HOUSING FIRST V. Treatment First

SHERIFF VIC REGALADO


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MENS APPAREL
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PUSH BUTTON FOR

HOW DID WE GET HERE???

- 780 AND 781
  - Effectively ended accountability and consequences- The Cornerstone of Sobriety.
  - Significant drop in participation numbers for Drug Court and Mental Health Court.

LEGALIZING MARIJUANA

- Dramatic and Visible increase Homelessness.
- Increase in Severe drug addiction and Mental Illness, Specifically Schizophrenia and other Psychosis.

LACK OF ACCESS TO QUALITY SUBSTANCE USE AND MENTAL HEALTH TREATMENT

SENATE BILL 484

AUTHORED BY SENATOR LISA STANDRIDGE R-NORMAN

PREVENT ALL MUNICIPALITIES UNDER 300 THOUSAND FROM USING CITY RESOURCES TO OPERATE SHELTERS OR PERFORM HOMELESS OUTREACH.

THERE IS NO SILVER BULLET FOR CURING HOMELESSNESS, AND HOUSING FIRST IS CLEARLY NOT IT.

TENS OF BILLIONS HAVE BEEN SPENT ON AFFORDABLE HOUSING IN THE PAST FOUR YEARS AND MANY CITIES HAVE SHIFTED FROM TREATMENT FIRST TO HOUSING FIRST.

THE RESULT HAS BEEN THE 33 PERCENT RISE IN HOMELESSNESS, SHOWING THAT HOUSING FIRST IS A FAILURE.

Housing First Does Nothing to Solve the Homelessness Crisis

ANDY BARR | BEN CARSON

Ben Carson Andy Barr

As a former Secretary of the Department of Housing and Urban Development (HUD) and a sitting United States Congressman, we share a deep concern about the ongoing crisis of homelessness in America. Despite decades of effort and billions of taxpayer dollars, the number of homeless individuals has continued to rise to unprecedented levels. More and more we are seeing the visible consequences of untreated substance abuse disorders and mental illness is having on individuals, the environment, and our communities. It is apparent that Housing First, the dominant approach to addressing homelessness in the United States for well over a decade, has proven ineffective in solving this problem.

Housing First is premised on the idea that by giving people housing without preconditions, the homeless individual will then have the means to stabilize his life. However, the problem with this approach is that it prioritizes permanent housing for the homeless without requiring them to address any of the underlying problems or root causes — usually substance abuse and mental illness — that led to their homelessness in the first place. For example, Housing First does not require homeless individuals to meet behavioral criteria such as any level of sobriety or participate in treatment programs which have proven instrumental in getting homeless individuals back on their feet as productive, functioning members of society.

The problem with this [Housing First] approach is that it prioritizes permanent housing for the homeless without requiring them to address any of the underlying problems or root causes...

A recent report from the US Interagency Council on Homelessness (USICH) has shown that Housing First **ultimately fails in its goal of addressing the root causes of homelessness.**

In fact, after years of increased investment, states like **California** that wholeheartedly embraced Housing First policies are **experiencing unprecedented increases in homelessness.**

At the end of the day, homelessness is not just a housing problem.

Homelessness is a complex issue that requires a multi-faceted approach, and the USICH report found that the **Housing First model fails to provide wraparound services such as job training, mental health services, and addiction treatment that are necessary to address the underlying issues at play. Often the key to success is a combination of housing and treatment, which is why more holistic wraparound services are essential for the homeless to achieve improved and lasting outcomes.**

Several cities and states show the failure of the Housing First approach. San Francisco has built enough permanent housing to house every single chronically homeless individual in the city back in 2011. Yet instead of “ending homelessness,” as then Mayor Gavin Newsom (now Governor) had promised, homelessness increased substantially until the city became an international byword for the homelessness crisis.

NR PLUS | POLITICS & POLICY

How Not to Address Homelessness in Arizona

Tents at a homeless encampment in Phoenix, Ariz., December 18, 2020. (Michelle Conlin/Reuters)

By **RACHEL SHEFFIELD**
July 3, 2024 6:30 AM

22 Comments | Listen ▶

Housing-first is not the solution. It's better to focus on underlying human needs so people can reconnect with their communities and truly find home.

The state of Arizona has built over 7,000 permanent homes for the homeless since 2010, enough to house every unsheltered person when they began, but the number of Arizonians living on the streets has increased by 50% in recent years.

Lessons learned from a failed bet on ‘Housing First’

BY REP. ROGER WILLIAMS (R-TEXAS) AND MICHELE STEEB, OPINION CONTRIBUTORS - 11/16/21 5:30 PM ET

APU GOMES/AFP via Getty Images

Buried deep within thousands of pages of the current Democrat partisan reckless tax and spending bill is a $24 billion housing voucher program doomed to fail from the start.

“Policies that do not address the real root causes of homelessness have exacerbated the homelessness condition in America, according to the federal government’s October 2020 report (U.S., Interagency Council on Homelessness 10/20.”

ONE SIZE FITS ALL APPROACH

Housing First is a one-size-fits-all solution, which means there is no need to figure out whether someone is homeless because they lost their job, they are mentally ill, or they are a drug addict.

Just build a shelter and stick them in it and declare victory.

THINK ABOUT WHO BENEFITS

Housing First can be highly profitable to **the groups building the housing.**

The federal, state, and local governments are collectively spending somewhere between $10 billion and $20 billion a year on affordable housing programs, and an average of 10 percent of that money — meaning well over a billion dollars a year — goes to “developer fees,” i.e., pure profit for the developers.

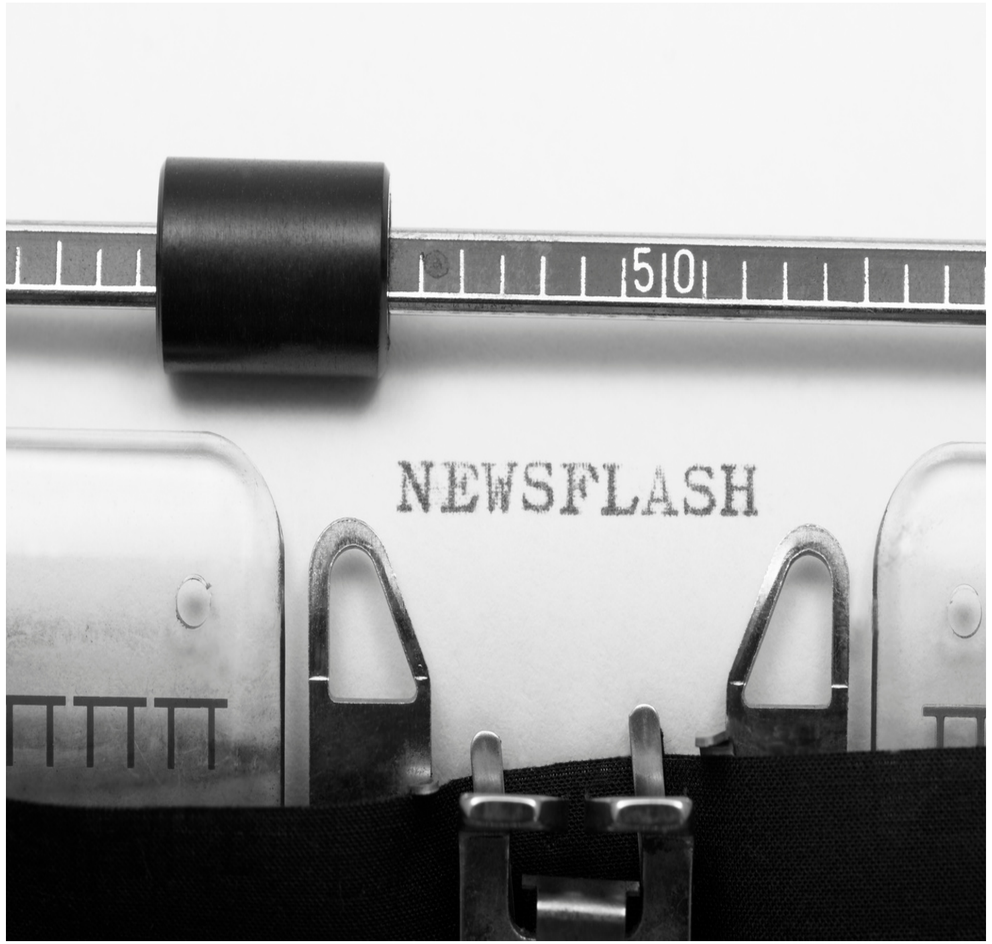
The developers also charge rents for the housing they build, and while the rents may be below market, since most of the construction costs are paid for by taxpayers, most of those rents are profits as well.

By comparison, Treatment First is not a huge profit center, which means the groups doing such practices do not have a lot of money to spend on lobbying and campaign contributions.

DATA

No one has seriously looked at whether either or both approaches can significantly reduce homelessness.

MISLEADING INFORMATION

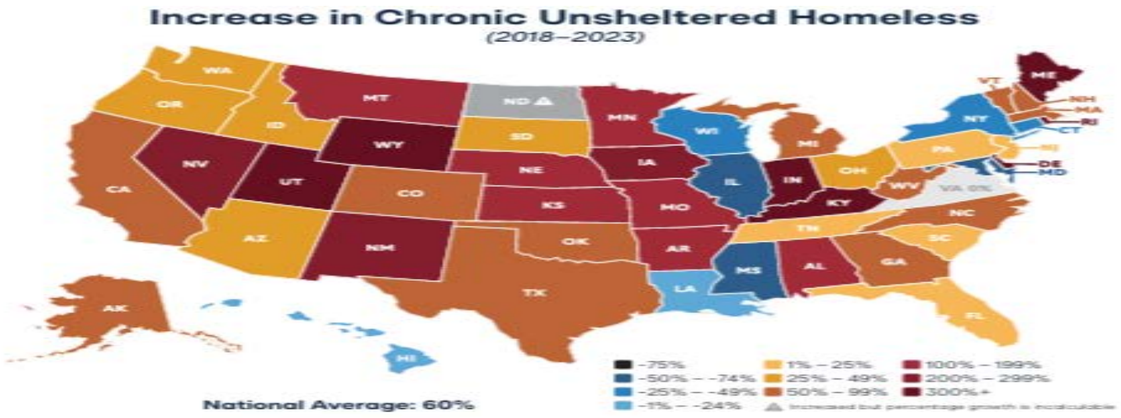


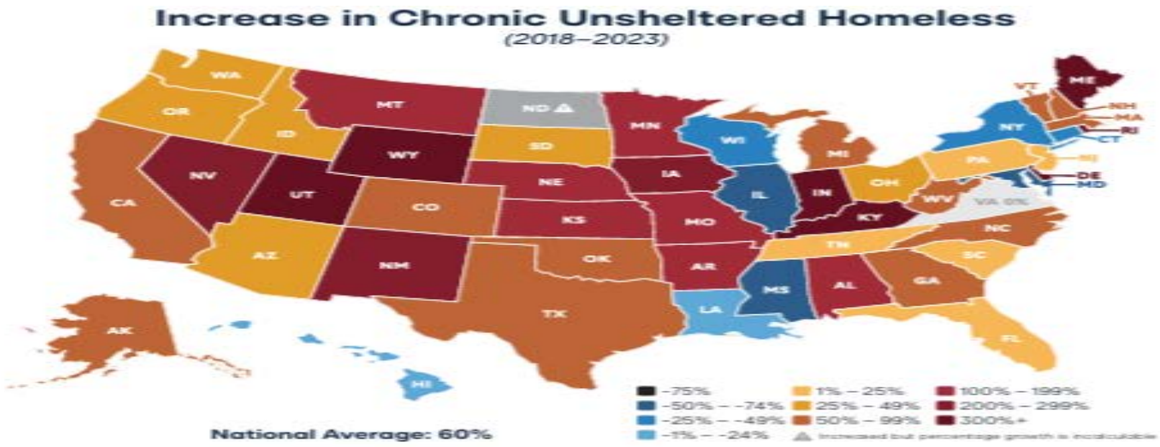
Groups such as the National Low-Income Housing Coalition strongly promoting Housing First to the exclusion of Treatment First.

- The coalition is a non-profit group that spends about $10 million a year promoting housing policies.
- Its president receives more than $340,000 a year in compensation and at least five other staff members receive around $175,000 or more.

California YIMBY, promotes construction of affordable housing in somebody else's backyard. MSNBC published an article by the group's policy director, Ned Resnikoff, proclaiming the success of Housing First.

- "Researchers have studied Housing First programs for decades," Resnikoff says, "and have consistently found that they are effective in getting people stably housed." **However, the studies he cites only find that housing programs benefit the people who take advantage of those programs, not that such programs actually reduce homelessness.**
  - Resnikoff notes that the HUD homeless census found that the number of homeless veterans had declined by more than 50 percent since 2010, and he attributes that success to the Department of Veterans Affairs adopting a Housing First program.
    - **What he doesn't say is that the VA program is not Housing First in the sense of government funding of affordable housing, which is what Resnikoff means by Housing First.**
    - Instead, **the VA program consists of a combination of rent vouchers with treatments for mental health, addiction, and other problems.**


Increase in Chronic Unsheltered Homeless
(2018–2023)
-75%
-50% – -74%
-25% – -49%
-1% – -24%
1% – 25%
25% – 49%
50% – 99%
100% – 199%
200% – 299%
300%+
Increased but percentage growth is incalculable
National Average: 60%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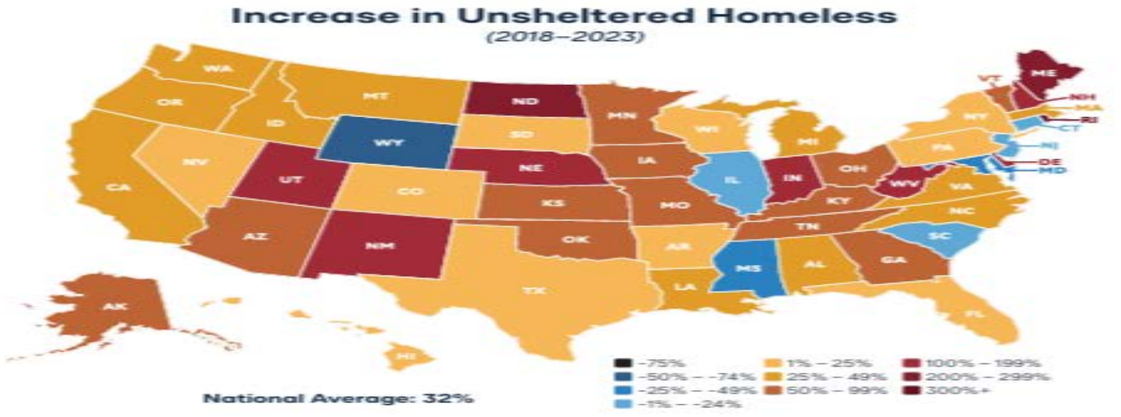
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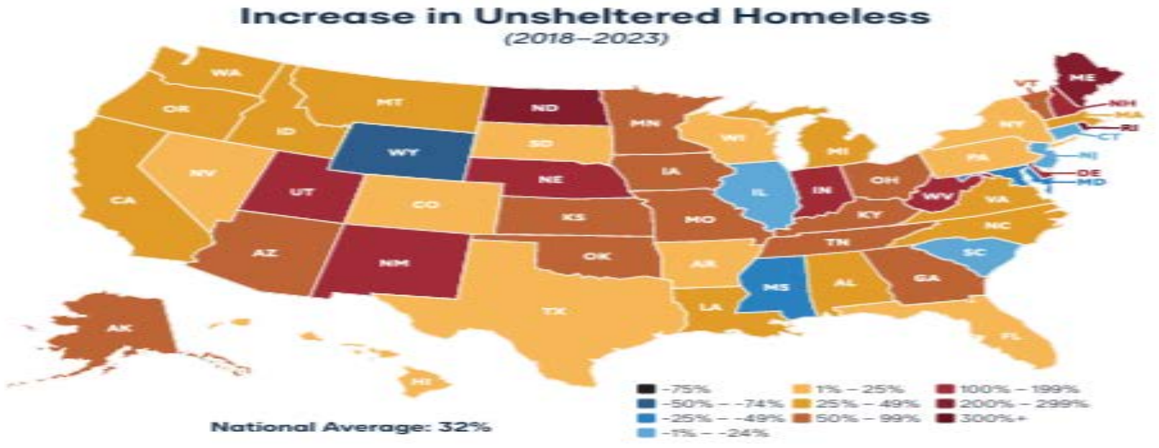
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COMMUNITY-LEVEL SOLUTIONS TO BETTER ADDRESS HOMELESSNESS

Conduct program evaluations and performance audits of organizations that receive funds to serve homeless populations.
These audits will offer local policymakers an overview of what is currently being spent and from what sources; what data are collected in relation to those programs; what outcomes these programs have achieved; and identify gaps in services, data collection, and performance evaluations.

This is an essential starting point for effective state-level policymaking to address the shortcomings of the federal approach, and states already have a model example in Georgia, which has led the effort by instituting audits of state-funded homelessness programs.

Using the information from performance audits, policymakers can develop community-level data collection that is tailored to the needs of their communities and the metrics that are important indicators of success.

Unsheltered homelessness is a distinct category of homelessness made up of people who are not sleeping in shelter spaces but in tents, cars, RVs, and makeshift shelters.

These unsheltered homeless individuals face significant challenges compared to sheltered homeless individuals. And over the last five years, their challenges have gotten much worse.

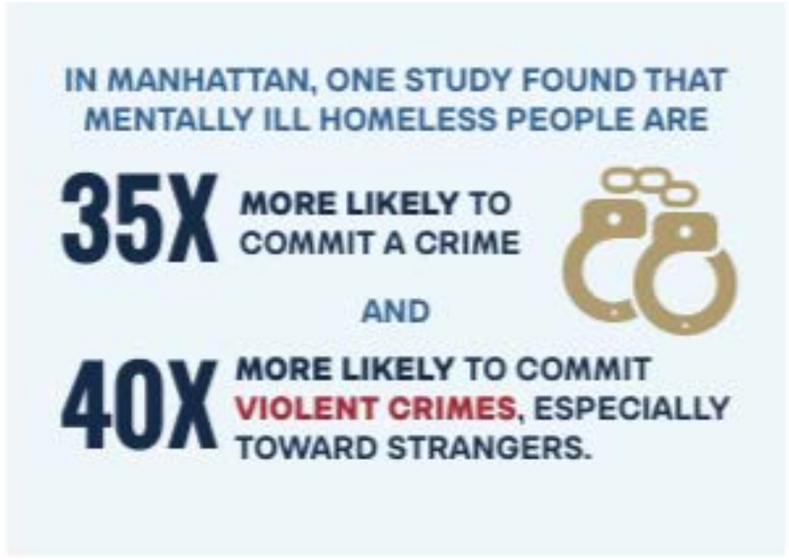
Since 2018, the likelihood of a homeless person with severe mental illness being without shelter has grown by 76 percent; among homeless people who use substances, the proportion without shelter has increased by 119 percent.

The conditions unsheltered individuals are exposed to are dangerous for themselves and the community more broadly.

The prevalence of crime, mental health and substance abuse disorders, and incarceration among the homeless population is staggering.

In Manhattan, one study found that mentally ill homeless people are 35 times more likely to commit a crime and 40 times more likely to commit violent crimes, especially toward strangers.

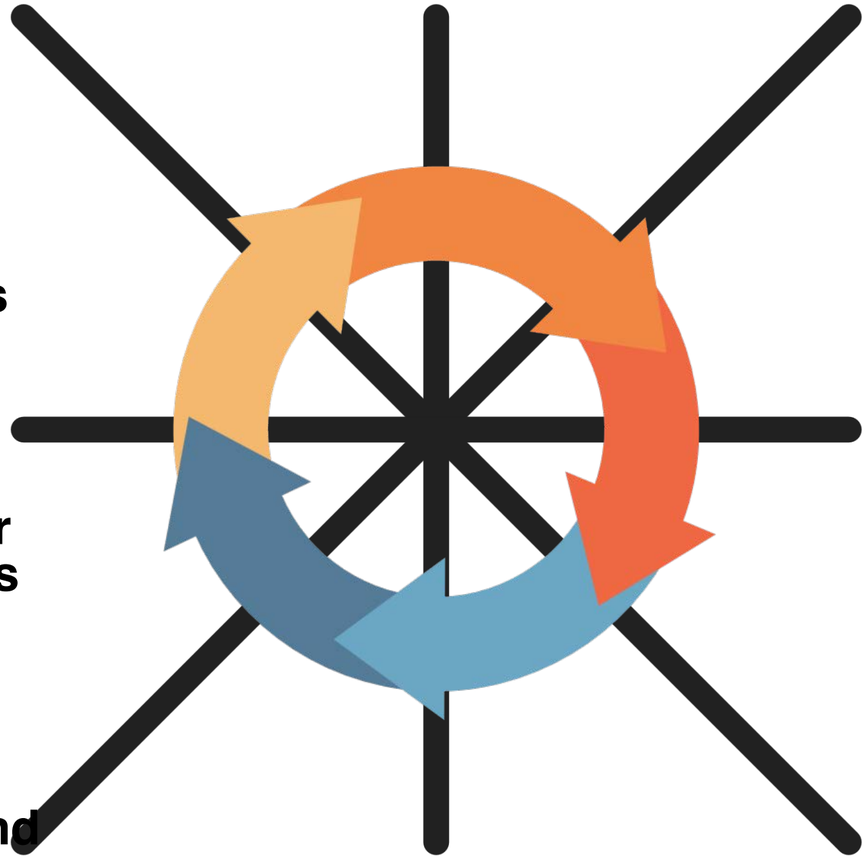
The San Diego County District Attorney's office found homeless individuals were 514 times more likely to commit a crime than the average citizen, and in 98% of cases, a homeless offender is a repeat offender.



Root Cause Analysis within our Community

Review Community Data

Direct Mental Health Funding Towards Homelessness



Get Creative and Back to Basics

1. Rebuild Transitional Housing Capacity
2. Create Accountability
3. Fund alternatives to Housing First to determine efficacy for those with significant barriers to housing

Identify Safe and Affordable Housing, setting up metrics that address entry & sustainability

Utilize Homeless Diversion Programs to Mandate Shelter and Treatment/Services

Improve Involuntary Commitment Procedures for those with Mental Health and Substance Use needs & Improve 988 Community level resources and stabilization

Expand Shelter and Transitional Capacity in High Need Areas

WE NEED LESS BARRIERS TO SERVICES AND TREATMENT-ADDRESSING NEEDS

The severe individual health risks correlated with unauthorized street camping and unsheltered homelessness warrant healthcare interventions.

Many homeless individuals, whether unsheltered, in an emergency shelter, or in a designated encampment, struggle to access healthcare due to the communications, scheduling, and transportation barriers involved. One alternative mode of care is street medicine, which brings healthcare providers to patients instead of requiring patients to visit a traditional office.

Street medicine is still fairly limited in the United States and is typically funded with grants that often lack stability and reliability.

The Centers for Medicare and Medicaid Services recently included street medicine as a covered service with Place of Service Code 27 (“outreach site or street” billing code).

States can now implement this change through a state plan amendment or bulletin to providers. This change can promote medical care through street medicine for those who have difficulty accessing care while homeless. Street medicine is an important tool for determining the level of acuity in unsheltered individuals. For those identified as high-acuity (their condition is severe and imminently dangerous), street medicine staff can be instrumental in providing a clinical foundation for court-ordered treatment, assisted outpatient treatment, and the administration of long-acting antipsychotics to stabilize health.

DISRUPTING THE PRISON-TO-HOMELESSNESS PIPELINE

Roughly half of people in homeless shelters have been to prison, with one in five having left within the last three years.

People who have recently been released from prison have a higher risk of becoming homeless than any other group in America. Within the first two years of release, approximately 11.4 percent of those exiting prison use a homeless shelter, with the greatest portion experiencing homelessness within their first 30 days post-incarceration.

Prisons provide minimal support and transitional services to ex-inmates, and those that do offer help have little incentive to deliver these services effectively to improve outcomes for their “clients.” It is no surprise, then, that more than one-quarter of the formerly incarcerated experience “a trajectory of persistent desperation and struggle, [with] frequent periods of homelessness and housing instability.”

The pay-for-success models can be applied to re-entry housing for individuals leaving prison.

- Rewarding organizations that support better outcomes for people leaving prison while holding organizations accountable for bad outcomes can disrupt both cycles of crime and the pipeline from prison to homelessness.
- Stabilizing former offenders at extremely high risk of homelessness should be a top prevention strategy for states.
  - Pennsylvania successfully implemented outcome-based contracts for their community corrections providers in 2015, seeing substantial reductions in recidivism following the implementation of new contracts.

GILROY, LEONARD, “PAY FOR SUCCESS CONTRACTING REDUCING RECIDIVISM IN PENNSYLVANIA.” REASON FOUNDATION. AUGUST 31, 2015. HTTPS://REASON.ORG/COMMENTARY/PENNSYLVANIA-CONTRACT-RECIDIVISM/

TODAY, OUR MENTAL HEALTH CARE SYSTEM IS FRAGMENTED, UNDERFUNDED, DIFFICULT TO NAVIGATE, AND LACKS ACCOUNTABILITY.

MENTAL ILLNESS OFTEN RESULTS IN A VICIOUS CYCLE OF POVERTY, HOMELESSNESS AND INCARCERATION.

JAILS ARE THE LARGEST PROVIDERS OF MENTAL HEALTH SERVICES IN THIS COUNTRY.

The Tulsa County Jail is supposed to be a facility where individuals arrested for violating the law, awaiting court or transportation to the Department of Correction are housed.

- **Already the largest mental health facility in the state of Oklahoma, neither the mental health program nor the facility was meant for long term treatment.**

As a result of the failed state of mental health care in Oklahoma our jail has been forced to respond to the increasing needs of inmates with serious mental illness.

2017-MENTAL HEALTH PODS OPENED

- MAX CAPACITY- 100
- Levels 1-4
- Staffed with Crisis Intervention Trained (CIT) Detention Officers.
- Psychologist/Psychiatrist
- Discharge Planner

2019- States first Jail-Based Medication Assisted Treatment (MAT)

- Vivitrol, Suboxone, Subutex

GOALS-

- 1. Reduce number of people with mental illness booked into the Jail.
- 2. Shorten the average length of stay for people with mental illness.
- 3. Increase the percentage of connections to care and alternatives to incarceration for those with mental illness.
- 4. Reduce Recidivism rates.

TULSA COUNTY SHERIFF'S MENTAL HEALTH UNIT:

Works closely with mental health court.

1. Mental Health pick-ups
2. Identification of repeat offenders.
3. Welfare Checks.
4. Transportation to essential appointments.

Law enforcement can no longer shoulder the responsibility of treatment and response to the mental health crisis in Oklahoma. The agency (ODMHSAS) that is statutorily obligated and funded (half a billion annually) needs to have an external audit, have true accountability, and do the fundamental job that they were created to do.

We must see relief in the form of long-term treatment facilities, proper accountability and funding of mental health treatment and a substantial increase in public mental health beds and community services.

Until the State of Oklahoma makes the commitment necessary to address the increasing needs of those suffering from mental illness the human, social, and economic impact will be devastating.

FAILURE TO TREAT

In 1960 the Oklahoma population was 2,328,284 and had 6,400 public mental health beds in the state. This is 275 beds for the mentally ill per 100,000 people.

In 2020 the Oklahoma population was 3,959,353 and had 559 public mental health beds in the state. This is 14.1 beds for the mentally ill per 100,000 people.

We need accountability for the spending at ODMHSAS.

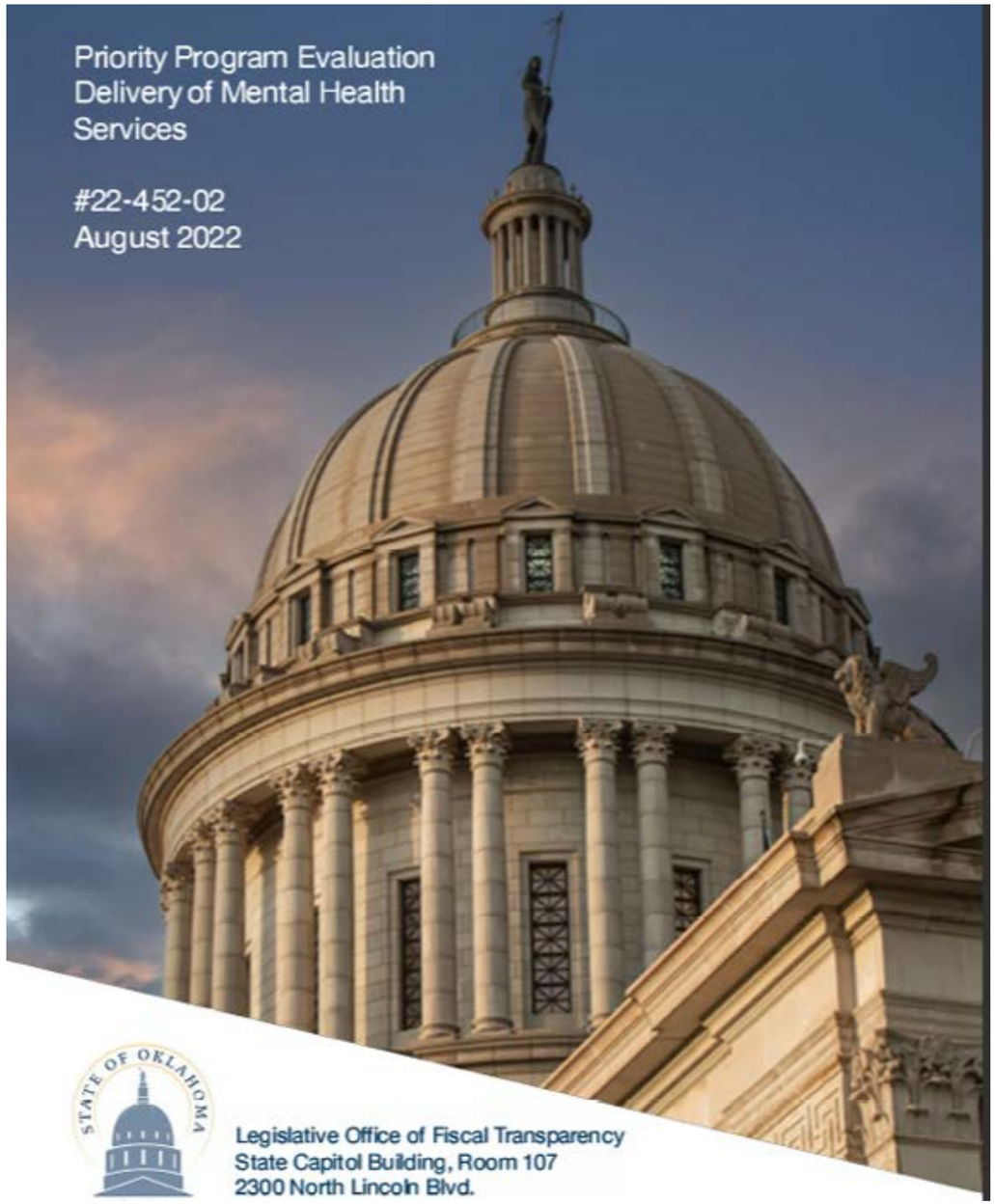
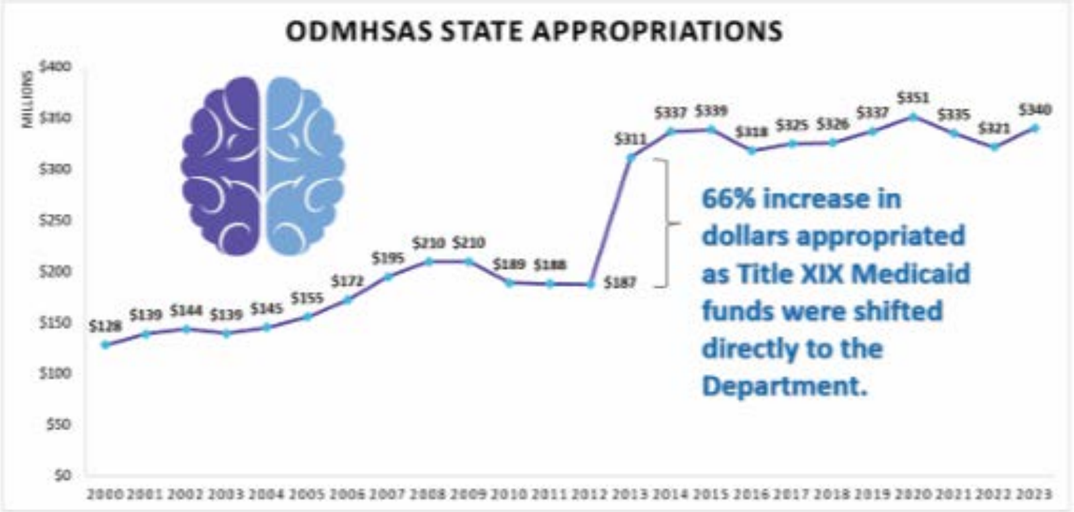


Exhibit 4: ODMHSAS State Appropriations Historical Trend. *(This line chart illustrates the historical trend of State appropriations allocated to the Department of Mental Health, by Fiscal Year.)*



Source: Oklahoma Senate appropriations reports.
Note: State appropriations increase from FY12 to FY13 is attributed to the transfer of Behavioral Health from the Oklahoma Health Care Authority (OHCA) to ODMHSAS. Approximately 112,000 Oklahomans received Medicaid only services through the Health Care Authority in FY'12. There was a $118 million State appropriations increase due to this transfer of responsibilities.
Note: In FY16 the Department was originally appropriated $340,691,561, but did not receive the entirety of funding due to the declaration of two revenue failures.

We must demand accountability of expenditures, including salaries and contracts for the very top of ODMHSAS.

We must demand that the Counties and cities stop shouldering the financial burden, while ODMHSAS maintains their budget.

2025 Legislative Session: ODMHSAS' budget request is $592.4 million (an increase), yet our mental health system continues to be broken and is now worse than ever before.

WHEN A PERSON IS FOUND INCOMPETENT AND REQUIRING TREATMENT.

TITLE 22. 1175.6A

RELEVANT LANGUAGE:

THE COURT SHALL FURTHER ORDER THE DEPARTMENT OF MENTAL HEALTH TO TAKE CUSTODY OF THE INDIVIDUAL AS SOON AS A FORENSIC BED BECOMES AVAILABLE, UNLESS, **BOTH** THE DEPARTMENT AND THE COUNTY JAIL WHERE THE PERSON IS BEING HELD, DETERMINE THAT IT IS IN THE BEST INTERESTS OF THE PERSON TO REMAIN IN THE COUNTY JAIL.

It is **NOT** in the persons best interest to languish in JAIL, they must be moved to a treatment environment and receive the **court-ordered** competency restoration services **AND it is ODMHSAS' job to ensure this happens.**

TULSA COUNTY JAIL IS CURRENTLY HOLDING 52 INDIVIDUALS AWAITING COMPETENCY RESTORATION.

I BELIEVE AS DO MANY EXPERTS IN THE FIELD THAT THESE PEOPLE BELONG IN A STATE HOSPITAL NOT A COUNTY JAIL.

THEY HAVE **NOT** BEEN CONVICTED OF A CRIME AND ARE SIMPLY AWAITING TRIAL.

A HOSPITAL OFFERS THEM GREATER FREEDOM OF MOVEMENT, A STAFF OF MEDICAL PROFESSIONALS COMMITTED TO PROVIDING TREATMENT RATHER THAN MERE DETENTION. IT ALSO PROVIDES FOR ACCESS TO PROGRAMS SUCH AS GROUP AND INDIVIDUAL THERAPY.

THANK YOU

CONTACT INFORMATION AVAILABLE