elderly unhoused people also frequently need help navigating complex application processes and, in its absence, remain without benefits despite eligibility.⁴⁶³

Older adults experiencing homelessness have unique needs compared to the general population.⁴⁶⁴ Generally, they are more likely to have mental and physical health concerns that need treatment. In particular, they might require specialized care beyond what is currently available at shelters. High health care needs put them at risk of institutionalization because the only permanent shelter available for them is often a nursing home or psychiatric hospital. In most cases, Medicaid funding only pays for nursing home care, thus, trapping individuals between 24-hour crisis care and the streets.⁴⁶⁵

Even without serious health conditions, living without a stable home becomes increasingly difficult with age: "the emergency shelter system can be an especially harsh environment for an elderly person."⁴⁶⁶ Shelters often only operate at night, which is a challenge for elderly clients. Frequently, shelters lack handicap accessibility, are in isolated locations and require standing in long lines to receive services, all of which make them harder for older adults to access. Shelters are also not a good place for individuals who are at greater risk of injury from falling. Mental health conditions and memory problems often make continued engagement and treatment more

458 Culhane, "The Age Structure of Contemporary Homelessness."

459 Maureen Crane et al., "The Causes of Homelessness in Later Life: Findings from a 3-Nation Study," *The Journals of Gerontology: Series B* 60, no. 3, 2005: S152–59, <https://doi.org/10.1093/geronb/60.3.S152>.

460 Marybeth Shinn et al., "Predictors of Homelessness Among Older Adults in New York City: Disability, Economic, Human and Social Capital and Stressful Events," *Journal of Health Psychology* 12, no. 5, 2007: 696–708, <https://doi.org/10.1177/1359105307080581>.

461 Shinn et al., "Predictors of Homelessness among Older Adults."

462 Crane et al., "The Causes of Homelessness."

463 Jennifer Goldberg, Kate Lang, and Vanessa Barrington, "How to Prevent and End Homelessness among Older Adults," *Justice in Aging*, April 2016, <https://www.justiceinaging.org/wp-content/uploads/2016/04/Homelessness-Older-Adults.pdf>.

464 Amanda Grenier et al., "Literature Review: Aging and Homelessness," *Gilbreath Centre for Studies in Aging*, 2013, <http://aginghomelessness.com/wp-content/uploads/2012/10/Literature-Review-Aging-and-Homelessness.pdf>.

465 "Fulfilling the Dream: Aligning State Efforts to Implement Olmstead and End Chronic Homelessness," U.S. Interagency Council on Homelessness, 2016, https://www.usich.gov/resources/uploads/asset_library/Olmstead_Brief_02_2016_Final.pdf.

466 Judith G. Gonyea, Kelly Mills-Dick, and Sara S. Bachman, "The Complexities of Elder Homelessness, a Shifting Political Landscape and Emerging Community Responses," *Journal of Gerontological Social Work* 53, no. 7, September 28, 2010: 575–90, <https://doi.org/10.1080/01634372.2010.510169>.

challenging.⁴⁶⁷ Finding and navigating available services is often more difficult for this population because of technological or cultural barriers.⁴⁶⁸ Older adults experiencing homelessness, especially women, are more likely to be victimized than their younger counterparts, be it by theft or physical abuse.^{469 470}

One innovative approach to preventing senior homelessness is the East Valley Home Sharing Program, which is being developed by three local organizations—Aster Aging, AZCEND, and the Tempe Community Action Agency. The program brings housing insecure seniors together as roommates who share housing costs and provides comprehensive wrap-round support so that participants can remain housed. Intensive screening and assessment are designed to bring seniors together that are a good match given their personalities, cultural preferences and other considerations. The staff helps with home-sharing agreements aimed at delineating shared responsibilities and reducing conflict. Additional services include case management, mediation, transportation, senior center activities, congregate meals and more intensive care, when appropriate. The hope is that this program will prevent homelessness among seniors on the verge of losing their home while also reducing isolation and loneliness. The program is set to be launched in March 2022.

When designing services for seniors experiencing homelessness, it is important to include expertise on the process of aging and the unique needs of older people. A good example of services offered in Phoenix is the Justa Center. While not an overnight shelter, the center offers many daily services for seniors experiencing homelessness, such as navigating applications to government services, identifying housing options, mail service, phones and computers, meals, showers and hygiene supplies, medical services, as well as shared activities.

This chapter discussed the unique challenges that come with caring for unhoused people over 50. Significant changes in the delivery of services will be necessary to accommodate this growing population. We have highlighted two programs that attempt just that: the East Valley Home Sharing and the Justa Center.

467 Jenny Ploeg et al., "A Case Study of a Canadian Homelessness Intervention Programme for Elderly People," *Health & Social Care in the Community* 16, no. 6, December 2008: 593–605, <https://doi.org/10.1111/j.1365-2524.2008.00783.x>.

468 Lynn McDonald, Julie Dergal, and Laura Cleghorn, "Living on the Margins," *Journal of Gerontological Social Work* 49, February 1, 2007: 19–46, https://doi.org/10.1300/J083v49n01_02.

469 Michelle S. Tong et al., "Persistent Homelessness and Violent Victimization among Older Adults in the HOPE HOME Study," *Journal of Interpersonal Violence* 36, no. 17–18, September 2021: 8519–37, <https://doi.org/10.1177/0886260519850532>.

470 Tracy Dietz and James D. Wright, "Victimization of the Elderly Homeless," *Care Management Journals* 6, no. 1, 2005: 15–21, <https://doi.org/10.1891/cmaj.2005.6.1.15>.

CHAPTER 24 — FOCUS ON VETERANS

Dr. Jonnie Arnold, Clinical Therapist, U.S.VETS-Phoenix
*Carole Benedict, M. Ed, LPC, Executive Director, U.S.VETS-
Prescott*

Acronyms in this Chapter

CRRCs—Community Resource & Referral Centers
PIT—Point-in-Time Count
PTSD—Post-Traumatic Stress Disorder
USICH—U.S. Interagency Council on Homelessness
VA—Veterans Affairs

Due to unique economic challenges, the transition from military to civilian life, and increased rates of mental illness, veterans are more vulnerable to homelessness than the general population.⁴⁷¹

Figure 29 shows the proportion of veterans among the unhoused population based on the 2020 Point-in-Time (PIT) Count. Some additional characteristics of this population are:

- The national rate of homelessness for veterans was 21 for every 10,000.
- Most veterans and most veterans experiencing homelessness are men.
- African American and Hispanic/Latino veterans were overrepresented and white veterans were underrepresented compared to their overall representation in the veteran population.
- The estimated number of veterans experiencing homelessness in the U.S. has declined by nearly 50% since 2009.⁴⁷²

Specific data on veterans at the intersection of mental health, substance use, and homelessness are not currently available.

471 Colleen M. Heflin, Janet M. Wilmoth, and Andrew S. London, "Veteran Status and Material Hardship: The Moderating Influence of Work-Limiting Disability," *Social Service Review* 86, no.1, 2012: 119–42, <https://doi.org/10.1086/665643>.

472 Meghan Henry et al., "The 2020 Annual Homeless Assessment Report (AHAR) to Congress," U.S. Department of Housing and Urban Development, January 2021, <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>.

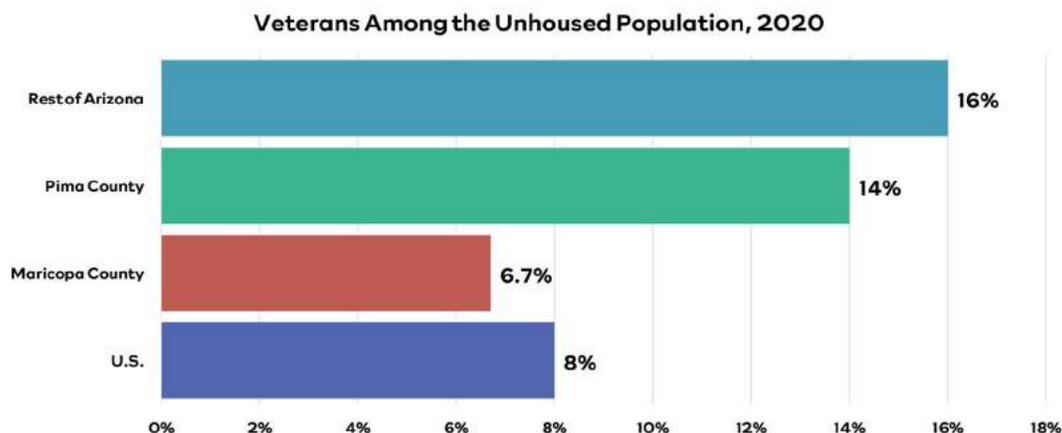


Figure 29. Veterans among the unhoused population in 2020 (PIT Count).^{473,474}

Veterans can face numerous barriers to receiving appropriate housing and health care. Many report high rates of physical illness and chronic mental health issues. However, according to the National Survey on Drug Use and Health, their rates of substance use and mental illness are comparable to the general population (see Figure 30). Active service members and veterans are more likely to report binge drinking or alcohol use than the general population.⁴⁷⁵ These numbers are expected to increase over the next several years as veterans return from the wars in Iraq and Afghanistan. With 18.5% suffering from Post-Traumatic Stress Disorder (PTSD) or depression, these newly returning veterans are more likely than their civilian counterparts to experience homelessness, be unemployed, use drugs or alcohol, and attempt suicide.⁴⁷⁶ The National Coalition for Homeless Veterans reports that 50% of veterans experiencing homelessness suffer from serious mental illness and 70% have substance use problems.⁴⁷⁷

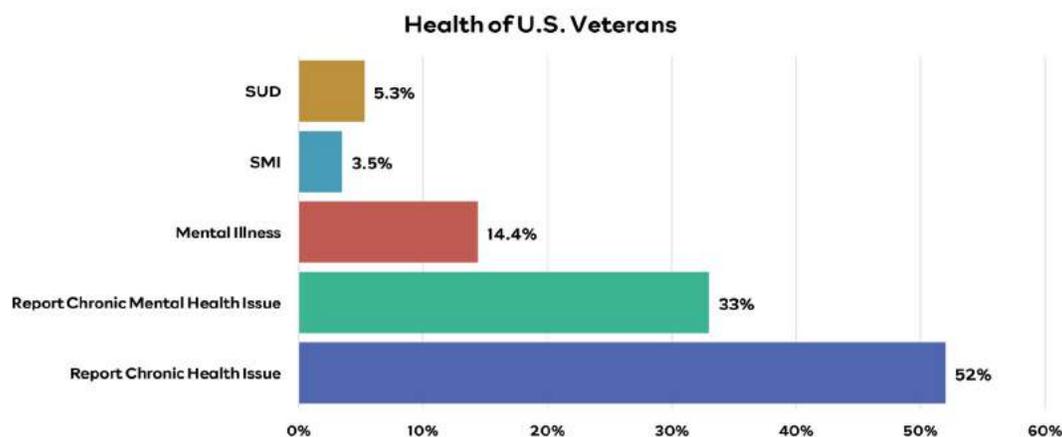


Figure 30. Selected health conditions of the American veteran population.^{478,479}

473 Henry et al., "The 2020 AHAR."

474 "2020 Point-in-Time (PIT) Count Report," Maricopa Regional Continuum of Care, 2020, <https://www.azmag.gov/Portals/0/Documents/MagContent/PIT-Count-Report-2020.pdf?ver=2020-07-27-155257-657>.

475 Sarah O. Meadows et al., "2015 Health Related Behaviors Survey: Substance Use Among U.S. Active-Duty Service Members," RAND Corporation, 2018, https://www.rand.org/pubs/research_briefs/RB9955z7.html.

476 Terri Tanielian et al., "Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans," RAND Corporation, 2008, https://www.rand.org/pubs/research_briefs/RB9336.html.

477 "Veteran Homelessness," National Coalition for Homeless Veterans, accessed October 5, 2021, <https://nchv.org/veteran-homelessness/>.

478 Dawne S. Vogt et al., "U.S. Military Veterans' Health and Well-Being in the First Year after Service," American Journal of Preventive Medicine 58, no. 3, March 2020, <https://doi.org/10.1016/j.amepre.2019.10.016>.

479 "Results from the 2018 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2019, https://www.samhsa.gov/data/sites/default/files/reports/rpt23251/6_Veteran_2020_01_14_508.pdf.

Additional barriers exist and interfere with veterans' potential to access and maintain housing. These include stigma, reinforcement of stigma by military culture, denial of a problem and logistics, such as family and employment responsibilities.⁴⁸⁰ Stigma is often a challenging barrier to manage, as many veterans are reluctant to acknowledge they need assistance, even in the face of pending homelessness, family discord or substance dependence. Fear of being seen as "weak" may keep these individuals from seeking services.⁴⁸¹ Many veterans do not see themselves as needing to talk to someone or being ready to talk to someone about their current problems. For some, alternative methods of managing anxiety or depression include the use of alcohol or drugs. These maladaptive coping strategies can lead to problems with school, family, employment and even the legal system.⁴⁸²

Finally, the lack of integrated transportation systems and the vast geographic make-up of rural Arizona make accessing more affordable housing in outlying areas difficult, particularly for veterans who are employed within a rural municipality.

To address housing vulnerabilities and shortages, a 100-day "boot camp" was created in partnership with the Department of Housing and Urban Development (HUD), the Veteran's Administration (VA), and the U.S. Interagency Council on Homelessness (USICH). In the "boot camp," local communities are advised on how to best allocate housing resources to veterans experiencing homelessness. This approach includes creating a list of veterans within each community, targeting interventions for the most vulnerable and using guides to address the needs of individual veterans.⁴⁸³

One form of assistance for veterans facing homelessness is through Community Resource & Referral Centers (CRRCs). The services at these facilities range from case management and outreach to providing showers, laundry, transportation and phone and internet access. Since 2012, over 27,000 veterans have received assistance from CRRCs across the country.⁴⁸⁴

Another service that is making a difference in the lives of veterans experiencing homelessness and mental health issues is U.S.VETS. This national program provides housing support, counseling and mental health services, case management, life skills training and career services for veterans. There are two U.S.VETS locations in Arizona: Phoenix and Prescott. The Phoenix location has served over 10,000 veterans since 2001, offering 162 transitional housing beds and 30 low-income rental units for veterans experiencing homelessness. Last year, this program helped over 440 veterans obtain permanent housing. The Prescott U.S.VETS program opened in 2003. It serves 437 veterans annually and has assisted 164 veterans with obtaining permanent housing. Please visit <https://usvets.org/> for more information.

In sum, veterans face unique risks of homelessness, mental illness and substance use related to physical and psychological injuries sustained during a military career. We discussed two organizations that have been successful at reducing veteran homelessness: Community Resource & Referral Centers (CRRCs) and U.S.VETS.

480 Joie D. Acosta et al., "Mental Health Stigma in the Military," RAND Corporation, 2014, https://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR426/RAND_RR426.pdf.

481 Ben Biles, "Hope for Veterans: Overcoming Barriers to Mental Health Treatment," American Veterans Group, September 2, 2021, <https://www.americanvetgroup.com/hope-for-veterans-overcoming-barriers-to-mental-health-treatment>.

482 Christine Timko et al., "Systematic Review of Criminal and Legal Involvement After Substance Use and Mental Health Treatment Among Veterans: Building towards Needed Research," Substance Abuse: Research and Treatment 14, 2020: <https://doi.org/10.1177/1178221819901281>.

483 "Best Practices: Sharing Information to End Veteran Homelessness," HUD Exchange, January 2014, <https://www.hudexchange.info/resource/3677/best-practices-sharing-information-to-end-veteran-homelessness/>.

484 "VA Homeless Programs," Department of Veterans Affairs, accessed October 5, 2021, <https://www.va.gov/homeless/nchav/models/crrc.asp>.

CHAPTER 25 — FOCUS ON DOMESTIC, SEXUAL, AND INTIMATE PARTNER VIOLENCE

Dana Martinez, Director of DV/SV Services, A New Leaf

Trigger Warning: This chapter offers content related to domestic and sexual violence and may include sensitive information that could be triggering to some individuals.

Acronyms in this Chapter

ACESDV—Arizona Coalition to End Sexual and Domestic Violence

ASAFSF—Arizona South Asians for Safe Families

CDC—Center for Disease Control

CPLC—Chicanos Por La Causa

DV—Domestic Violence

IPV—Intimate Partner Violence

PTSD—Post-Traumatic Stress Disorder

SV—Sexual Violence

SWIWC—Southwest Indigenous Women's Coalition

VI-SPDAT—Vulnerability Index—Service Prioritization Decision Assistance Tool

DEFINITIONS OF DV/SV/IPV

Domestic violence (DV), sexual violence (SV) and intimate partner violence (IPV) are terms that are often used interchangeably. Although similarities among the terms exist, there are also important distinctions to clarify. While each term uses the word “violence,” physical abuse need not be present, yet the similar characteristics of each are rooted in oppressive behaviors the offender uses to gain power and control over another person.

Domestic violence can include various types of abuse that create a power dynamic within the context of dating, spouse/partner, romantic or familial/household relationships. Coercive elements may include manipulation, for instance, gaslighting, isolation, and threats. Other abuses may include verbal, emotional, financial, spiritual abuse and the use of children or other family members. Patterns of behavior may develop, and abuse may escalate to physical violence. Domestic violence is a learned behavior. It is not a direct result of anger management or mental health issues; intoxication or substance use as commonly assumed.

Sexual violence may occur within the above-mentioned relationships, in which case it is a form of domestic violence. However, sexual violence is not dependent upon the relationship rather the act itself, which includes force, coercion or manipulation of unwanted sexual activity, whether or not there is contact. This includes when a person is unable to consent due to age, illness, influence of alcohol/drugs, disability or unconsciousness. The permissiveness of sexual violence in our society is perpetuated by victim-blaming and trivialization of sexual assault through music, television and movies. This rape culture is one of the reasons that sexual violence is one of the most underreported crimes in our country.

IPV is a term used to reflect multiple types of abuse that may occur within the context of an intimate partner relationship. According to the CDC, “the term ‘intimate partner violence’ describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.”⁴⁸⁵

It is important to note that DV/SV/IPV occurs across all racial, socioeconomic and gender identities, and therefore gender-neutral language will be used throughout this chapter. At the same time, DV/SV/IPV is rooted in oppression and gender-based violence, and women experience it disproportionately more (see Figure 31). For instance, about 40% of female murder victims are killed by intimate partners.⁴⁸⁶ For this chapter, all three terms will be used as DV/SV/IPV.



Figure 31. Women and men experiencing IPV in the U.S. in 2015.⁴⁸⁷

HOW ARE DV/SV/IPV SURVIVORS UNIQUELY AFFECTED/IMPACTED?

People experiencing DV/SV/IPV are particularly vulnerable to homelessness. Specific vulnerabilities in this population include poverty, job loss, poor credit, and lack of childcare and transportation. For instance, women in lower-income groups are dramatically more likely to be victimized compared to higher income groups.⁴⁸⁸ While some people may have a hard time understanding why survivors stay in abusive relationships, the reality is that many don't have the necessary resources or support to leave—and this is often a direct result of tactics that abusive individuals use to control their partner and keep them in the relationship. Survivors often stay in relationships because of their sense of hope that things “will be better when” Many survivors are driven by fear in its many forms. Others feel they have no plausible safe way to get out or nowhere else to go. As a result, homelessness, particularly among women, is often the direct result of DV/SV/IPV. One study of 110 DV survivors found that 38% became homeless immediately after leaving their partner.⁴⁸⁹ Another study that interviewed around 10,000

485 "Intimate Partner Violence," Centers for Disease Control and Prevention, October 9, 2021, <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>.

486 Alexia D. Cooper and Erica L. Smith, "Homicide Trends in the U.S., 1980–2008," Bureau of Justice Statistics, November 2011, <https://bjs.ojp.gov/library/publications/homicide-trends-united-states-1980-2008>.

487 "Preventing Intimate Partner Violence," Centers for Disease Control and Prevention, November 2, 2021, <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>.

488 Eldin Fahmy, "Evidence and Policy Review: Domestic Violence and Poverty," University of Bristol, 2015, https://research-information.bris.ac.uk/ws/portalfiles/portal/128551400/JRF_DV_POVERTY_REPORT_FINAL_COPY_.pdf.

489 Charlene K. Baker, Sarah L. Cook, and Fran H. Norris, "Domestic Violence and Housing Problems: A Contextual Analysis of Women's Help-Seeking, Received Informal Support, and Formal System Response," *Violence Against Women* 9, no. 7, July 1, 2003: 754–83, <https://doi.org/10.1177/1077801203009007002>.

unhoused people in Minnesota found that 29% of women in the sample were fleeing domestic violence.⁴⁹⁰ The COVID-19 pandemic increased financial insecurity and isolation, worsening the situation of many victims of DV/SV/IPV.⁴⁹¹ Data from 2020 indicates a stark rise in domestic violence incidents and severity.^{492 493}

Then, there is the added impact of trauma from experiencing IPV. Over the past 20 years, science and research has helped us to understand how trauma can contribute to mental health issues like depression, Post-Traumatic Stress Disorder (PTSD) and substance use.^{494 495 496} Some IPV survivors have been found to use alcohol as a way to cope with the violence they experience while others are coerced by their abusive partner to use.⁴⁹⁷ One study found that women who reported IPV and alcohol-related problems were far more likely to also report moderate to severe depression symptoms, suggesting that the effects of IPV, problematic alcohol use and depression are cumulative.⁴⁹⁸

DV is often targeted toward undermining a partner's mental health treatment and recovery



1 in 2 of the 2,733 National Domestic Violence Hotline callers who had sought help for feeling depressed or upset said their partners had tried to prevent or discourage them from getting help or taking prescribed medications.



4 in 5 said their partner accused them of being "crazy."



3 in 4 said their partner deliberately did things to make them feel like they were losing their mind.



1 in 2 said their partner threatened to report they were "crazy" to keep them from getting something they wanted or needed (e.g., protection order or custody of their children).

DV is often targeted toward undermining a partner's substance use disorder treatment and recovery

60% of the 3,224 National Domestic Violence Hotline callers who had sought help for substance use said their partner had tried to prevent or discourage them from getting help.

26% had used substances to reduce the pain of DV.

27% had been pressured or forced to use substances or made to use more than they wanted.

24% were afraid to call the police because their partner said they would be arrested or not believed.

38% said their partner had threatened to report their substance use to authorities to prevent them from getting something they wanted or needed (e.g., protection order or custody of their children).

Figure 32. Characteristics of callers to the National Domestic Violence Hotline.⁴⁹⁹

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497 Carole Warshaw et al., "Mental Health and Substance Use Coercion Surveys," National Center on Domestic Violence, Trauma & Mental Health, 2014, http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf.

498 Anuradha Paranjape et al., "Are Alcohol Problems Linked with an Increase in Depressive Symptoms in Abused, Inner-City African American Women?," Women's Health Issues 17, no. 1, January 2007: 37–43, <https://doi.org/10.1016/j.whi.2006.08.004>.

499 Warshaw et al., "Mental Health and Substance Use."

BARRIERS FACED GENERALLY, AND RELATED TO ACCESSING HOUSING

We often hear on hotline calls, “I was told I needed to go to a shelter, so I’m calling for help.” Time and again, DV/SV/IPV survivors are told by first responders, family, friends and even well-intended advocates that they need to leave the abusive partner in order to be safe. However, the risks of staying in an abusive relationship may not be much different than the risks of leaving. Loss of job, financial distress, family pressure, children’s wellbeing, safety, fear of retaliation—all of these factors can be experienced if someone leaves AND if someone stays with their partner. For this reason, trained advocates spend time discussing what safety means to the survivor. They are the experts in their lives and the ones facing the risks. Service providers work diligently to provide options and resources while allowing survivors to decide what is best for their unique situation. Sometimes the discussion is focused on what is safer rather than “safety.”

If the general population were to be asked about what services were available for someone experiencing DV/SV/IPV, many responses would center around shelter. However, in Maricopa County, Arizona’s largest county by population, there are only about 420 beds available in shelters specifically designated for DV survivors. Notably, many shelters have some sort of congregate living settings, which are not always easy for people who are in crisis. Most people are unaware of the myriad resources and services available to survivors other than shelter. These services include community and mobile case management, therapeutic and psycho-educational support groups, individual counseling, lay-legal advocacy and assistance, and medical/forensic advocacy.

Arizona, like many other states, has seen population growth, low rental vacancy rates and an extraordinary increase in housing costs. This creates a “perfect storm” of housing shortages, particularly in the affordable housing sector for those in middle-to-lower-income levels. For survivors of DV/SV/IPV, the option of leaving an abusive relationship is more challenging now than ever. Some survivors find themselves faced with the choice of leaving their abusive relationship or becoming homeless. In many cases, these individuals may feel their only option for survival is the latter. Within the U.S., research has indicated that many women and children experiencing homelessness have also experienced DV/SV/IPV.⁵⁰⁰ Studies find that between 22% and 57% of homeless women report that domestic violence directly led to their homelessness.⁵⁰¹ While the need for safe, affordable housing is a vital concern for all survivors of DV/SV/IPV, it is even more pronounced for marginalized members of our communities (see [SPARC report 2018 Center for Social Innovation](#) and [REEP report 2018 Center for Survivor Agency and Justice](#)).^{502 503}

500 “Domestic Violence and Homelessness,” American Civil Liberties Union, accessed September 30, 2021, <https://www.aclu.org/sites/default/files/pdfs/dvhomelessness032106.pdf>.

501 “Domestic Violence, Housing and Homelessness,” National Network to End Domestic Violence, July 2019, https://nnev.org/wp-content/uploads/2019/07/Library_TH_2018_DV_Housing_Homelessness.pdf.

502 Jeffrey Olivet et al. “SPARC: Supporting Partnerships for Anti-Racist Communities Phase One Study Findings,” Center for Social Innovation, March 2018, <https://c4innovates.com/wp-content/uploads/2019/03/SPARC-Phase-1-Findings-March-2018.pdf>.

503 Zoe Flowers et al., “Showing Up: How We See, Speak, and Disrupt Racial Inequity Facing Survivors of Domestic and Sexual Violence,” Center for Survivor Agency and Justice, March 12, 2018, https://csaj.org/document-library/REEP_Report_Showing_Up_FINAL.pdf.

ACCESS TO HOUSING INTERVENTIONS THROUGH FEDERALLY SUPPORTED SERVICES

Survivors of DV/SV/IPV face specific barriers when trying to access housing resources. The standard assessment tool used by most organizations that regionally coordinate entry into services, a so-called VI-SPDAT score, often does not accurately reflect the needs of DV/SV/IPV survivors and thus does not adequately prioritize them. Across the state, there are relatively few HUD-funded, DV-specific housing units available to DV/SV/IPV survivors. In Maricopa County, when these units are full, prioritization of access to housing services is based on chronicity, length of time on the streets, and VI-SPDAT scores. Because DV/SV/IPV survivors rarely meet the standards for prioritization, they are often not connected to housing resources. To this point, it would be beneficial if HUD's definition of homelessness was expanded to include survivors who seek safety at family or friends while they are fleeing.

Federal data reporting requirements make it frequently challenging for survivors to access housing services like shelter while protecting their privacy. Survivors are understandably hesitant to share information that may make them vulnerable to being found by an abuser. It is also very difficult for survivors to open up about the violence they've experienced to service providers, particularly if they have not been trained to serve survivors.⁵⁰⁴

Despite these challenges, the DV/SV/IPV provider community continues to work with regional Continuum of Care programs in creating lasting solutions to support survivors' needs for safe housing.

UNIQUE TO ARIZONA

The National Network to End Domestic Violence annually conducts a survey on domestic violence services provided during a 24-hour period across the country. On a single day in September 2020, 76,525 adults and children were served in domestic violence programs across the U.S.—11,047 requests for services went unmet, with 57% of those requests being specific to shelter and housing.⁵⁰⁵ In Arizona, 1,863 adults and children were served in domestic violence programs, with 78% of domestic programs participating. 124 requests for services were unmet, with 94% of those requests being for shelter and housing.⁵⁰⁶

The large remote areas of the rural counties in Arizona pose challenges regarding access to resources and services, including housing. For survivors of DV/SV/IPV in rural areas, additional barriers include increased chances for isolation, lack of transportation and access to critical services, and timeliness of crisis responders.

504 Heather L. McCauley and Taylor Reid, "Assessing Vulnerability, Prioritizing Risk: The Limitations of the VI-SPDAT for Survivors of Domestic & Sexual Violence," Safe Housing Partnerships, July 2020, https://safehousingpartnerships.org/sites/default/files/2020-08/CE_McCauleyReid_FINAL.pdf.

505 "15th Annual Domestic Violence Counts Report," National Network to End Domestic Violence, May 2021, <https://nnev.org/wp-content/uploads/2021/05/15th-Annual-DV-Counts-Report-Full-Report.pdf>.

506 "15th Annual Domestic Violence."

507 Michael Runner, Mieko Yoshihama, and Steve Novick, "Intimate Partner Violence in Immigrant and Refugee Communities: Challenges, Promising Practices and Recommendations," Robert Wood Johnson Foundation, March 2009, <https://www.rwjf.org/en/library/research/2009/03/intimate-partner-violence-in-immigrant-and-refugee-communities.html>.

508 Daniel Wiessner, "U-Visa Applicants Can Sue Over Processing Delays—6th Circuit," Reuters, September 13, 2021, <https://www.reuters.com/legal/litigation/u-visa-applicants-can-sue-over-processing-delays-6th-circuit-2021-09-13/>.

Immigrant survivors of DV/SV/IPV face unique challenges.⁵⁰⁷ Abusers can use the fact that their partner is undocumented or dependent on visa or green card sponsorship as a weapon. Immigrant survivors are less likely to ask for help because they fear deportation or separation from children. Additionally, cultural and language barriers can make it hard to access services. At times, there is community pressure to stay silent because a positive community image is seen as essential for survival. While there is a visa program for victims of certain crimes, including domestic violence, availability is inadequate, and protection is often hard to access.⁵⁰⁸

Several organizations are active in supporting survivors of DV/SV/IPV in Arizona. The Arizona Coalition to End Sexual and Domestic Violence (ACESDV) offers education and training, public policy advocacy, collaboration, technical assistance and direct services through their helpline. They have a strong membership of providers across the state, including several culturally specific programs such as Arizona South Asians for Safe Families (ASAFSF) and Chicanos Por La Causa (CPLC). Additionally, the Southwest Indigenous Women's Coalition (SWIWC) serves all 22 American Indian tribes in Arizona with culturally sensitive and supportive services.

Over the years, domestic violence-related programming and services have become more survivor-focused. Maricopa County providers collaborate to operate a county-wide hotline for centralized shelter intake. The hotline also operates an overflow program for when shelters are full. This program supports the safety of survivors who are fleeing high-risk situations. Shelter programs across the state have collaborated with various community partners to increase their capacity to also host pets on site. Many providers now offer community-based programming, such as case management, support groups (in-person and virtual), crisis counseling, vocational counseling, relocation assistance and legal services. Tucson has created a specialized Domestic Violence Court that makes taking legal action more accessible for survivors. Arizona Courts have created an online portal, AZPOINT, that allows survivors to file protective orders. A protective order is a civil court order that prohibits a defendant from contacting the survivor.

The COVID-19 pandemic has challenged regular modes of service delivery. Some newly implemented changes, such as virtual hearings for protective orders, make services more accessible and will continue to be used beyond the pandemic.

507 Michael Runner, Mieko Yoshihama, and Steve Novick, "Intimate Partner Violence in Immigrant and Refugee Communities: Challenges, Promising Practices and Recommendations," Robert Wood Johnson Foundation, March 2009, <https://www.rwjf.org/en/library/research/2009/03/intimate-partner-violence-in-immigrant-and-refugee-communities.html>.

508 Daniel Wiessner, "U-Visa Applicants Can Sue Over Processing Delays—6th Circuit," Reuters, September 13, 2021, <https://www.reuters.com/legal/litigation/u-visa-applicants-can-sue-over-processing-delays-6th-circuit-2021-09-13/>.

CONCLUSION

Domestic and sexual violence, in all its forms, is a pervasive problem in our society that impacts the lives of individuals and families in many ways. It is a public safety and health issue that requires community support to adequately assist survivors as they strive to live a life free from violence.

This can only be accomplished when we recognize the impact of homelessness on all members of our community and work to ensure all individuals and families have access to safe and affordable housing. Housing is often a critical first step for survivors that enables them to seek assistance for the trauma they've experienced and the complex issues they may face.

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