ARIZONA TOWN HALL

Creating Solutions

MENTAL HEALTH, SUBSTANCE USE, AND HOMELESSNESS

THE 114TH ARIZONA TOWN HALL

2022 REPORT

ARIZONA TOWN HALL

Creating Solutions

In 2022, Arizonans across the state will participate in Arizona Town Hall programs on the topic of "Mental Health, Substance Use, and Homelessness."

An essential element to the success of these consensus-driven discussions is this background report that is provided to all participants before each program. The Morrison Institute at Arizona State University coordinated this informative background material in partnership with other industry professionals who have lent their time and talent to this effort. Together they have created a unique resource for a full understanding of the topic.

For sharing their wealth of knowledge and professional talents, our thanks go to the report's authors. Our deepest gratitude also goes to Kristi Eustice, Senior Research Analyst, and Benedikt Springer, Postdoctoral Scholar at Morrison Institute for Public Policy at Arizona State University, who marshaled authors, created content and served as editors of the report.

After the culmination of various programs, including community town halls, future leaders' town halls, and the statewide town hall, the background report will be combined with consensus recommendations of participants into a final report. This final report will be available to the public on the Arizona Town Hall website and will be widely distributed and promoted throughout Arizona. The background report and recommendations will be used as a resource, a discussion guide, and an action plan on how best to address the intersecting issues of mental health, substance use, and homelessness.

Sincerely,

Evelyn Casuga
Board Chair, Arizona Town Hall
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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).

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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_NatlTerrDC_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.

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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 controversial[24], 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]

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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 Joober, 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/fpsyt.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 require 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).

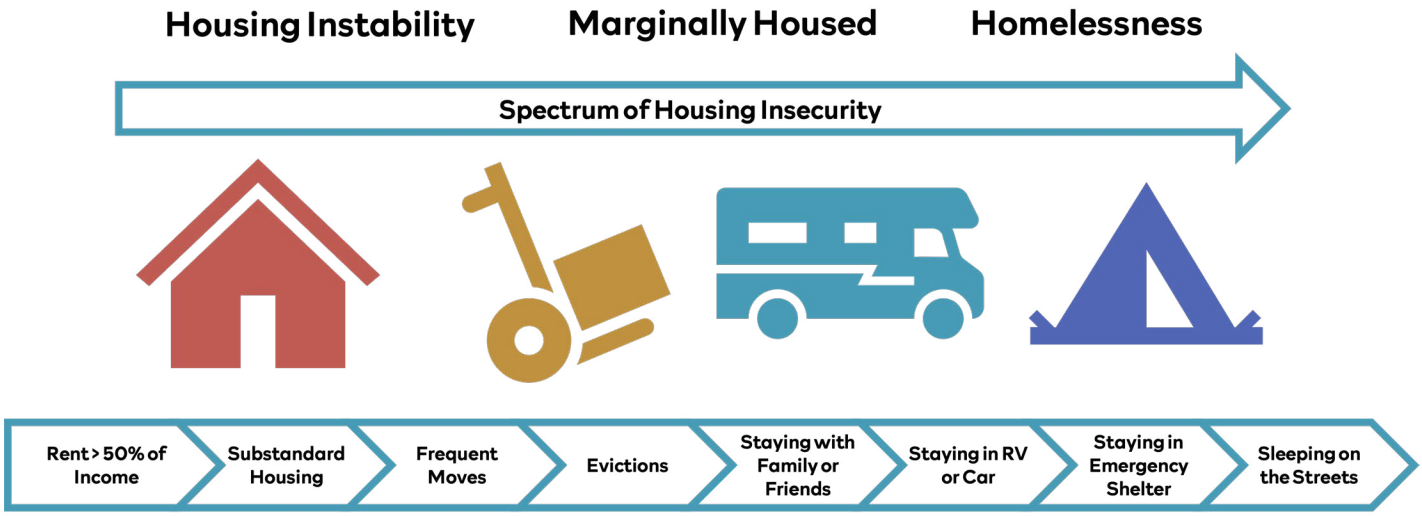

Figure 1. Spectrum of housing insecurity.

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]

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36 Lilanthi Balasuriya, Eliza Buelt, and Jack Tsai, "The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality," Psychiatric Times 37, no. 5, 2020, https://www.psychiatrictimes.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/10.1177/0011128713511571.

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.capolicylab.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).

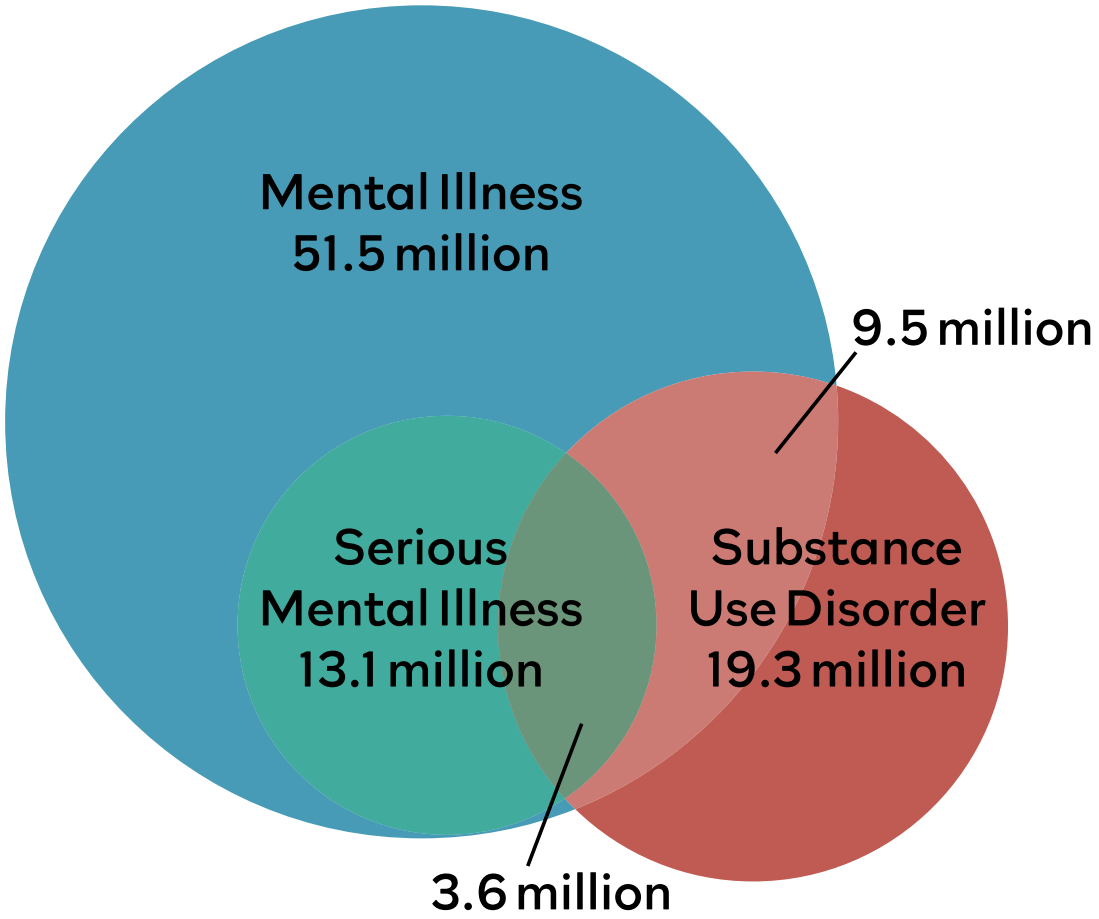

Figure 2. Overlap between homelessness, mental illness, substance use among adults in the U.S. in 2019. The total U.S. population is 332 million and about 580,000 people are experiencing homelessness nationwide.[52]

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.

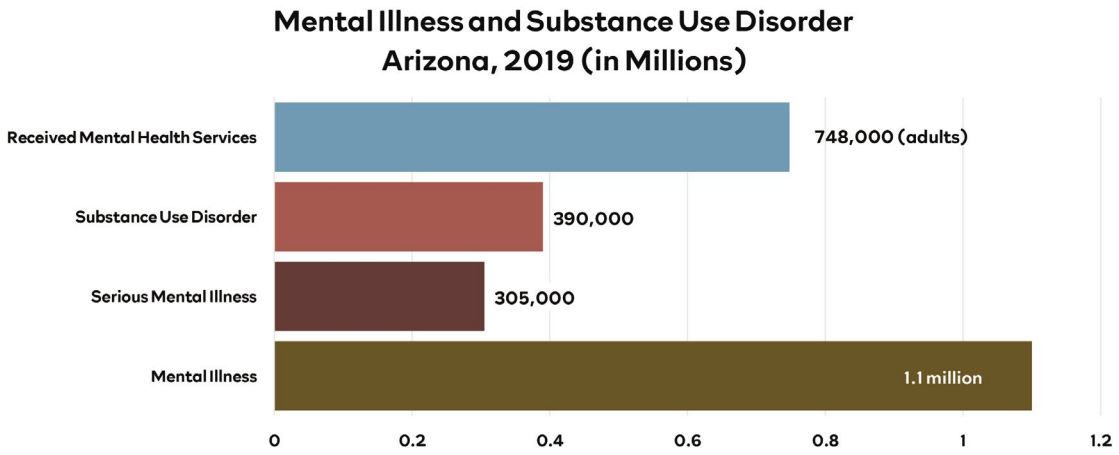

Figure 3. Mental illness and substance use disorder among adults, Arizona 2019.[54]

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 Continua 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]

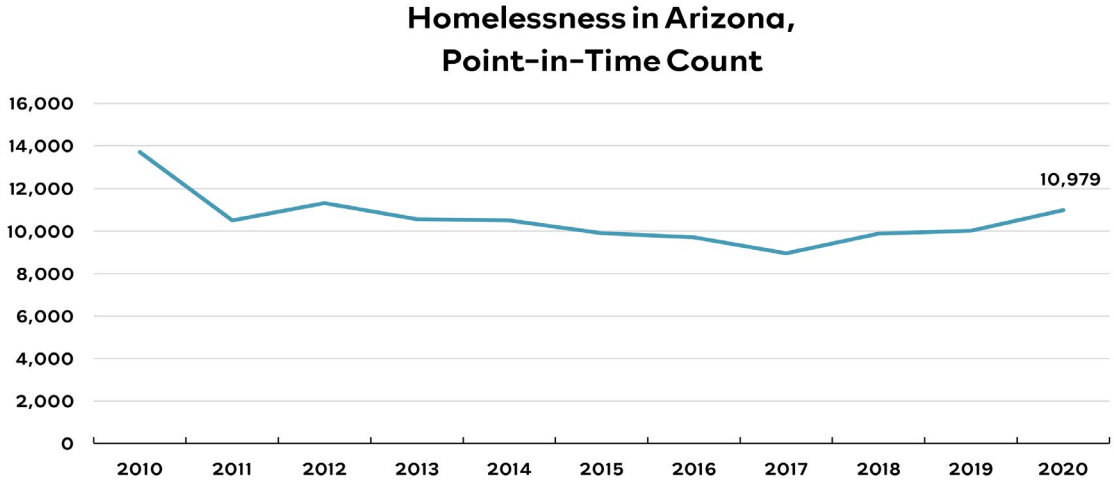

Figure 4. Homelessness in Arizona, Point-in-Time Count.[63]

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 Briscombe, 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.

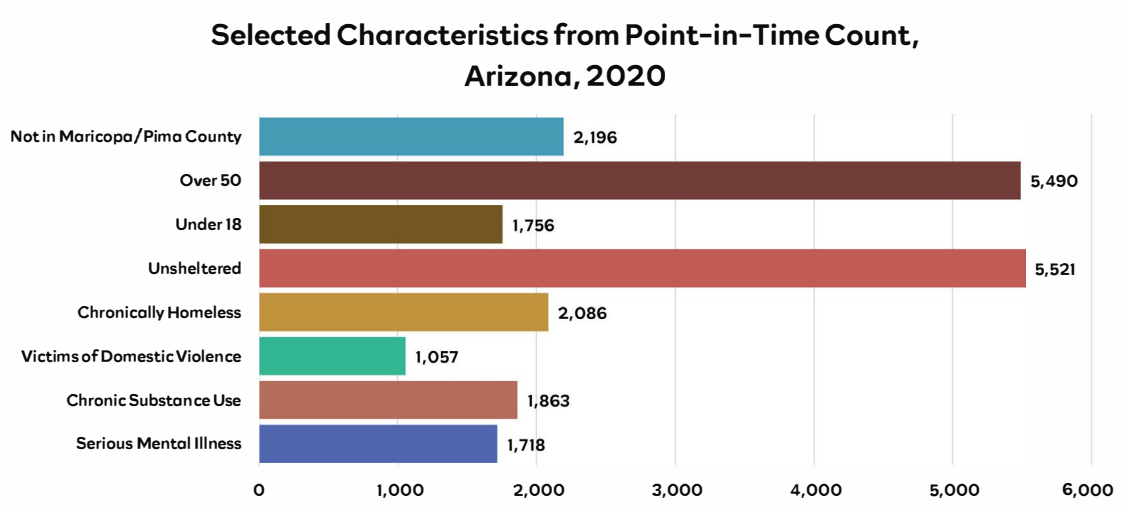

Figure 5. Selected characteristics from Point-in-Time Count, Arizona 2020.[64]

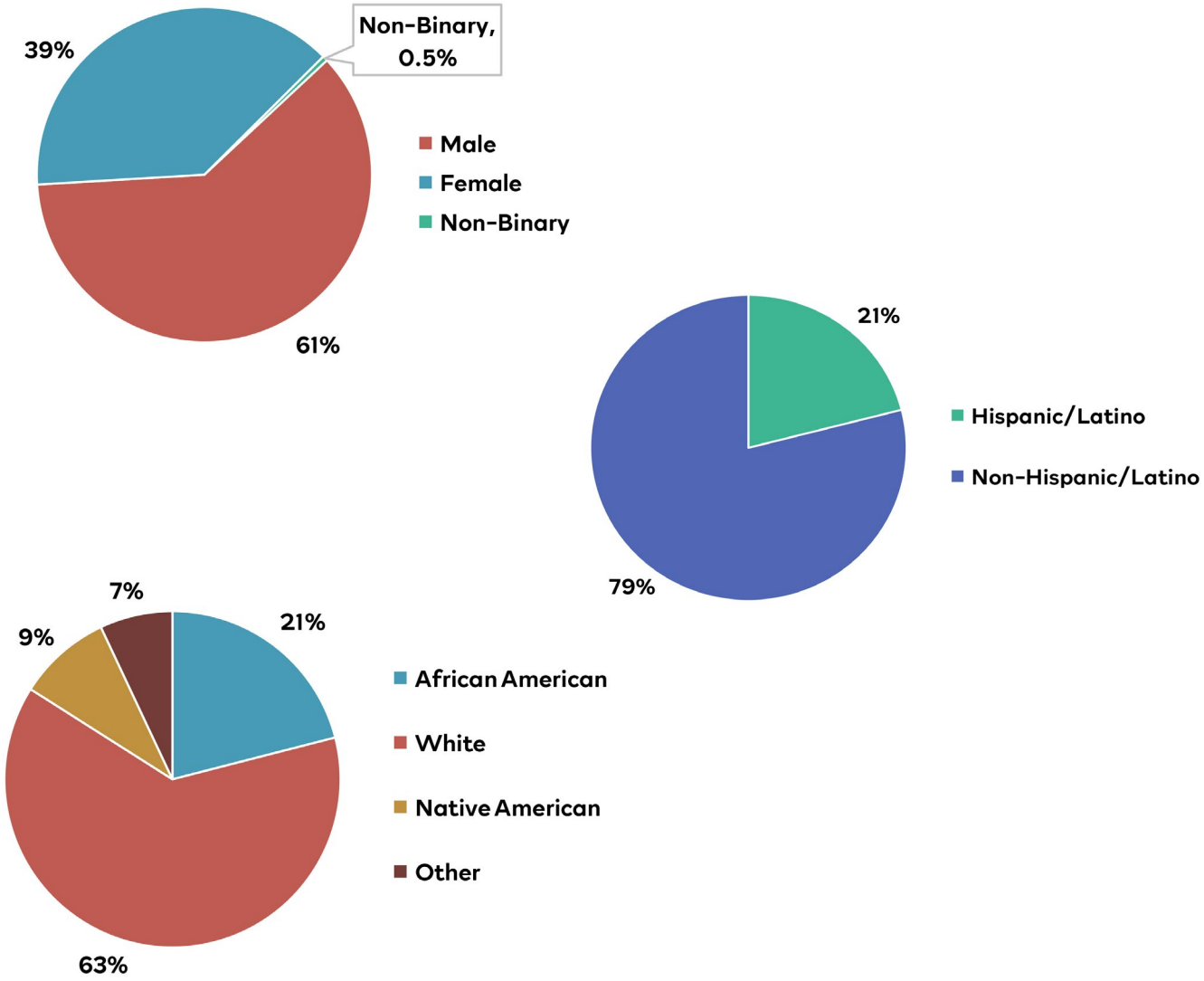

Figure 6. Selected characteristics from Point-in-Time Count, Arizona 2020.[65]

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	Desciption
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	Desciption
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 XIII, 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 involuntary 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=YW5qJ0mfg-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"

Christine "Krickette" Wetherington, Project Manager, Arizona State University

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]

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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.

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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.[75][76] 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.[78][79]

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.

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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/rwjf71795.

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.

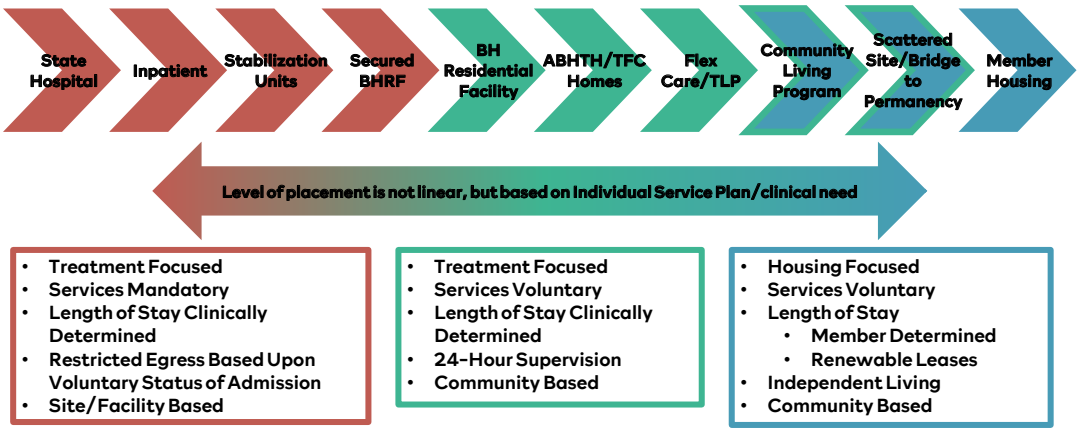

Figure 8. Overview of continuum of behavioral health settings ranging from treatment facilities (left) to community-based housing, including permanent supportive housing (right). Members access programming and settings based upon their individualized service need and not by linear progression from one 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/iycjournal/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	Desciption
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/.

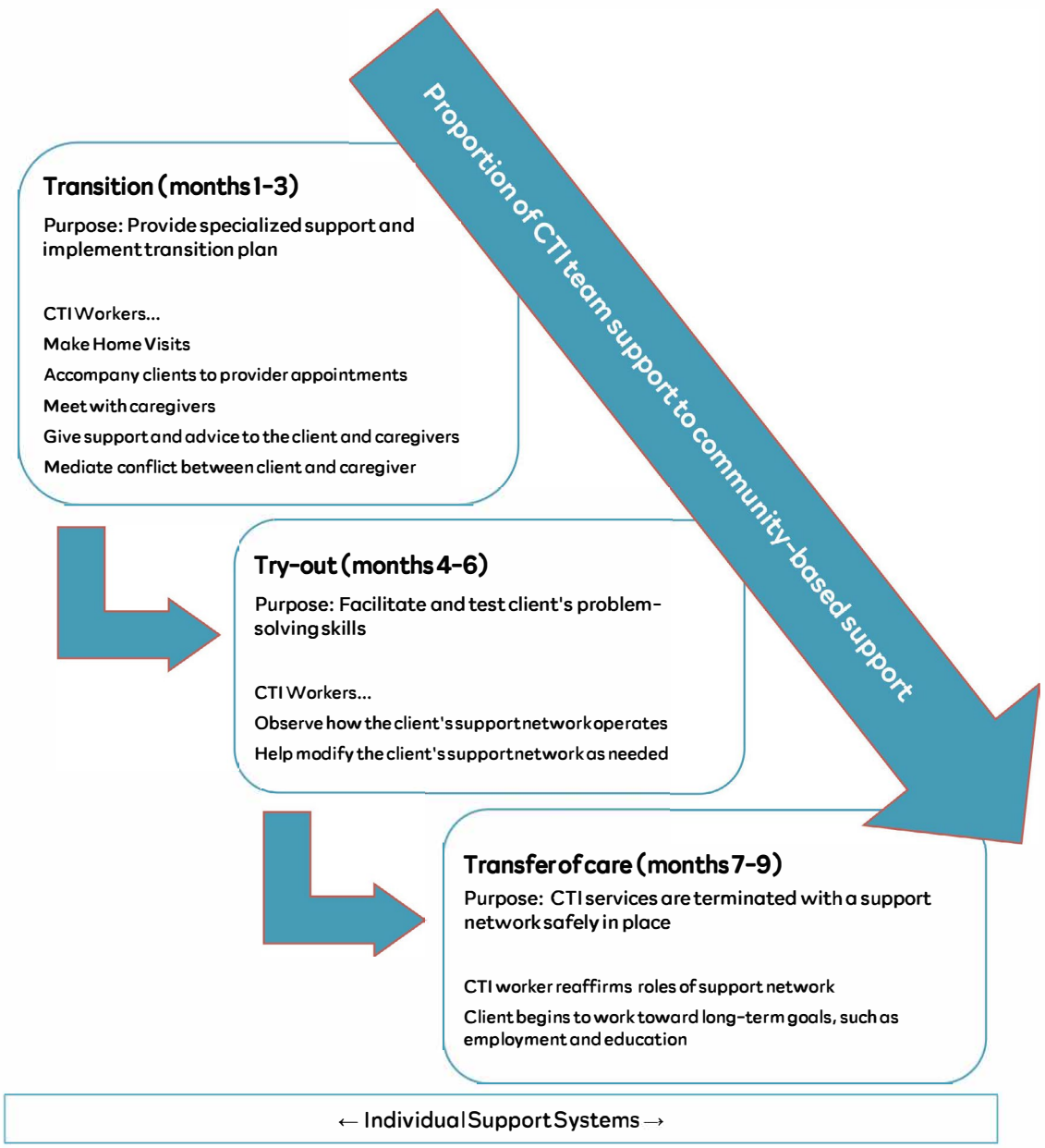

Figure 9. Critical Time Intervention service model–adapted from Herman et al.[100]

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]

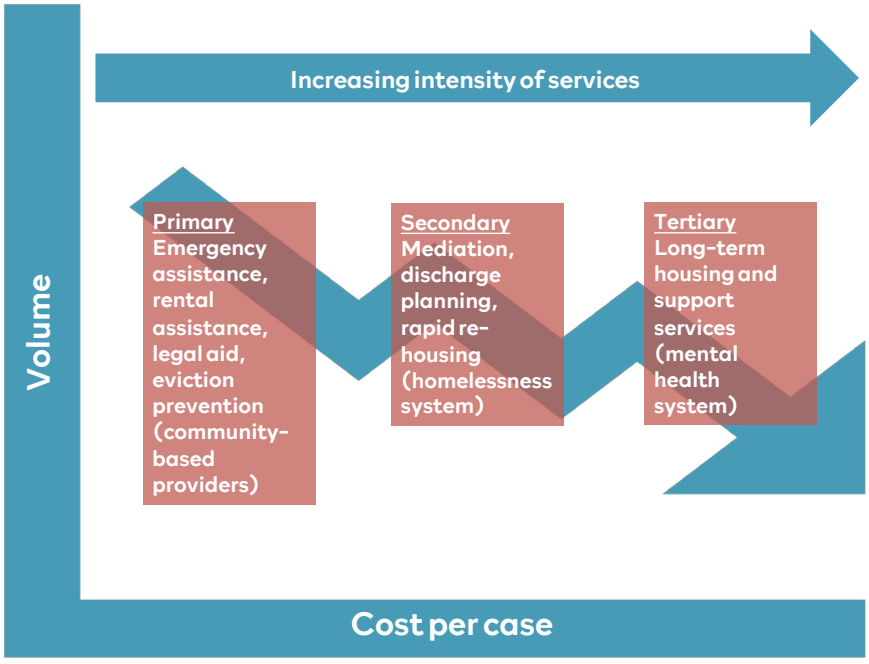

Figure 10. Homelessness prevention framework for individuals with Serious Mental Illness.[103]

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.[115] [116] 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.

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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.jsat.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.jsat.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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Robert Olson, Frazer Ryan Goldberg & Arnold LLP

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]

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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 DrugFacts," 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.

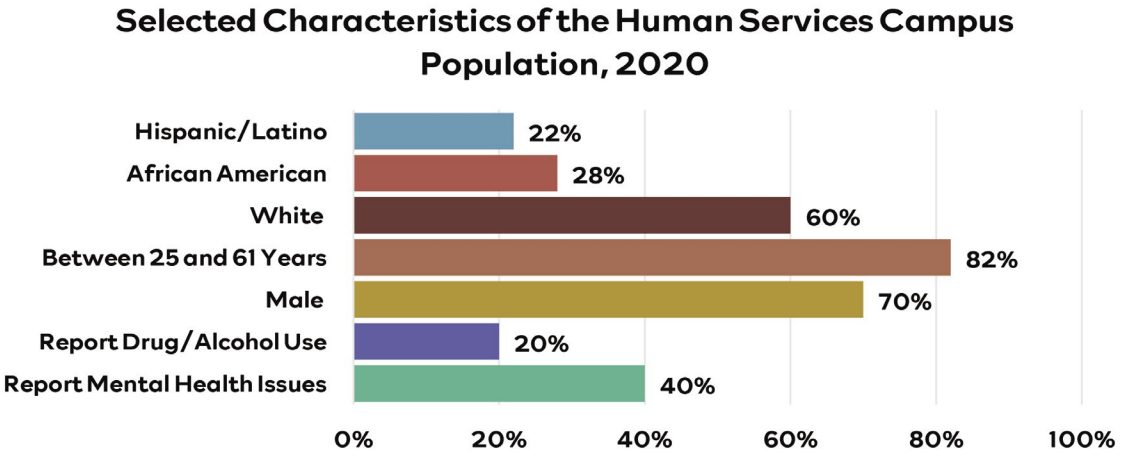

Figure 11. Selected characteristics of the Human Services Campus population, 2020.[133]

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.

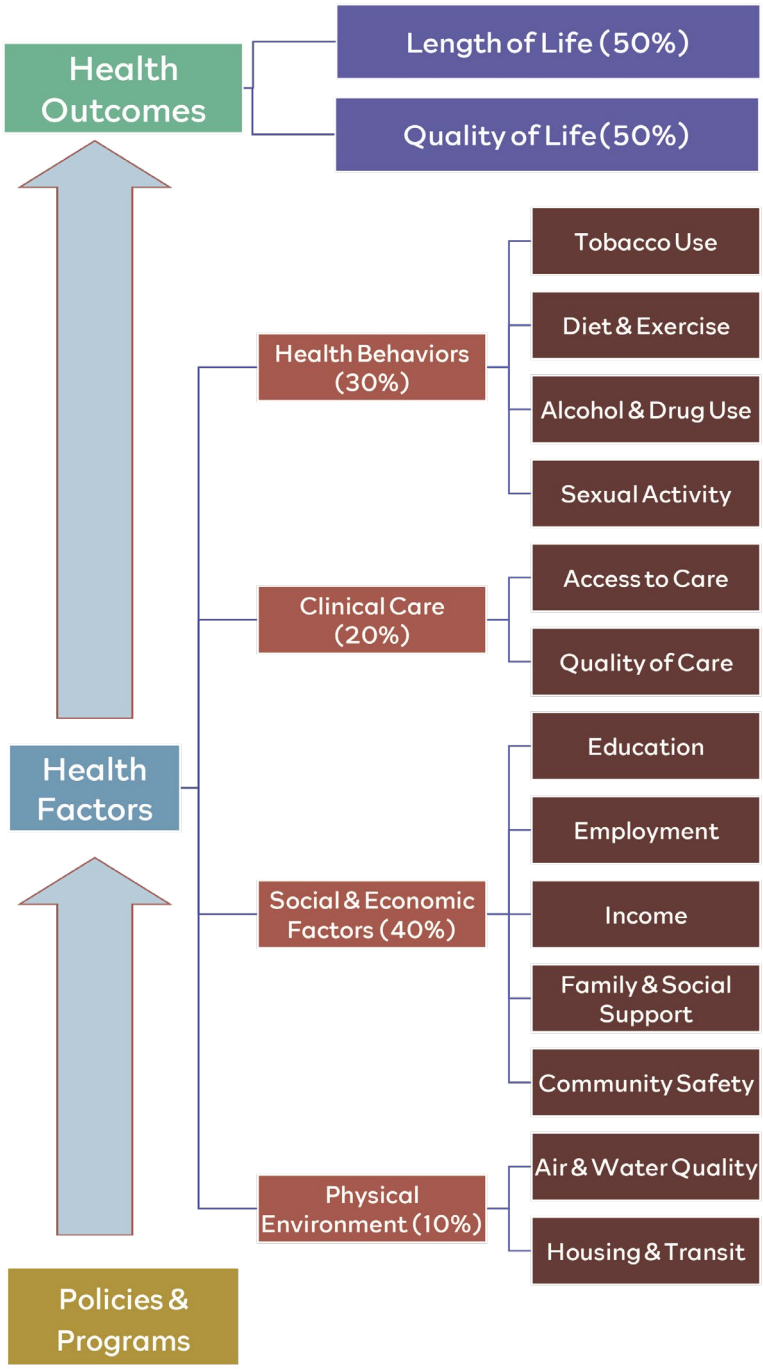

Figure 12. Social determinants of health.[134]

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.[137][138] 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.

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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://sbdww.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 Continua 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.[149] [150] 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 acts 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-RelatedSructuralStigmaReport_ENG_0_0.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]

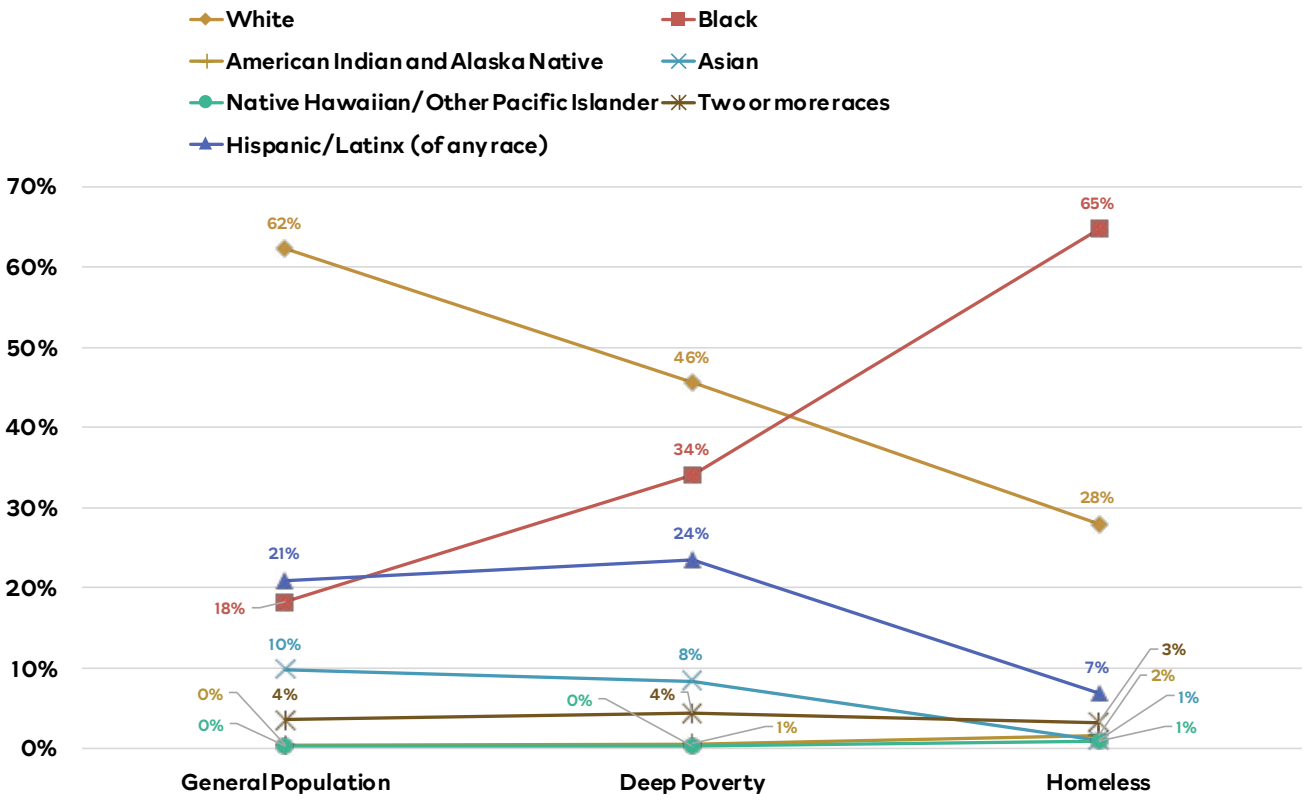

Figure 13. Race/ethnicity breakdown of the general population, the population in deep poverty and the homeless population in five SPARC communities.[163]

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-1-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.[166][167][168] 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.[169][170][171] 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.[173][174][175] 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–

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 Fesseler, "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/10.1177/0011128708328864.

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/bmj.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.[180] [181] 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.

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178 Janet R. Cummings, Hefei Wen, Michelle Ko, and Bejamin 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/crsj/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.[185] [186] 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;

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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.[195] [196] 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.[198] [199]

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/10.1177/0011128702239236.

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.[206][207] 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.[208][209] 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]

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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. Sauceda 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 Stated 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.

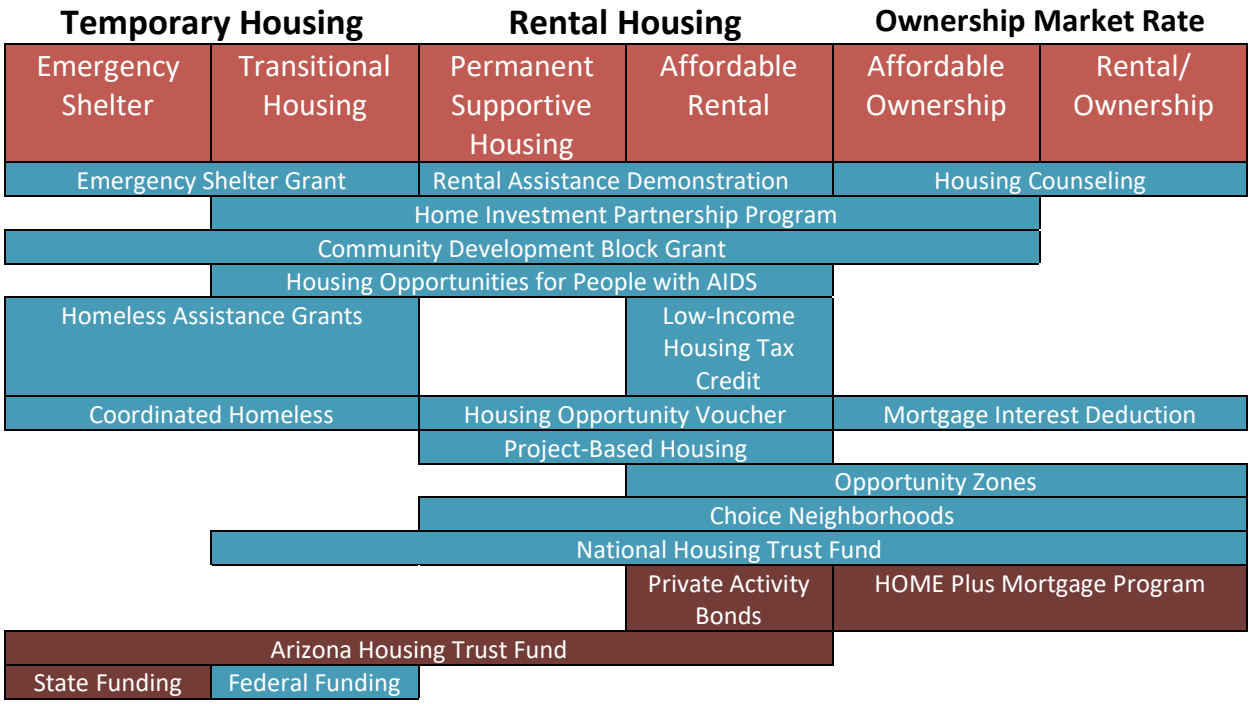

Figure 14. Continuum of housing and funding sources.[214]

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/HsngSpctrmFunding-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:

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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

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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 Continua 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 Continua of Care.[251][252][253]

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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 Continua 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.

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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://cronkitezine.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?g=0400000US04&tid=ACSDP1Y2019.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.

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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%3E3.0.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.

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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 Servies 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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Megan Lee, PhD, Community Bridges, Inc.

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]

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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]

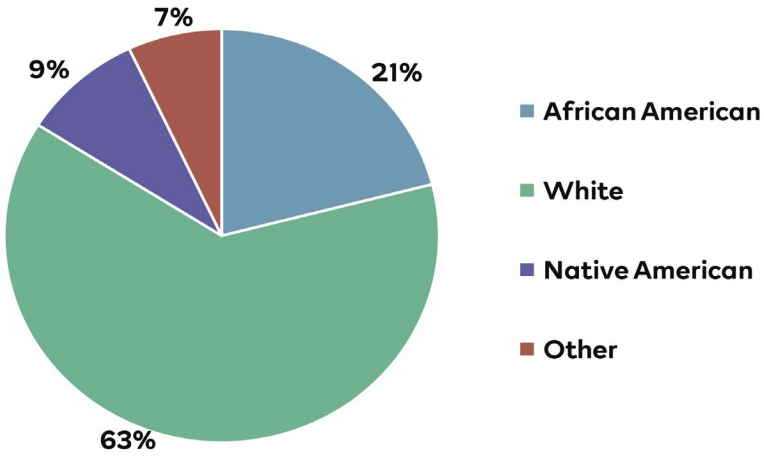

Figure 15. Racial characteristics of the Arizona homeless population (PIT Count) in 2020. [288]

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&g=0400000US04&tid=ACSDP1Y2019.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."

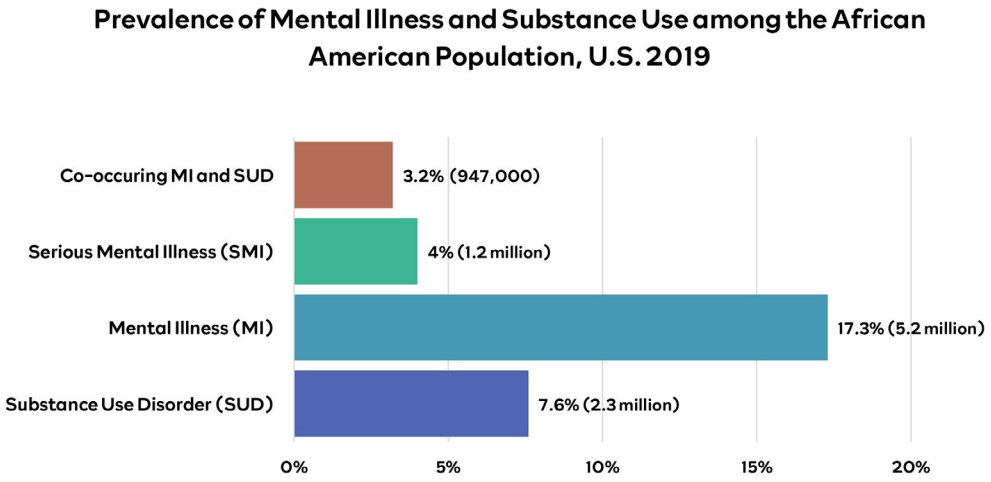

Figure 16. Prevalence of mental illness and substance use among African Americans in the U.S. in 2019.[289]

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]

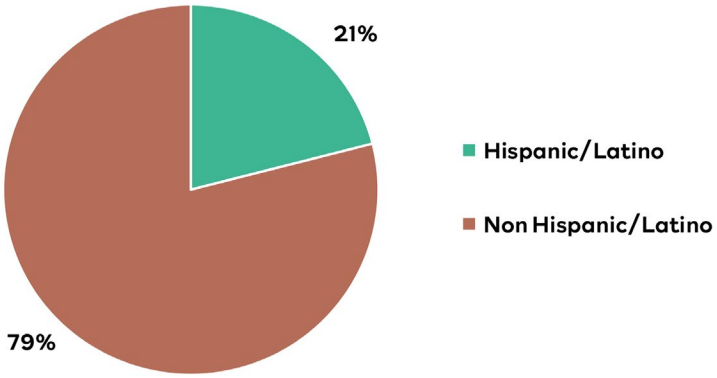

Figure 17. Hispanic/Latino unhoused population (PIT Count) in Arizona in 2020.[292]

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

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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-4f1c-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]

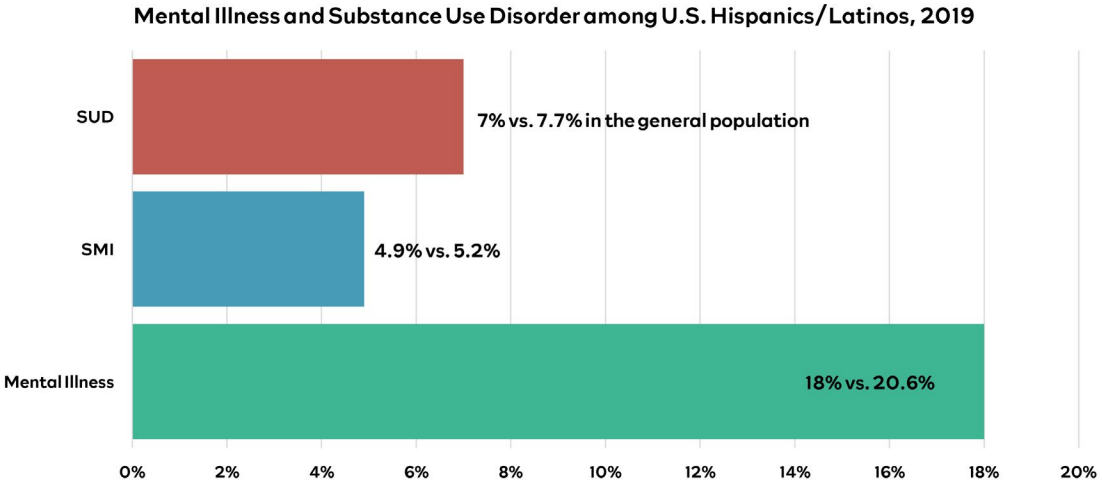

Figure 18. Mental illness and SUD among adult Hispanics/Latinos in the U.S. in 2019. [310]

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 Alegría 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/geroni/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]

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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 Reinosa-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 Auntré 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 Avideh 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.[323][324] 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.

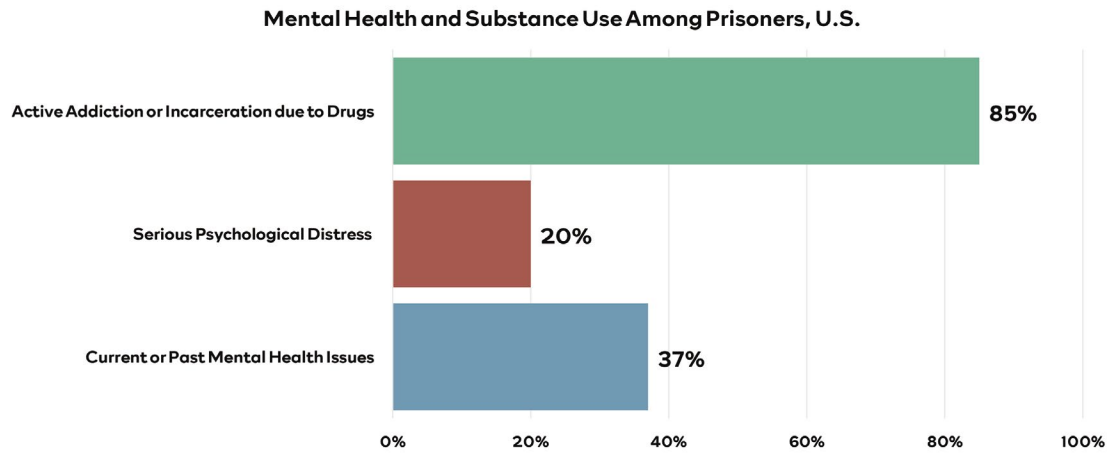

Figure 19. Mental health and substance use among U.S. prisoners. [322] [333]

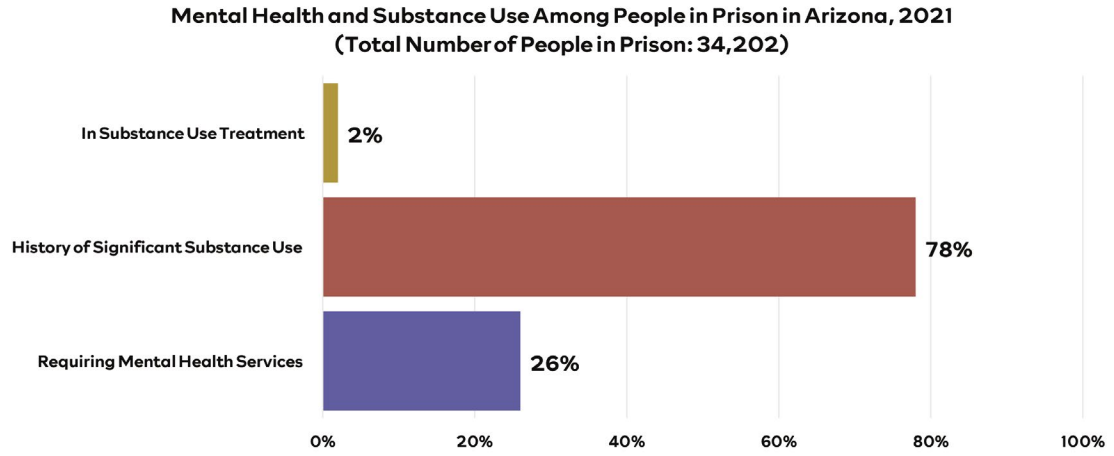

Figure 20. Mental health and substance use among people in Arizona prisons 2021. [334]

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/imhprpji1112.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][343][344] 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]

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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]

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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/ccjr/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.

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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]

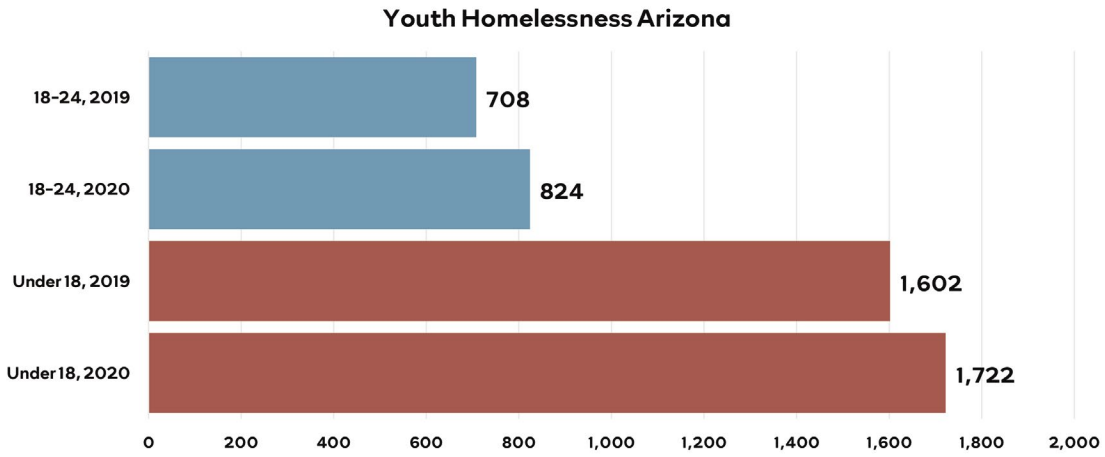

Figure 22. Youth homelessness in Arizona.[370]

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]

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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.

389 "Summary of NYTD Baseline Survey Results," Center for Child Well-Being, Arizona State University, unpublished data, 2021.

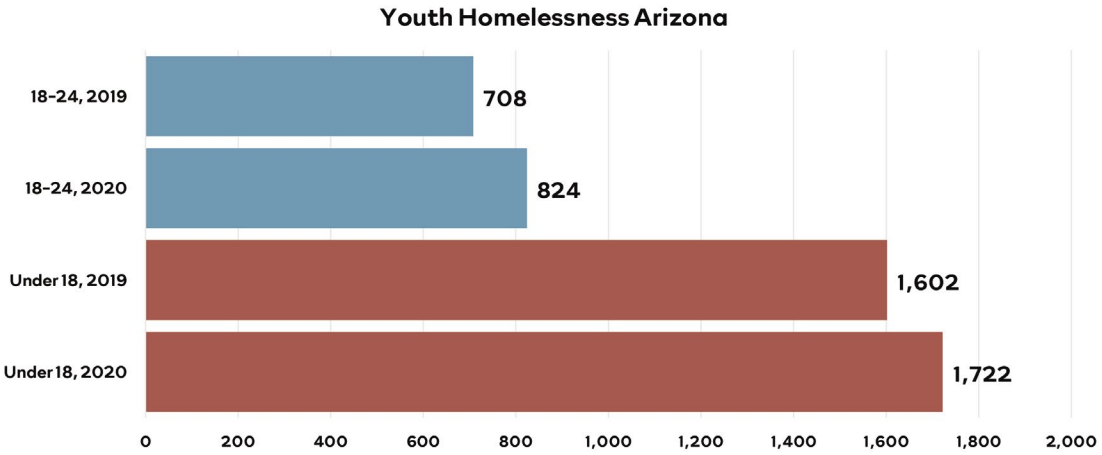

Figure 23. 2020 Youth Experiences Survey of 18-25-year-olds experiencing homelessness in Arizona.[390]

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.

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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]

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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.

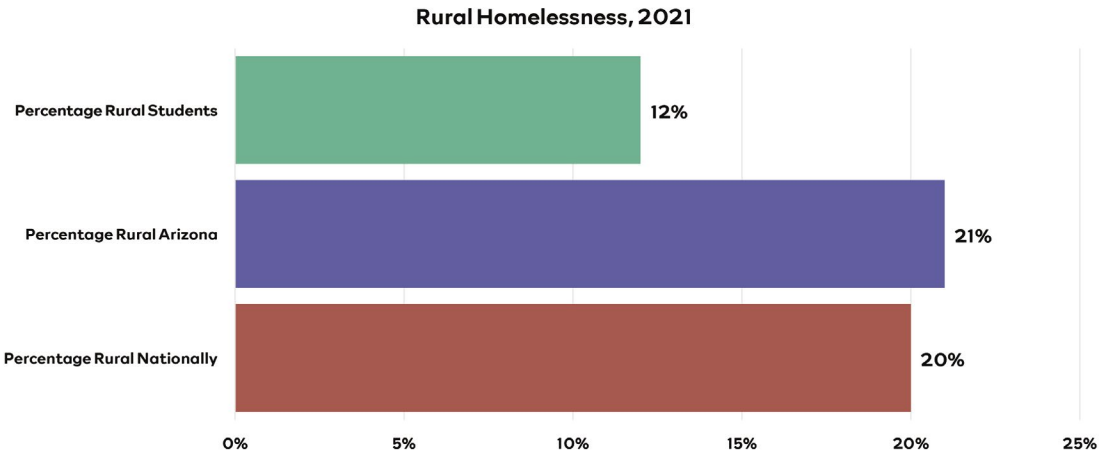

Figure 24. Rural homelessness as a percentage of total homelessness (PIT Count) in 2020.[408][409][410][411]

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]

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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-1.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.

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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
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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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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.

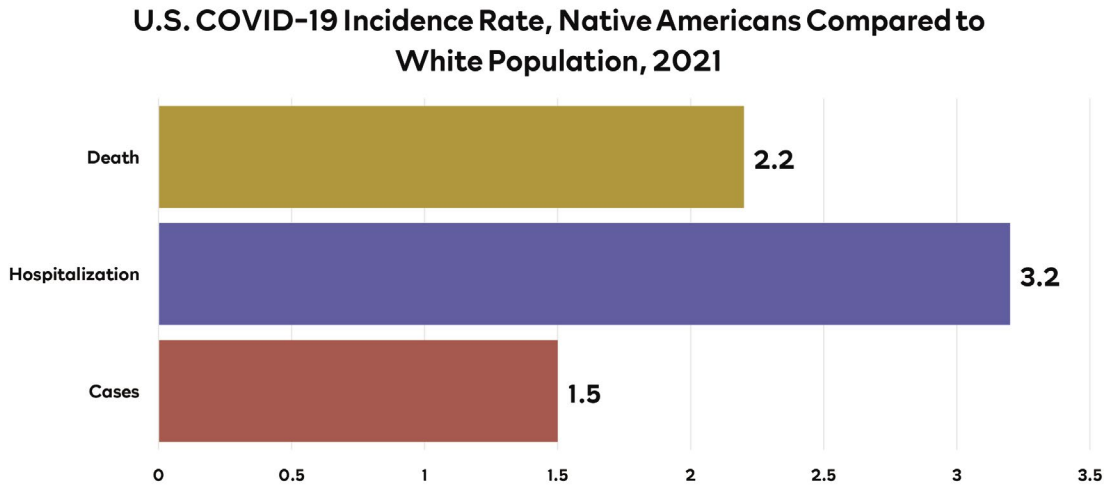

Figure 25. COVID-19 incidence among Native Americans compared to the white population in the U.S. in 2021.[435]

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 Ntsaaíggíí-19 (COVID-19)," Navajo Nation Department of Health, updated December 1, 2021, https://www.ndoh.navajo-nsn.gov/COVID-19/Data.

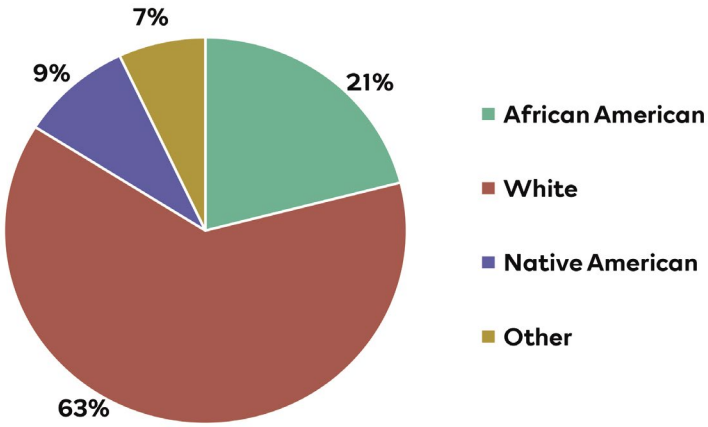

Figure 26. Racial characteristics of the Arizona homeless population (PIT Count) in 2020.[437]

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.

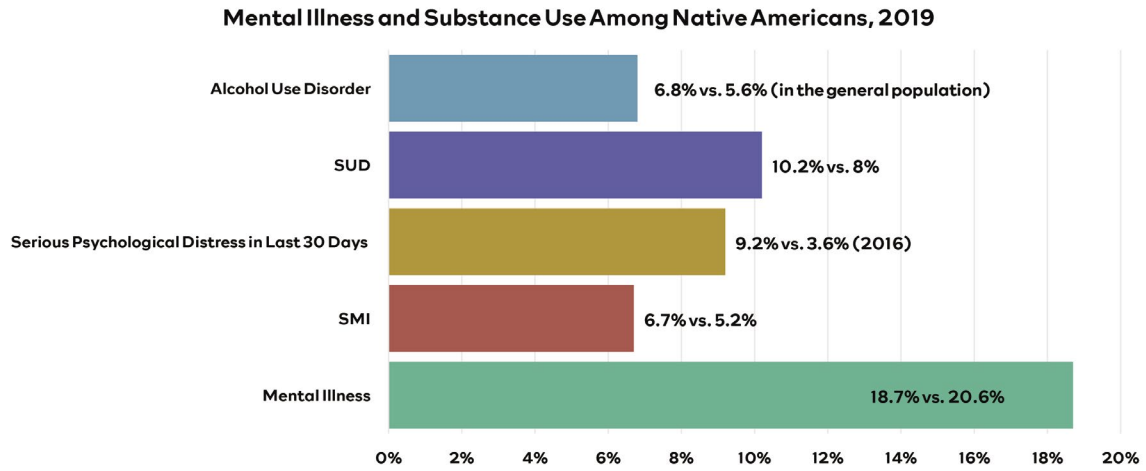

Figure 27. Mental illness and substance use among Native Americans in the U.S. in 2019.[442][443][444][445]

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/hus/hus17.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-homelesssurvey.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.[459] [460] 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.[461] [462] 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," Gilbrea 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.

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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.

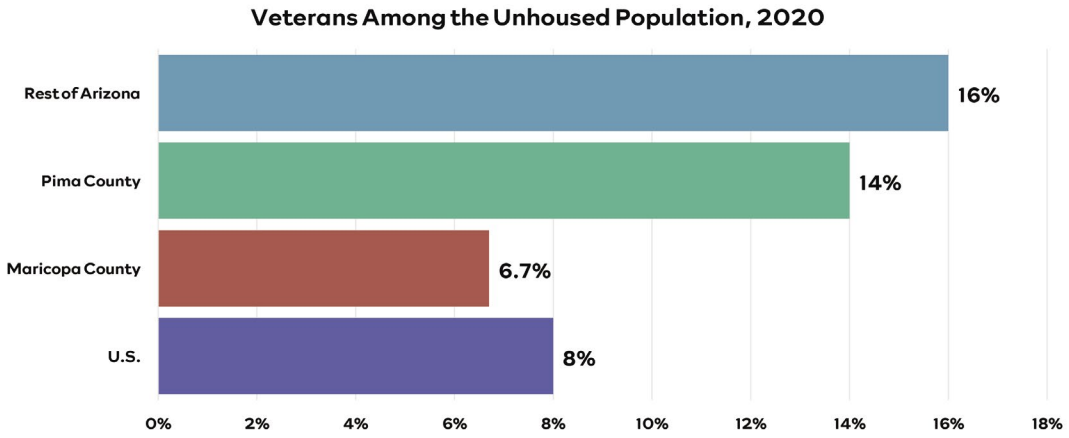

Figure 29. Veterans among the unhoused population in 2020 (PIT Count).[473][474]

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]

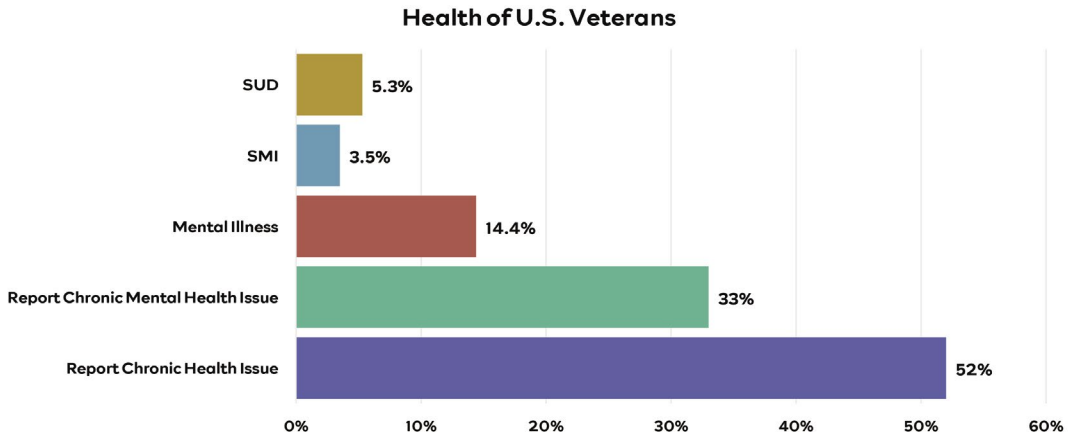

Figure 30. Selected health conditions of the American veteran population.[478][479]

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 CCRCs 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.

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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.americanvetsgroup.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]

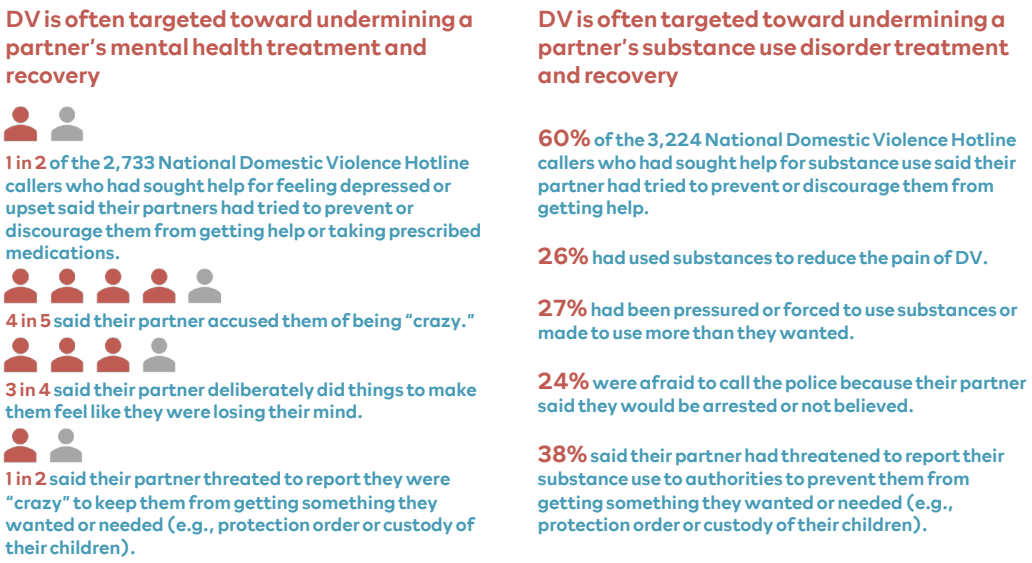

Figure 32. Characteristics of callers to the National Domestic Violence Hotline.[499]

490 Ellen Shelton, "Homelessness in Minnesota: Key Findings from the 2009 Statewide Survey," Wilder Research, May 2010, https://www.wilder.org/sites/default/files/imports/HomelessnessInMN_2009_KeyFindings_5-10_.pdf.

491 Jeffrey Kluger, "Domestic Violence and COVID-19: The Pandemic Within the Pandemic," Time, February 3, 2021, https://time.com/5928539/domestic-violence-covid-19/.

492 Brad Boserup, Mark McKenney, and Adel Elkbuli, "Alarming Trends in U.S. Domestic Violence during the COVID-19 Pandemic," The American Journal of Emergency Medicine 38, no. 12, December 1, 2020: 2753–55, https://doi.org/10.1016/j.ajem.2020.04.077.

493 Babina Gosangi et al., "Exacerbation of Physical Intimate Partner Violence during COVID-19 Pandemic," Radiology 298, no. 1, January 1, 2021: E38–45, https://doi.org/10.1148/radiol.2020202866.

494 Michele C. Black, et al. "The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report," Centers for Disease Control and Prevention, November 2011, https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

495 Hind A. Beydoun et al., "Intimate Partner Violence Against Adult Women and its Association with Major Depressive Disorder, Depressive Symptoms and Postpartum Depression: A Systematic Review and Meta-Analysis," Social Science and Medicine 75, no. 6, September 2012: 959–75, https://doi.org/10.1016/j.socscimed.2012.04.025.

496 Julie A. Schumacher and Deborah J. Holt, "Domestic Violence Shelter Residents' Substance Abuse Treatment Needs and Options," Aggression and Violent Behavior 17, no. 3, May/June 2012: 188–97, https://www.ojp.gov/ncjrs/virtual-library/abstracts/domestic-violence-shelter-residents-substance-abuse-treatment-needs.

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://nnedv.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://nnedv.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.

Notes

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