

PROTECTING OUR COMMUNITIES

ALL NEIGHBORHOODS NEED HEALTH-CENTERED
APPROACHES TO BE SAFE AND JUST



**DRUG
POLICY
ALLIANCE.**

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PROTECTING OUR COMMUNITIES

ALL NEIGHBORHOODS NEED HEALTH-CENTERED APPROACHES TO BE SAFE AND JUST

A toolkit to help advocates understand recent trends in health, houselessness, crime, and enforcement and needed responses to support communities.

**DRUG
POLICY
ALLIANCE.**

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EXECUTIVE SUMMARY

We all want healthy and safe communities. The safest places in America have access to the things people need to thrive, such as jobs, education, housing, and health care. They do not have more police, more jails, more prisons, or harsher sentences. We need to fully fund what is proven to create safer, thriving neighborhoods.

Yet a small but vocal contingent continues to call for more criminalization, coercive interventions, and to disappear people who are struggling, instead of investing the resources communities need. Let's be clear: Long-term underinvestment in public health systems; the dismantling of programs that ensure people can access housing, food, healthcare, and other basic needs; the criminalization of social issues; and the systemic segregation and marginalization of people of color (and particularly Black people) have all fueled several concurrent crises. Communities across the country are facing worsening health outcomes, increasing poverty, and visible houselessness. These problems, along with misleading media reports, have fueled a frenzy over so-called rising "public disorder."

There is no denying that these are serious challenges, but we know what works, and we have the power to address these challenges in productive and positive ways. Elected officials, advocates, and community organizations must come together at all levels of government to adopt health-centered approaches that address root causes and systemic challenges and barriers to ensure healthy and safe communities for all residents.

THIS TOOLKIT PROVIDES ADVOCATES WITH:

- data on recent trends in health, houselessness, crime, and enforcement
- recommendations to address intertwined crises through health-centered policy responses
- information on how to fund health-centered responses

We hope that advocates will use this toolkit as a resource to partner with their local and state governments to move away from harmful and wasteful criminalization and toward health-centered approaches. It is past time we invest in communities with the services and supports that are needed, that recognize people's humanity, and undo the systemic, racist policy failures that have led us to this point.

UNDERINVESTMENT IN PUBLIC SYSTEMS IS IMPACTING HEALTH, HOUSELESSNESS, AND CRIME

After decades of underinvestment in public systems¹ and the social safety net², whole communities are suffering the consequences. In the last two years, many parts of the country have experienced historic increases in alcohol, drug, and suicide deaths.³ In the last five years alone, the unsheltered houseless population has

30%

In the last five years alone, the unsheltered houseless population has expanded by 30%.⁴

expanded by 30%.⁴ And a spike in homicides in 2020 created sensationalized headlines claiming that a “crime wave” was either already occurring or was imminent.⁵ In reality, though, the overall rate of major crimes – a broad category that includes various violent and property crimes such as rape, armed assault, robbery, burglary, car thefts, and murder – actually fell.⁶

Structural racism is at the root of this underinvestment, which continues to exclude people of color from the same access as white people to basic human needs like education, employment, housing, and health care – while disproportionately exposing people of color to abuse, violence, arrest, prosecution, incarceration, and illness.⁷ We must demand thoughtful and cautious policy responses and public investments – not knee-jerk reactions to double down on “tough-on-crime” policies. Indeed, research has shown that opting against prosecution for minor misdemeanors, for example, actually reduces the likelihood of a new criminal complaint over the next two years *with no apparent increase in local crime rates*.⁸

AMERICAN VOTERS CONTINUE TO OVERWHELMINGLY EMBRACE AN APPROACH THAT TREATS SUBSTANCE USE DISORDER AS A PUBLIC HEALTH RATHER THAN A CRIMINAL ISSUE.



SEVEN HEALTH-CENTERED APPROACHES POLICYMAKERS CAN SUPPORT TO MAKE COMMUNITIES SAFER AND HEALTHIER

Recommended policy responses include creating and fully resourcing community response programs to crises, scaling up harm reduction programs, decriminalizing poverty and homelessness, realizing the vision of community-based mental health care, expanding *voluntary* access to quality addiction and recovery services, and expanding access to affordable and supportive housing – all while emphasizing individual safety, dignity, and agency. Specifically, communities should:

1. CREATE AND FULLY RESOURCE COMMUNITY RESPONSE PROGRAMS

Police encounters with vulnerable populations – including unhoused people and people with mental health disabilities* – often end in use of force, arrest, or even death. Communities should minimize law enforcement engagement where it can do more harm than good by creating civilian response programs to respond to calls related to mental health, substance use, and homelessness crises that do not require a law enforcement response.¹⁰ When designed properly, community response programs can significantly reduce law enforcement contact with over-policed and marginalized communities – including people of color, people living in poverty, people with mental health disabilities, people who use drugs, and unhoused people – while substantially reducing costs and improving both public safety and public health outcomes.¹¹

2. EXPAND AND BETTER FUND HARM REDUCTION PROGRAMS

Communities should dramatically expand harm reduction programs to protect individuals against overdose and other potential harms of drug use – and to increase connection to other systems of support. Harm reduction services include provision of sterile drug use equipment, including syringes and pipes; health and safer use education, including overdose prevention education; distribution of



* "Mental health disabilities" is the preferred term of many mental health and disability justice advocates and is intended here to encompass what people may refer to broadly as mental health issues or conditions or more specifically as psychiatric diagnoses or people in acute mental health crises.



naloxone; hepatitis C (HCV) and HIV prevention and testing; operation of overdose prevention centers where people can bring pre-obtained drugs to use under medical supervision; medical and mental health care; distribution of hygiene kits; connections to social services; and advocacy. While criminalization increases these risks of drug use harm reduction services reduce risky behavior and improve health outcomes.¹² Crucially, harm reduction services are delivered without judgment, emphasizing an individual's autonomy and agency over their own lives.¹³ These programs are cost-effective and have been proven to reduce negative health outcomes.

3. DECRIMINALIZE POVERTY AND HOUSELESSNESS

Communities should end the criminalization of poverty and houselessness and the widespread, racialized enforcement of so-called "quality of life" offenses (including loitering, panhandling, and sleeping in public spaces). Criminalization has devastating consequences for individuals and whole communities – and, because of racially targeted enforcement, criminalization and its consequences are experienced most harshly by people and communities of color, and especially Black people and communities. Being arrested for even a minor misdemeanor offense has significant negative impacts on employment, housing, education, and the likelihood of being arrested and/or convicted in the future. And research has shown that among individuals who are not arrested for "quality of life" offenses, less than 1% go on to commit any crime relevant to public safety, refuting the commonly held notion that criminalizing poverty effectively targets people who commit violent offenses.¹⁴ Instead of criminalization, communities should shift to supportive services that address root causes without creating additional harms.

Among individuals who are not arrested for “quality of life” offenses, less than 1% go on to commit any crime relevant to public safety.

4. REALIZE THE VISION OF COMMUNITY-BASED MENTAL HEALTH CARE

Communities across the country must improve access to and the quality of community-based mental health care available to all residents. Communities need comprehensive crisis response systems – including call centers, community response teams, and community crisis stabilization centers – as well as strategies and systems to connect people to ongoing care based on the assessed needs of the individual.¹⁵ Investments in a community’s capacity to provide preventative and ongoing care in people’s homes and communities will improve health outcomes, while reducing the damaging and costly cycling of people with mental health disabilities in and out of jails, emergency rooms, hospitals, and shelters.¹⁶

5. EXPAND ACCESS TO AND QUALITY OF ADDICTION AND RECOVERY SERVICES

Communities should increase evidence-based addiction and recovery services and remove barriers to access, so that anyone who wants help is able to access quality treatment that works for them *when they want it*. Not everyone who consumes alcohol or other substances does so problematically,¹⁷ and not everyone with a substance use disorder will need or desire help.¹⁸ However, there are many people who do want help who do not get it. Communities need to address the range of barriers to addiction services that people now face, including stigma, affordability/lack of insurance, program accessibility, transportation issues, and waiting lists. Another significant focus should be to reduce barriers to and expand access to gold-standard addiction

services – including medications for opioid use disorder (MOUD) and contingency management (CM) for stimulant use disorder – in the community and particularly in communities of color, where the best treatments are least available.

6. INCREASE VOLUNTARY SUPPORTIVE SERVICES

Communities must not force people into addiction services against their will. Experience and research are clear: A policy of compulsory drug treatment does more harm than good.

IN THE CRIMINAL LEGAL SYSTEM, COERCED TREATMENT HAS BEEN LINKED TO HARMS INCLUDING INCREASED INCARCERATION, INADEQUATE OR INAPPROPRIATE PROVISION OF ADDICTION SERVICES, AND RACIALLY DISPARATE INCREASES IN DRUG ARRESTS.¹⁹

At the same time, involuntary civil commitment is linked to heightened risk of severe withdrawal, relapse, and opioid-involved mortality.²⁰ And, despite being an effort to reduce the criminalization of people with substance use disorders, civil commitment may not reduce the likelihood of future incarceration.²¹ Finally, coerced treatment subjects already vulnerable people to institutional control, which brings the very real risk of abuse and mistreatment. Instead of being coerced into addiction services, people should be offered a range of options and support – and empowered to make decisions about their own care.²²

7. EXPAND ACCESS TO AFFORDABLE AND SUPPORTIVE HOUSING

Communities must expand supports that both help people stay housed in the first place and create more pathways to move unhoused individuals into housing with any necessary supportive services, while respecting their safety, dignity, and agency. As communities work to increase their affordable housing stock over the long term, they can immediately enact several proven strategies to

help people and families at risk of homelessness to stay in their homes, including subsidies and eviction protections. To address the needs of the most vulnerable, many of whom currently live unsheltered on the streets, communities should significantly expand permanent supportive housing using a Housing First approach, which offers housing without preconditions like abstinence or treatment participation.²³

CONCLUSION: POLICYMAKERS MUST PRIORITIZE A HEALTH-CENTERED APPROACH, NOT MORE CRIMINALIZATION

Systemic policy failures have led us to where we are now. The overdose crisis and worsening health outcomes, growing homelessness and poverty, and the perception of increasing crime will not be quickly solved. However, doubling down on the very policies that gave rise to these conditions while expecting a different outcome is certain to

compound them. We know much about how to respond to these crises most effectively – and how not to. Especially at this time of crisis, we must avoid knee-jerk reactions that fall back on the failed approach of criminalization. A health-centered approach that recognizes and respects human dignity and individual agency will create healthier and safer communities for all residents.



INTRODUCTION: PUBLIC POLICY MUST ADDRESS ROOT CAUSES OF HOUSELESSNESS AND CRIME, NOT CRIMINALIZE MORE PEOPLE

We all want healthy and safe communities. As this toolkit will show, recent trends – including the ongoing overdose crisis and increased visible houselessness – present challenges that, though immense, can and must be addressed through wise public policy and investments in health-centered strategies.

Many people instinctively understand this. As original public opinion research presented in this toolkit shows, even during concerns about rising houselessness and crime, voters continue to believe that the drug war has failed and that punitive drug laws worsen – rather than solve – these challenges. Voters overwhelmingly embrace an approach that treats substance use disorder as an issue of public health rather than criminal justice.

Public policy must address the root causes of rising houselessness and crime. This toolkit provides several approaches to addressing both immediate responses to behavioral health emergencies and the overdose epidemic, as well as longer-term solutions to the lack of adequate public health services, mental health care, addiction services, and affordable housing that so many communities are now struggling with.

We must not make the same mistakes of the past.

WE KNOW THAT CRIMINALIZATION, INCARCERATION, AND INSTITUTIONALIZATION WORSEN OUTCOMES FOR INDIVIDUALS, FAMILIES, AND COMMUNITIES.

It is time to focus on real solutions to societal challenges, not punishment for individuals suffering societal neglect.

UNDERINVESTMENT IN PUBLIC SYSTEMS IS IMPACTING HEALTH, HOUSELESSNESS, AND CRIME

After decades of underinvestment in public systems and the dismantling of the social safety net, whole



communities are suffering the consequences: worsening health, increasing poverty and houselessness, and gun homicides. Undergirding these trends is structural racism, which means even more hardship for people of color, especially Black people, than white people. These trends demand thoughtful and cautious policy responses and public investments – not knee-jerk reactions to double down on “tough-on-crime” policies.

If we have learned anything from the drug war, it is that criminalization exacerbates, rather than improves, public health and social problems – and disproportionately harms people and communities of color – while consuming public resources that could be used more effectively to address root causes. Responding to cities’ current challenges through increased criminalization moves us in the wrong direction. Instead, cities must act to address root causes of these public health and social problems by implementing some of the many health-centered approaches that have been shown to be effective and which are identified in subsequent sections of this toolkit.

TRENDS & IMPACTS

HEALTH TRENDS AND IMPACTS



COVID-19 CONTRIBUTED TO INCREASED ALCOHOL, DRUG, AND SUICIDE DEATHS

In addition to infecting many millions of people and taking the lives of 1.1 million as of January 2023,²⁴ the Covid-19 pandemic has had a significant negative impact on mental health in the United States.²⁵ In the last two years, many parts of the country experienced historic increases in alcohol, drug, and suicide deaths.²⁶ Drug overdoses, driven by both increased social isolation and an increasingly toxic drug supply, accounted for 106,699 deaths in the U.S. in 2021, up more than 14% from 2020,²⁷ a year that itself saw a 30% increase.²⁸ Another estimated 476,446 people died of suicide nationwide in 2021, up 4% from a year earlier²⁹ and up 31% over the last 20 years.³⁰ Driven primarily by Covid-19 and overdose deaths, life expectancy in the U.S. is now the lowest it has been in two decades.³¹

LACK OF HEALTH INSURANCE REMAINS A BARRIER TO LIFESAVING CARE

Although more people have gained access to health insurance in the U.S. in the last decade, the lack of health insurance remains a major barrier to accessing quality health care services

106,699

drug overdose deaths in the U.S., driven by both increased social isolation and an increasingly toxic drug supply in 2021.²⁸

that could help tackle these trends. Following the implementation of the Affordable Care Act (ACA), the proportion of nonelderly adults lacking health insurance fell from 20.5% in 2013 to 12.3% in 2017.³² In states that elected to expand Medicaid eligibility (newly allowed under the ACA), uninsured rates fell by 49%. In states that did not expand Medicaid, uninsured rates fell by 27%. The biggest absolute reductions in uninsured rates occurred among Hispanic*, Black, and lower-income, nonelderly adults in Medicaid expansion states.³³ Despite these improvements, many adults remain uninsured or under-insured (including those lacking continuous or adequate insurance and/or those whose out-of-pocket costs exceed what they can afford), and the uninsured/under-insured rate among Black and

* While our preferred term is "Latinx," we use the term "Hispanic" throughout this toolkit where the original data sources do so.

Hispanic people is substantially higher than the rate among white people.³⁴

80-90%

Social determinants of health are estimated to contribute as much as 80–90% to a person's health outcomes, while traditional health care accounts for just 10–20%.³⁸

LACK OF FOOD SECURITY, EMPLOYMENT, EDUCATION, AND HOUSING WORSENS HEALTH OUTCOMES

The social and economic crises brought on by the pandemic, coupled with barriers to mental health and addiction services as well as racial disparities in access to treatment, put people in need at particular risk.³⁵ The pandemic also exacerbated a decades-long underinvestment in social determinants of health, including safe and affordable housing, employment, food security, quality education, and health care.³⁶ These and other non-medical factors – including race, income, and geography – have a major influence on individual and community health.³⁷ Indeed, social determinants of health are estimated to contribute as much as 80–90% to a person's health outcomes, while traditional health care accounts for just 10–20%.³⁸

POVERTY WORSENS HEALTH OUTCOMES

One fundamental social determinant of health is economic stability, including poverty.³⁹ After falling for five years, the U.S. poverty rate increased to 11.4% in 2020, to a total of 37.2 million people.⁴⁰ In 2021, the rate held mostly flat at 11.6% (37.9 million people).⁴¹ An individual was considered impoverished in the U.S. in 2021 if their income was below \$12,880, and a family of four qualified as impoverished if their income was below \$26,500.⁴² In high-cost cities, even families

who make substantially more will struggle to meet their basic needs. People living in poverty are much more likely to experience negative health impacts.⁴³ Complicating these challenges, this population is also less likely to have access to health care.⁴⁴

ACROSS THEIR LIVES, PEOPLE LIVING IN IMPOVERISHED COMMUNITIES ARE AT INCREASED RISK FOR MENTAL HEALTH DISABILITIES, CHRONIC DISEASE, HIGHER MORTALITY, AND LOWER LIFE EXPECTANCY.⁴⁵

RACISM WORSENS HEALTH OUTCOMES FOR NATIVE AND BLACK PEOPLE

Due to the historical and ongoing legacy of structural racism, people of color are much less likely than white people to have access to health care and much more likely to be living in poverty.⁴⁶ As a result, health outcomes are substantially worse for people of color than for white people.⁴⁷ This trend worsened during the pandemic. As of mid-2022, American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, and Black people were still about twice as likely to die from Covid-19 as their white counterparts.⁴⁸ Like Covid-19 deaths, overdose mortality is also marked by extreme racial disparities. In 2015–2020, overdose deaths among Black men and women rose a staggering 213% and 144%, respectively, and Native and Black people now have the highest overdose mortality rates among all racial and ethnic groups.⁴⁹ These rates were doubtless affected by racial disparities in incarceration rates as well as access to medications for opioid use disorder, harm reduction services, and health care. Racism negatively affects mental and physical health both directly and by creating inequities across the social determinants of health.⁵⁰ Any policies aimed at improving health outcomes must intentionally and explicitly address racial disparities.

HOUSELESSNESS TRENDS AND IMPACTS

The unsheltered houseless population is growing rapidly, rising by 30% in the past five years alone.⁵¹ Perhaps contributing to this growth, the number of unhoused people residing in shelters decreased in the same period. This social issue has given rise to a political one: People report that seeing unhoused individuals in their neighborhood makes them feel unsafe.⁵²

HOUSELESSNESS IS A HOUSING PROBLEM, THOUGH ADDICTION AND MENTAL HEALTH SERVICES ARE ALSO NECESSARY

Images of growing tent cities and unsheltered individuals exhibiting erratic behavior understandably invoke calls for increased access to mental health care and addiction services. That is certainly part of the answer: One study of people experiencing unsheltered houselessness found that nearly 80% report having a mental health condition and 75% report having a substance use disorder.⁵³

WHILE ADDICTION AND MENTAL HEALTH MAY LEAD SOME INTO HOUSELESSNESS, THE CHRONIC STRESS RELATED TO LACK OF HOUSING ITSELF LEADS TO ADDICTION AND MENTAL HEALTH DISABILITIES.⁵⁴

That is, addressing addiction and mental health is insufficient to ending houselessness. It must not be forgotten that houselessness is first and foremost a housing problem, driven by a lack of affordable, accessible housing options rather than by drug use or mental health disabilities alone.⁵⁵

INCREASED HOUSING COSTS ARE MAKING PEOPLE AND FAMILIES HOUSELESS

As housing costs have increased, many low-income individuals and families have been priced out of the housing market. An increase of \$100 in the median rent is associated with a 9% increase in the estimated houselessness rate.⁵⁶ Even before the pandemic, from 2014-2018, rising housing costs



\$100

increase in the median rent is associated with a 9% increase in the estimated houselessness rate.⁵⁶

were pushing the number of unsheltered houseless people up dramatically: 25% in California, nearly 50% in Oregon, 80% in Washington, and more than 100% in Colorado.⁵⁷ Rising rents, income inequality, a lack of a social safety net, and the unavailability of affordable housing are all structural-level factors associated with higher rates of houselessness.⁵⁸

PEOPLE OF COLOR BEAR THE BURDEN OF HOUSELESSNESS

Houselessness is disproportionately experienced by Indigenous people and people of color. Native Hawaiians and Pacific Islanders have the highest rate of houselessness (per 10,000 people in the population). American Indians/Alaska Natives have the second highest rate, followed by Black, people who identify as two or more races, and Hispanic people.⁵⁹ While Native Americans represent just 1.3% of the national population, they account for at least 10% of people experiencing houselessness in South Dakota, Alaska, New Mexico, Montana, North Dakota, Oklahoma, and Minnesota.⁶⁰ Nationally, Black people comprise 40% of the unhoused population, despite being only 13% of the general population.⁶¹

BLACK AND NATIVE AMERICANS ARE THE MOST OVERREPRESENTED AMONG PEOPLE EXPERIENCING HOUSELESSNESS, WITH RESEARCH SUGGESTING THE CAUSES INCLUDE BARRIERS TO HOUSING AND ECONOMIC MOBILITY; RACISM AND DISCRIMINATION WITHIN HOUSELESS SERVICES; AND INVOLVEMENT IN MULTIPLE SYSTEMS, INCLUDING THE CRIMINAL LEGAL SYSTEM.⁶²

As has been extensively documented, discriminatory criminal legal policies and practices have historically and unjustifiably targeted Black and Native people in particular, a legacy that continues today.⁶³ This form of structural racism further exacerbates houselessness due to housing policies that exclude people with criminal convictions and more broadly by making it harder to find a place to live, secure a job, or gain access to supportive services.⁶⁴



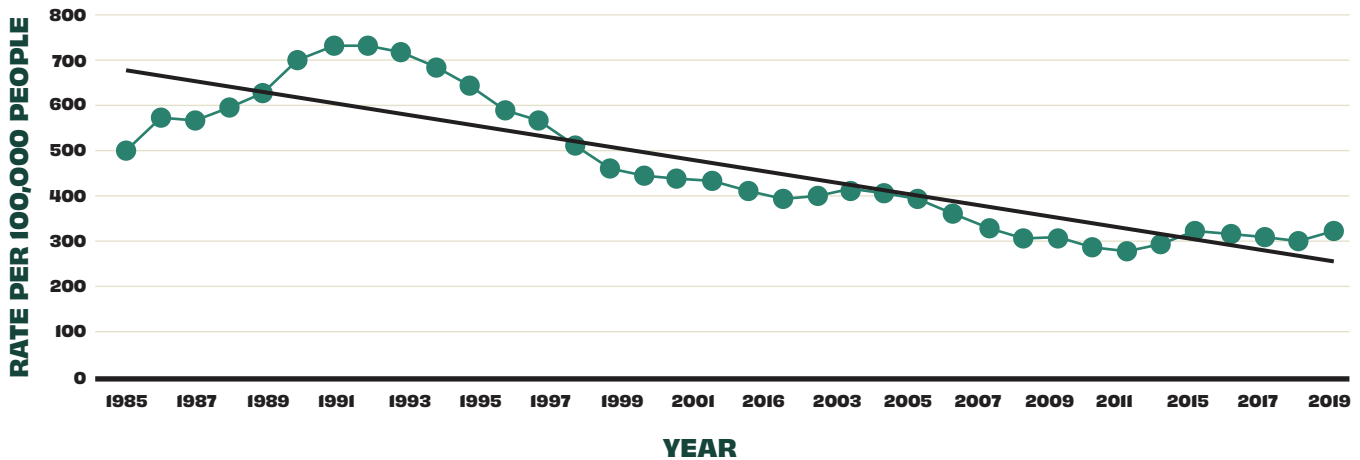
CRIME TRENDS AND IMPACTS

MAJOR CRIME FELL IN 2020, YET THE "CRIME WAVE" NARRATIVE STILL STUCK

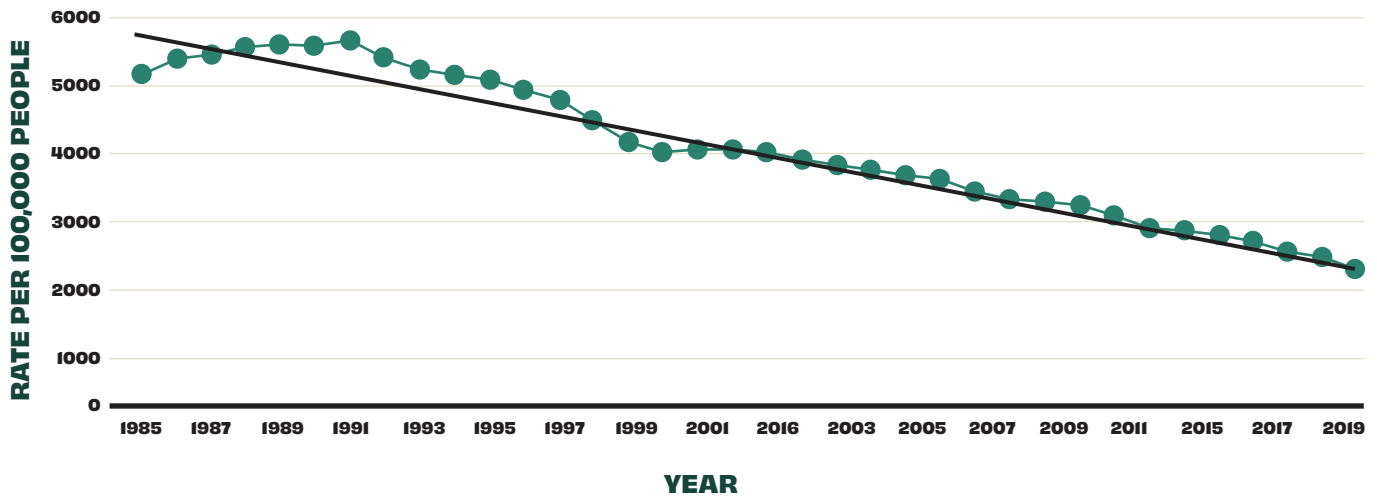
A dramatic rise in homicides in 2020 led to sensationalized headlines claiming that a "crime wave" was either already occurring or was imminent.⁶⁵ But no crime wave materialized. Homicides did rise by a shocking 30% in the first year of the pandemic, and some smaller cities, including Albuquerque, Indianapolis, and Milwaukee, set homicide records in 2020.⁶⁶ The jump in homicides in 2020 was, fortunately, a rarity – the biggest increase in homicides in one hundred years.⁶⁷ However, the overall rate of major crimes – a broad category that includes various violent and property crimes such as rape, armed assault, robbery, burglary, car thefts, and murder – actually fell.⁶⁸

By the end of 2022, according to estimates from the Council on Criminal Justice (CCJ), the trends appeared to reverse themselves. In the 35 American cities included in the CCJ survey, homicides and gun assaults appeared to be decreasing – though the annual gun homicide rate was still up by more than one-third over the 2019 pre-pandemic rate⁶⁹ – and property crimes appeared to be increasing.⁷⁰ Historically, with some annual fluctuations, both violent and property crime have fallen significantly since the 1990s.⁷¹ Nationwide, the percentage of people who experienced rape or sexual assault, robbery, or aggravated assault fell by 68% from 1993 to 2021.⁷² And people in large U.S. cities, including New York and Los Angeles, were close to half as likely to be victims of murder in 2020 than they were in 1990.⁷³

RATE OF VIOLENT CRIME OFFENSES IN THE UNITED STATES: 1985-2020



RATE OF POVERTY CRIME OFFENSES IN THE UNITED STATES: 1985-2020



COMMUNITY DISINVESTMENT IMPACTS CRIME RATES NEGATIVELY

When talking about crime, it is important to understand that not all communities have been impacted equally. The recent rise in gun homicides disproportionately affected the same neighborhoods that have long been experiencing high murder rates.⁷⁴ It is not just that these are impoverished neighborhoods. What they have in common is systemic disinvestment (except in policing), racial segregation, and economic inequality.⁷⁵ These communities need and deserve public investments in effective community-based

responses (for example, violence interrupters⁷⁶) and in the community infrastructure shown to actually keep neighborhoods safe, including quality housing, youth workforce development and employment programs, green spaces, and civic and community-based organizations.⁷⁷

ENFORCEMENT TRENDS AND IMPACTS



POLICE BUDGETS EAT UP \$115 BILLION ANNUALLY

Community calls to redirect public funding from policing into community investment were largely ignored in 2020. Despite widespread community demands to reduce law enforcement budgets in order to increase funding for community-based services, the share of cities' general expenditures going toward policing actually increased in 2021.⁷⁸ Police departments consume a significant portion of city spending, often accounting for 20–30% of city budgets and sometimes substantially more.⁷⁹ Nationally, the cost of policing is a staggering \$115 billion per year.⁸⁰

PEOPLE EXPERIENCING HOUSELESSNESS ARE CRIMINALIZED FOR SURVIVING

As unsheltered houselessness has increased in recent years, states and municipalities have increasingly enacted laws criminalizing activities engaged in largely by people experiencing houselessness and housing insecurity.⁸¹ Nationally, more than 80% of arrests are for low-level offenses.⁸² U.S. laws criminalize relatively common “quality of life” behaviors – including disorderly

\$115B

The national cost of policing is a staggering \$115 billion per year.

conduct, disturbing the peace, possession of small quantities of prohibited drugs, trespassing, and driving without a valid license/registration/insurance – whose root causes often include poverty, mental health disabilities, or addiction.⁸³ People of color, especially Black people, are particularly hard hit by these arrests, due to both their overrepresentation in the unhoused population and racially targeted law enforcement practices.⁸⁴ Rather than reducing these behaviors, criminalization is likely to actually increase their occurrence.⁸⁵

A CRIMINAL RECORD CAN BLOCK PEOPLE FROM EMPLOYMENT, HOUSING, AND OTHER BASIC NEEDS

Involvement in the criminal legal system makes life more difficult for people and their families in many

respects, including negative impacts on employment, education, and the likelihood of being arrested and/or convicted in the future.⁸⁶

FELONY CONVICTIONS COME WITH THOUSANDS OF LIFELONG BARRIERS TO EMPLOYMENT, HOUSING, AND PROFESSIONAL LICENSES, AMONG MANY OTHERS.⁸⁷

Even misdemeanor arrests decrease employment and housing prospects, disrupt daily responsibilities like taking care of children or reporting to one's job, and result in burdensome legal fees.⁸⁸

RESEARCH SHOWS OPTING AGAINST PROSECUTION FOR MINOR MISDEMEANORS REDUCES NEW CRIMINAL ACTIVITY

Recognizing that low-level arrests harm communities, some elected prosecutors have decided not to prosecute them.⁸⁹ Critics predicted the worst. Research has shown, however, that opting against prosecution for minor misdemeanors reduces the likelihood of a new criminal complaint over the next two years *with no apparent increase in local crime rates*.⁹⁰

IN ONE ANALYSIS OF CRIME DATA FROM 35 CITIES WHERE MORE PROGRESSIVE LAW ENFORCEMENT OFFICIALS ENTERED OFFICE, RESEARCHERS FOUND NO SIGNIFICANT EFFECTS OF THEIR REFORMS ON LOCAL CRIME RATES.⁹¹

Research has shown that among individuals who are not arrested for quality-of-life offenses, less than 1% go on to commit any crime relevant to public safety, refuting the commonly held notion that criminalizing poverty effectively targets people who go on to commit violent offenses.⁹² For felony offenses, too, people whose cases were dismissed following a successful completion of probation (referred to as "deferred adjudication") had significantly lower likelihood of future conviction (48%) and higher probabilities of future employment (53%) as well

as higher earnings (64%) compared to people who received traditional felony sentencing.⁹³ The impacts of diversion away from the criminal legal system are lifelong and are particularly impactful among young Black men.⁹⁴

CRIME RATES IN CALIFORNIA HAVE FALLEN OVER THE PAST DECADE AMID MAJOR CRIMINAL LEGAL SYSTEM REFORMS

At the state level, too, evidence suggests that criminal legal system reforms have not led to increased crime. In California, crime rates have fallen steadily over the past decade amid major criminal legal reforms, including some that reduced prison and jail populations and lessened penalties for low-level offenses.⁹⁵ Statewide property crime and violent crime rates have declined by 32% and 29%, respectively, since 2000, while incarceration dropped by 46%.⁹⁶ Meanwhile, California counties that lock up more people per capita experienced twice as many homicides per capita than low-incarceration counties, flying in the face of tough-on-crime rhetoric.⁹⁷ This supports the already robust evidence that incarceration does not decrease recidivism.⁹⁸

POLICYMAKERS MUST PRIORITIZE HEALTH-BASED APPROACHES BACKED BY EVIDENCE, NOT RESORT TO MORE CRIMINALIZATION BECAUSE OF PANIC

Communities are facing serious challenges that demand thoughtful responses. The knee-jerk reaction to ramp up "tough-on-crime" approaches is not the answer. Instead, evidence guides us toward health-centered approaches to these social issues. Only by addressing root causes and systemic challenges will we ensure healthy and safe communities for all residents. In the following sections, this toolkit provides advocates with recommendations to address these intertwined crises through health-centered policy responses, as well as how to fund them.

CREATE AND FULLY RESOURCE COMMUNITY RESPONSE PROGRAMS

When someone is in crisis, we want to ensure that there is an immediate, expert, safe response for that person and those around them. Yet too often, police have become the de facto response for crisis – despite not having the appropriate expertise to deal with noncriminal emergencies, such as acute mental health or intoxication episodes. As such, some of the immense resources directed to law enforcement budgets could be better spent funding non-police crisis response teams that are desperately needed.

CONTEXT

RESEARCH SHOWS NON-POLICE CRISIS TEAMS CAN RESPOND TO THE MAJORITY OF EMERGENCY CALLS CURRENTLY HANDLED BY POLICE

New research suggests that as many as two-thirds of emergency calls involving disorder, mental health, medical, and noncriminal behavior to which police currently respond could instead be handled by mental health crisis experts and other first responders.¹⁰² Many 911 professionals and police officers agree that a range of service calls would be better handled by specially trained civilians.¹⁰³ Across the U.S., a majority of calls to 911 do not require a police, fire, or medical response.¹⁰⁴

16X

People with serious mental health disorders are 16 times more likely than the general public to be killed during a police encounter.¹⁰⁸

Calls related to mental health, substance use, or homelessness crises take up an inordinate amount of law enforcement resources.¹⁰⁵ One study found that, on average *per year*, an unsheltered homeless person comes in contact with police more than 40 times, is jailed 14 times, is admitted to the emergency

room 16 times, and is transported by an ambulance six times.¹⁰⁶ Police encounters with vulnerable populations often end in use of force, arrest, or even death.¹⁰⁷ People with serious mental health disorders, for example, are 16 times more likely than the general public to be killed during a police encounter.¹⁰⁸ And officers responding to an overdose are as likely to make an arrest as they are to administer naloxone to reverse an overdose.¹⁰⁹

Law enforcement generally acknowledge that they do not have the infrastructure necessary to respond appropriately to mental health crisis calls.¹¹⁰ Although some jurisdictions have attempted to equip law enforcement to respond to behavioral health crises (through training and/or attaching a mental health practitioner to a police response), the very presence of uniformed and armed police officers can escalate certain situations, including behavioral health crises.¹¹¹

POLICY SOLUTION

An increasing number of cities are choosing to create emergency response programs staffed by civilians for calls that do not require a law enforcement response.¹¹² Researchers finally asked people with serious mental health disabilities and their family members and friends what they wanted: They overwhelmingly prefer non-police crisis responses over several types of responses that involved police.¹¹³ Community response programs vary in design and scope, but they hold the promise of dramatically reducing law enforcement contact with over-policed and marginalized communities – including people of color, people living in poverty, people with mental health disabilities, people who use drugs, and unhoused people – while substantially reducing costs and improving both public safety and public health outcomes.¹¹⁴ (See Additional Resources below for a model best-practices law: *The Model Behavioral Health Crisis Mobile Response Team Act*.)

RECOMMENDATIONS

1. HOUSE THE PROGRAM OUTSIDE OF LAW ENFORCEMENT

Civilian response programs should not be placed in law enforcement agencies or staffed by sworn officers. Instead, civilian response programs should be housed within a city's civilian public safety department (e.g., New York's Office of Neighborhood Safety), in a local human services department (e.g., Rochester, NY's Department of Recreation and Human Services), or in a county's mental health department (e.g., Los Angeles's Psychiatric Mobile Response Teams). In San Francisco, the Street Crisis Response Team is housed in the Department of Public Health, in collaboration with the Fire Department and the Department of Emergency Management.¹¹⁵ If your city does not yet have an office of neighborhood safety or something similar, consider whether it should.¹¹⁶ What's important is that, similar to how physical health providers respond to physical health emergencies, mental health providers should respond to mental health emergencies rather than responders who are more concerned with the surrounding area or businesses.

2. IDENTIFY FUNDING STREAMS.

According to the Council of State Governments Justice Center, the four most common sources of funds for a community responder program include: the local general fund (a flexible pool of revenue used for many city operations, including policing), a dedicated tax, federal funding, and private grants.¹¹⁷ Other funding strategies could include state and county funding, or a countywide or multi-jurisdictional partnership.¹¹⁸ The National Association of Counties has a useful resource on county funding opportunities.¹¹⁹ Additional federal funding sources may have recently become available through the American Rescue Plan Act and direct appropriations for civilian crisis response.¹²⁰



3. TRAIN OPERATORS TO DIVERT APPROPRIATE CALLS TO COMMUNITY RESPONDERS

Operators involved in the local emergency response system – preferably both 911 and the national mental health and substance use crisis hotline, 988 – must be trained on when to divert calls from a police response to the community response program. Some civilian response programs also publish a non-emergency number and others can also be reached through a non-emergency resource line, such as 211.

4. ENSURE THE PROGRAM IS EQUIPPED TO CONNECT PEOPLE WITH THE LONGER-TERM HELP THEY NEED

According to an analysis by the Alliance for Safety and Justice, a community needs at least 24 working medics, counselors, caseworkers, and administrators for a mobile crisis response unit, as well as community capacity for at least 2,800 referrals to treatment *per 100,000 people in that community*.¹²¹ In later sections of this toolkit, we specify the types of voluntary, evidence-based, harm reduction programs that should be available in every community.



PROGRAM SPOTLIGHTS

PHOTO COURTESY OF CAHOOTS

A COLORADO COMMUNITY RESPONSE PROGRAM LED TO A 34% REDUCTION IN OFFENSES LIKE TRESPASSING, PUBLIC DISORDER, AND RESISTING ARREST.

Community response to mental health crises is likely to lead to less use of force, better connection to services, and fewer arrests, particularly those related to quality of life (e.g, trespassing, public disorder, and resisting arrest).¹²² One review of the Support Team Assistance Response (STAR) program in Denver – which provides a mobile crisis response for community members experiencing problems related to mental health, depression, poverty, houselessness, and/or addiction issues – found that civilian response led to a 34% reduction in offenses like trespassing, public disorder, and resisting arrest, and no evidence of increased offenses like violent crime.¹²³

AN OREGON COMMUNITY RESPONSE PROGRAM SAVES AN ESTIMATED \$8.5 MILLION IN TAXPAYER DOLLARS EVERY YEAR.

The oldest and most evaluated community response program is the Crisis Assistance Helping Out on The Streets (CAHOOTS) program in Eugene, Oregon. Operating since 1989 and managed by the White Bird Clinic, CAHOOTS receives calls either through the city's 911 call system or through non-emergency numbers. In 2021, CAHOOTS responded to roughly 20% of total 911 dispatches, and only called for police backup in 1% of those calls, saving an estimated \$8.5 million in taxpayer dollars every year.¹²⁴

When it receives a call, CAHOOTS first conducts triage to determine the appropriate response. When necessary, CAHOOTS dispatches a two-person team consisting of a medic – either a nurse, a paramedic, or an emergency medical technician – and a trained crisis worker.¹²⁵

CAHOOTS specialists are trained to provide a wide range of services, including wellness checks, behavioral health crisis interventions, substance use-related de-escalation, family conflict

mediation, and first aid.¹²⁶ Critically, CAHOOTS offers connections and transportation to social services to help support clients' long-term needs.¹²⁷

Several programs have attempted to replicate or improve upon the CAHOOTS approach. In San Francisco, for example, the Street Crisis Response Team expanded on the CAHOOTS model and is a best practice by incorporating a peer specialist with lived experience into the team, as well as by following up and connecting clients with services.¹²⁸

ADDITIONAL RESOURCES

- [**Beyond Policing: Investing in Offices of Neighborhood Safety**](#)
- [**The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call**](#)
- [**Community-Based Services for Black People with Mental Illness: Advancing an Alternative to Police**](#)
- [**Developing a Community-Based Emergency First Responders \(EFR\) Program**](#)
- [**Framework for Public Safety**](#)
- [**The Model Behavioral Health Crisis Mobile Response Team Act**](#)
- [**Reform/Transform: Creating a Community Responder Program**](#)

EXPAND AND PROVIDE MORE FLEXIBLE FUNDING FOR HARM REDUCTION PROGRAMS

CONTEXT

We want safety for all people, including people who use drugs, while respecting their bodily autonomy. Harm reduction accepts that drug use is part of our world and always has been and focuses on minimizing its potential harmful effects rather than simply ignoring or condemning people who use drugs.¹²⁹ Harm reduction strategies measure success according to health, social, and economic outcomes, as opposed to only measuring success as complete cessation of drug use.¹³⁰

Harm reduction strategies support drug users in meeting their own goals while helping them identify and overcome barriers to meeting those goals. From a harm reductionist perspective, "recovery" should be defined by the person who uses drugs. Recovery is what they want for themselves (e.g., better managing particular substances or relationship success), and it does not necessarily mean abstinence.

OVERWHELMING EVIDENCE SHOWS THAT HARM REDUCTION STRATEGIES ARE EFFECTIVE AT KEEPING PEOPLE ALIVE AND HEALTHIER THAN THEY OTHERWISE WOULD BE.¹³¹

Adoption and expansion of these evidence-based interventions, however, has been stymied by policy restrictions, opposition from law enforcement, and lack of political and financial support for program implementation and sustainability.¹³²

This is in contrast with the criminalization of drug use, which has failed to reduce drug-related harms while devastating lives, families, and whole communities.¹³³ Unfortunately, the punitive mindset persists, reinforcing stigma around people who use drugs and limiting the expansion of strategies proven effective at reducing the harms associated with drug use.¹³⁴ Meanwhile, the U.S. is experiencing an overdose crisis that continues to worsen.¹³⁵ And

increasing hepatitis C infections and localized HIV outbreaks are linked to a lack of access to sterile syringes and subsequent syringe sharing among people who inject drugs.¹³⁶

POLICY SOLUTION

Harm reduction services include provision of sterile drug use equipment, including syringes and pipes; health and safer use education, including overdose prevention education; distribution of naloxone; hepatitis C (HCV) and HIV prevention; medical and mental health care; hygiene kits; connections to social services; and advocacy. These services reduce risky behavior and improve health outcomes.¹³⁷ Crucially, harm reduction services are delivered without judgment, emphasizing an individual's autonomy and agency over their own lives.¹³⁸

5X

People who recently started using syringe service programs are five times as likely as those who do not to enter treatment and three times as likely to stop using drugs altogether.¹⁴⁰

While not the goal, it turns out that the nonjudgmental harm reduction approach is excellent at getting people connected to addiction services and achieving abstinence, where clients choose to pursue that option.¹³⁹ People who recently started using syringe service programs are five times as likely as those who do not to enter treatment and three times as likely to stop using drugs altogether.¹⁴⁰

Despite robust evidence that harm reduction is effective, these services remain woefully underfunded. While the Centers for Disease Control estimates that even the smallest syringe services



programs require an annual budget of \$450,000, for example, most syringe service programs in the U.S. run on annual budgets of under \$100,000 cobbled together from private funding.¹⁴¹ Some 50 years after President Nixon declared the war on drugs, the Biden administration has finally included a harm reduction component in its federal drug control strategy.¹⁴² While federal funding is now flowing toward these evidence-based, lifesaving programs,¹⁴³ the funding is still *far* too little and too restricted. Federal funds cannot be used to purchase sterile syringes and other drug use equipment, for example.¹⁴⁴ Much more must be done to increase funding at the federal and local levels to end the overdose crisis.

RECOMMENDATIONS

1. PROTECT AND EXPAND ACCESS TO HARM REDUCTION CENTERS, INCLUDING SYRINGE SERVICE PROGRAMS

Without judgment, harm reduction centers offer a wide range of health and support services, including overdose prevention education, naloxone for overdose reversal, HIV/HCV testing, and more – and help connect people to social and health services.¹⁴⁵ Among the most studied of these services is the provision of sterile syringes.¹⁴⁶ As of 2018, there were 320 syringe service programs in 40

states, the District of Columbia, and Puerto Rico.¹⁴⁷ In comparison, there were an estimated 3.7 million people who injected drugs in the U.S.¹⁴⁸ Communities need to be educated on the efficacy of harm reduction centers and, in particular, syringe service programs, which are one of the most scientifically based methods for reducing the spread of HIV and hepatitis – and do not contribute to increased drug use.¹⁴⁹ With adequate funding, most existing syringe service programs could be expanded, made mobile, and/or open 24 hours a day, seven days a week. And additional programs should be established where they can be easily accessed by people who inject or smoke drugs. Law enforcement should give these programs a wide berth: Police should not target syringe service programs or people who visit them for arrest, which only discourages access to their lifesaving supports.¹⁵⁰

2. INVOLVE AND SUPPORT PEERS IN REACHING PEOPLE WHO USE DRUGS

People who use drugs have been central to the development and delivery of harm reduction services from the start and are a critical part of what makes these interventions so effective.¹⁵¹ Peer involvement in HIV and harm reduction programs are essential to effective responses to

the health, social, and political challenges people who use drugs face.¹⁵² Stigma around drug use has limited funding and support for peer involvement.¹⁵³ This is a terrible mistake. Peers are uniquely able to increase levels of trust, safety, and comfort for people who utilize harm reduction services.¹⁵⁴ Advocates and elected officials must provide the political and funding support programs need to involve peers, because they can reach and educate people that institutional professionals cannot. In recognition of their expertise, peers must receive adequate compensation, training, and support.¹⁵⁵ Additionally, policymakers should involve peers and people actively using drugs on municipal task forces and commissions and ensure they have regular input into policy decisions. Harm reduction programs should include people who actively use drugs in the design, implementation, and evaluation of programming.

3. WIDELY DISTRIBUTE NALOXONE AND OVERDOSE PREVENTION EDUCATION

Distribution of naloxone, a medicine that rapidly reverses an opioid overdose, is key to reducing opioid-related overdose deaths.¹⁵⁶ Research recommends that the number of naloxone doses distributed annually should be about 20 times

the number of a region's opioid-related deaths.¹⁵⁷ Anywhere naloxone can be made available, it should be – without a prescription and for free, as out-of-pocket costs for naloxone have skyrocketed.¹⁵⁸ Distribution strategies should ensure they put naloxone in the hands of people most likely to use it: people who use drugs.¹⁵⁹ Many state and local governments are experimenting with naloxone distribution through pharmacies, syringe exchange programs, city and county jails, and even vending machines.¹⁶⁰ School nurses are also pushing for naloxone in schools, as Los Angeles, Des Moines, and Philadelphia are doing.¹⁶¹

4. OPEN OVERDOSE PREVENTION CENTERS

Also known as supervised consumption sites, overdose prevention centers (OPCs) are places where people can bring pre-obtained drugs to use with sterile equipment under the supervision of staff trained and equipped to respond to overdoses and other emergencies.¹⁶² The first such facility was established in Switzerland in 1986, and about 180 sites now operate in 14 countries.¹⁶³ An evaluation of an unsanctioned OPC that operated in an undisclosed U.S. city from 2014 to 2021 found high rates of center use without any overdose deaths.¹⁶⁴ In November 2021, OnPoint NYC opened the first two



government-sanctioned OPCs in the U.S., recording more than 600 overdose reversals in its first year.¹⁶⁵ These sites are an essential strategy for addressing the overdose crisis.¹⁶⁶ In addition to preventing deaths, OPCs can provide people with education; infectious disease testing and treatment; supplies for safer drug use; and connections to withdrawal management care and addiction services, health care, and other social services.¹⁶⁷ OPCs should be places where people can carry and consume drugs without the risk of arrest.¹⁶⁸ These facilities should be common, open around the clock and every day of the week, and allow smoking of substances, not only injecting.

5. CHECK THE DRUG SUPPLY

Because the illicit drug supply is completely unregulated, both sellers and consumers often have limited information about what they are getting.¹⁶⁹ Drug checking empowers drug consumers with information that lets them make positive behavior choices, including not consuming or consuming more cautiously, like starting more slowly or with a lower dosage.¹⁷⁰ In recent years, fentanyl, a synthetic opioid many times stronger than morphine, has saturated the drug supply and, due to policy failures that could address its spread, has pushed overdose rates to historic highs.¹⁷¹ By 2021, fentanyl and other synthetic opioids were involved in 64% of overdose deaths – up from just 4% a decade earlier.¹⁷² Fentanyl is increasingly found in non-opioid substances (including in stimulants like cocaine and methamphetamine and in benzodiazepines like counterfeit Xanax or Valium), posing risks to consumers of a wide range of illicit substances.¹⁷³ At the same time, xylazine, a veterinary tranquilizer, is increasingly common in Puerto Rico and the Northeast U.S.¹⁷⁴ Appropriately, more states are legalizing possession and use of drug checking technologies, and the Biden administration authorized the use of federal funds for drug checking in 2021.¹⁷⁵

Fentanyl test strips are accurate, inexpensive, and easy to use.¹⁷⁶ (Test strips also exist for benzodiazepines but are less common. Test strips for xylazine are just becoming available.¹⁷⁷) They should be made widely available to drug consumers at places people are known to use drugs, including bars, clubs, and festivals, as well as through harm reduction programs, including harm reduction centers, syringe service programs, and overdose prevention centers. Unfortunately, fentanyl test strips can reveal whether a substance contains fentanyl, but not *how much* fentanyl is in a substance. For more complete information, a limited number of programs now use Fourier-transform infrared (FTIR) spectroscopy to detect a variety of licit and illicit substances. Although these machines are small and portable, they cost around \$40,000 each and require extensive training to use – putting them out of reach for many cash-strapped harm reduction programs.¹⁷⁸ Because there are specific advantages to each of these testing strategies, programs should ideally have access to various test strips as well as FTIR testing.



PROGRAM SPOTLIGHT

PHOTO COURTESY OF ONPOINT NYC

IN ITS FIRST YEAR, TWO U.S.-BASED OVERDOSE PREVENTION CENTERS REVERSED NEARLY 700 OVERDOSES.

OnPoint NYC describes itself as the largest harm reduction service provider on the East Coast, distributing and collecting more syringes and other drug use equipment than any other provider.¹⁷⁹ Since the early 1990s, OnPoint NYC has provided a range of services and innovative overdose prevention programs to communities in Washington Heights, East Harlem, and the Bronx. OnPoint NYC operates two drop-in centers; provides sterile equipment and education; conducts in-house clinical services; runs a hotline; and offers various other support services, including mental health services, benefits navigation, advocacy, health navigation, case conference sessions with various providers, drug education groups, individual counseling, and modalities for safer drug use.

642

overdose interventions recorded by the end of 2022 – and no fatal overdoses.¹⁸³

In November 2021, OnPoint NYC expanded its services to open the first two government-sanctioned overdose prevention centers (OPCs) in the U.S. In their first two months of operation, the OPCs were heavily utilized: 613 individuals used OPC services 5,975 times, and staff responded to overdoses 125 times.¹⁸⁰ Visitors were overwhelmingly male; about half were Latinx; and more than one-third were living unsheltered on the streets.¹⁸¹ More than half of visitors received additional support during their visit, including naloxone distribution, counseling, hepatitis C testing, and medical care.¹⁸²

50,000

By the end of 2022, the OPCs had been utilized nearly 50,000 times by just over 2,000 individuals.¹⁸³

By the end of 2022, the OPCs had been utilized nearly 50,000 times by just over 2,000 individuals and had recorded 642 overdose interventions – and no fatal overdoses.¹⁸³ New York City Mayor Eric Adams has called for the OPCs to be open 24 hours a day.¹⁸⁴

ADDITIONAL RESOURCES

- [**Pain in the Nation: The Drug, Alcohol and Suicide Crises and The Need for A National Resilience Strategy**](#)
- [**National Harm Reduction Technical Assistance Center**](#)
- [**Harm reduction therapy: a practice-friendly review of research**](#)
- [**Harm Reduction Is Healthcare: Sustainable Funding for Harm Reduction Programs**](#)
- **For naloxone delivery, visit: nextdistro.org**

DECRIMINALIZE POVERTY, DRUG USE, AND HOUSELESSNESS

CONTEXT

Many of us are concerned with the effects of criminalization on our communities. We know that more arrests, convictions, and incarceration will not solve issues caused by massive disinvestment. Our communities require more investments of funding, services, and other supports to address issues like poverty, public drug use, and houselessness.

19M

individuals in the U.S., including incarcerated people, have been convicted of a felony.

THE U.S. INCARCERATION RATE IS SEVERAL TIMES HIGHER THAN OTHER NATIONS, INCLUDING THE U.K., JAPAN, AND CANADA.

Nearly 6 million people are under the direct control of the criminal legal system in the U.S.: Almost 2 million of them are locked behind bars and 3.7 million of them are under the supervision of a probation or parole officer in the community.¹⁸⁵ Including incarcerated people, some 19 million individuals in the U.S. have been convicted of a felony, and a whopping 79 million have a criminal record of some kind.¹⁸⁶ It does not have to be this way. The U.S. incarceration rate – at 664 per 100,000 population – is several times that of other wealthy nations, including Australia (160), the U.K. (129), and Canada (104), and well ahead of Norway (54), Japan (38), and Iceland (33), for example.¹⁸⁷

AN UNSHELTERED PERSON IN THE U.S. COMES IN CONTACT WITH POLICE MORE THAN 40 TIMES AND IS JAILED 14 TIMES.

The staggering numbers of incarcerated people in the U.S. hide a constantly churning system: At least

4.9 million people are arrested and jailed each year, with 25% of them booked into jail more than once in the same year, for a massive total of 10 million jail admissions per year.¹⁸⁸ One study found that, on average *per year*, an unsheltered houseless person comes in contact with police more than 40 times and is jailed 14 times.¹⁸⁹ The more times a person was arrested, the more likely they were to be from at least one marginalized group, and the more likely that the offenses were low-level.¹⁹⁰

PEOPLE OF COLOR, LGBTQ PEOPLE ARE MORE LIKELY TO BE CRIMINALIZED DUE TO TARGETED ENFORCEMENT AND DISCRIMINATION.

Due to a number of systemic drivers of mass criminalization – including targeted enforcement and disparities in arrest, prosecution, and incarceration – the population under criminal legal system control in the U.S. consists disproportionately of people of color, especially Black people, and members of other marginalized communities, including LGBTQ+ people.¹⁹¹ They are also much likelier than those outside of the justice system to be cash poor, unemployed, lacking a high school diploma, and have mental health and/or substance use disorders.¹⁹²

U.S. LAWS CRIMINALIZE PEOPLE STRUGGLING WITH POVERTY, MENTAL HEALTH DISABILITIES, AND DRUG USE INSTEAD OF HELPING THEM.

U.S. laws criminalize relatively common behaviors – including disorderly conduct, disturbing the peace, possession of small quantities of prohibited drugs, trespassing, and driving without a valid license/registration/insurance – whose root causes often include poverty, mental health disabilities, or drug use.¹⁹³ And while people of all races and ethnicities engage in these behaviors, people of color, and Black people in particular, are much more likely to be arrested due to targeted enforcement and unequal application of the law.¹⁹⁴ Providing social services to



people engaged in these behaviors is likely to be a more effective response, whereas criminalization may actually increase the incidence of these behaviors by further marginalizing people and pushing them away from supports, including access to housing and mental health care.¹⁹⁵ Criminalization is also extremely expensive, swallowing up tax dollars that could be more wisely and productively invested in community supports.¹⁹⁶

POLICY SOLUTION

Involvement in the criminal legal system makes life more difficult for people and their families in many respects, including negative impacts on employment, education, and the likelihood of being arrested and/or convicted in the future.¹⁹⁷

FELONY CONVICTIONS COME WITH THOUSANDS OF LIFELONG BARRIERS TO EMPLOYMENT, HOUSING, AND PROFESSIONAL LICENSES, AMONG MANY OTHERS.¹⁹⁸ EVEN MISDEMEANOR ARRESTS DECREASE EMPLOYMENT AND HOUSING PROSPECTS, DISRUPT DAILY RESPONSIBILITIES LIKE TAKING CARE OF CHILDREN OR REPORTING TO ONE'S JOB, AND RESULT IN BURDENSOME LEGAL FEES.¹⁹⁹

Choosing not to prosecute minor misdemeanors has demonstrated a decrease in the probability of a subsequent criminal complaint within the following two years, without any noticeable rise in local crime rates.²⁰⁰ Similarly, for felony offenses, individuals whose cases were dismissed after successfully fulfilling probation requirements (referred to as “deferred adjudication”) exhibited significantly lower chances of future convictions (48%), along with increased likelihood of future employment (53%) and higher earnings (64%) compared to individuals who underwent traditional sentencing.²⁰¹ These diversionary measures away from the criminal justice system have long-lasting effects, particularly among young Black men, making them highly impactful.²⁰²

RECOMMENDATIONS

I. DECRIMINALIZE DRUG POSSESSION; INVEST IN HEALTH SERVICES.

Decriminalization of drug possession is one of the most immediate steps policymakers can take to reduce the harms of the drug war. Drug arrests are one of the leading causes of arrest in the U.S., with over one million arrests per year, or one arrest every 30 seconds. Over 85% of those arrests are for possession alone, making decriminalization an

urgent priority. Drug possession decriminalization is the removal of criminal penalties for drug possession and personal use law violations. When implemented, people are no longer arrested, prosecuted, deported, or incarcerated for possessing or using small amounts of drugs.

Additionally, drug possession decriminalization efforts can significantly increase funding for needed addiction services, including low-barrier and culturally competent substance use disorder treatment, harm reduction, and recovery support services. Without the fear of arrest and incarceration and without the burden of criminal records – which all lead to dire health impacts and consequences in employment, housing, public benefits, and education sectors – people can better access harm reduction, treatment, and supportive services they may want and need to remain healthy. Support for drug decriminalization is at an all-time high, with a poll by the Drug Policy Alliance and the American Civil Liberties Union (ACLU) finding that 66% of Americans now support eliminating criminal penalties for drug possession and replacing them with a new approach centered in public health.

2. DECRIMINALIZE SEX WORK.

Like drug use, sex work is highly stigmatized, and many of the harms related to sex work occur because of the criminalization of sex work and people involved in the sex trade. Criminalization increases violence against sex workers – especially street-based sex workers; sex workers who use or sell drugs; sex workers of color; and trans and queer sex workers – and cuts people off from services, including health care and harm reduction. Decriminalization of sex work would remove criminal penalties for consenting adults who trade sex, people who collaborate with sex workers, and clients of sex workers, and ultimately keep people safer and healthier.

3. REMOVE CRIMINAL PENALTIES FOR SURVIVAL AND OTHER “QUALITY OF LIFE” BEHAVIORS.

Beyond drug use and sex work, such offenses include public intoxication, jaywalking, fare evasion,

driving without a valid license/insurance, license suspensions, license revocations, blocking sidewalks, loitering and/or other “quality-of-life” crimes, as well as those having to do with unsheltered houselessness, street-level drug selling, and street vending. Research has shown that among individuals not arrested for quality-of-life offenses, fewer than 1% go on to commit any crime relevant to public safety, refuting the commonly held notion that criminalizing poverty effectively targets violent offenders.²⁰³ Instead, people should be connected with resources to meet their basic human needs, including safety, income, food, shelter, bathrooms, menstruation/hygiene supplies, and physical and mental health care.

4. PROVIDE COMMUNITIES WITH ALTERNATIVES TO CALLING THE POLICE.

People call 911 with a range of complaints, a sizable and increasing number of which are not urgent public safety threats but are instead related to noncriminal issues, including behavioral and physical health incidents.²⁰⁴ In July 2022, the national behavioral crisis hotline began operating with a new three-digit dialing code – 9-8-8 – creating an opportunity to change the way communities respond to behavioral crises.²⁰⁵ Local governments should ensure that the hotline is connected to a system of care (not law enforcement) from the initial call to 988, to a mobile response by a team of community responders (not law enforcement), to a location for receiving and stabilizing individuals in crisis, and follow-up care including prevention services.²⁰⁶ Where communities are unable or unwilling to connect 988 to a community responder program, a community responder program should be established with a direct phone line that is widely publicized.

5. CHANGE LAW ENFORCEMENT AND PROSECUTION PRACTICES.

Local governments should implement programs that incentivize or require law enforcement to stop making small-time arrests, especially of unsheltered people for minor misdemeanors and drug offenses. Community response programs can be an important part of changing police behavior by



giving community members and law enforcement an alternative to calling the police or making an arrest.²⁰⁷ Similarly, prosecutors should stop pursuing convictions for minor misdemeanors and instead participate in establishing pathways out of the criminal legal system for people who would benefit from social support services. To be clear, these services should be provided outside of the criminal legal system and with no threat of criminal sanction, lest they *increase* legal system involvement rather than decrease it.²⁰⁸

6. ADOPT, EXPAND, AND PROMOTE GOOD SAMARITAN LAWS.

Fear of arrest is a major disincentive to calling for help in the case of a drug overdose.²⁰⁹ Good Samaritan laws reduce legal penalties for an individual seeking help for themselves or others experiencing an overdose.²¹⁰ By 2021, 47 states and the District of Columbia had enacted some version of a good Samaritan law (excluding Kansas, Texas, and Wyoming).²¹¹ These laws exemplify that removing criminal penalties can improve outcomes, in this case reducing overdose deaths both compared to death rates prior to a law's enactment and death rates in states without such laws.²¹²

In many settings, however, these laws remain narrow and have limited eligibility requirements that can reinforce existing racial and socioeconomic inequities in drug enforcement.²¹³ Good Samaritan laws should be expanded and enforced, so that anyone involved in an overdose incident – regardless of criminal history and drug use/sales involvement – is protected from arrest and conviction and other noncriminal legal punishments (like child removal from treatment programs, etc.). Furthermore, local governments should educate the public about these laws and encourage people to call for help to save lives. City governments should hold law enforcement agencies accountable for adherence to these laws as well as their intent: saving lives.

7. RESIST DRUG-INDUCED HOMICIDE LAWS.

Jurisdictions and prosecutors that choose to respond to overdose by prosecuting "drug-induced homicide" – whereby a person is charged with homicide for providing drugs to a person who later dies of an overdose – are doubling down on a failed approach that does not alleviate the risk of fatal overdoses; is an ineffective deterrent to drug use, drug sales, and overdose deaths; can be legally problematic and consume significant resources;

often targets friends and family members; and worsens racial disparities in the system.²¹⁴

8. ELIMINATE FINE AND FEE TRAPS.

Fines, fees, and other monetary sanctions are the most common form of punishment in the U.S. justice system.²¹⁵ Typically set without regard to a person's income, these sanctions might amount to an inconvenience for a person of means, but they can be impossible to pay for a person living in poverty. When people *cannot* pay, courts often treat them as though they *refused* to pay, and they are subjected to punishments that trap them in a cycle of poverty: incarceration, driver's license suspension, additional fees, and, in some cases, even the loss of the right to vote.²¹⁶ This debt can also stand in the way of clearing a past conviction, limiting employment prospects.²¹⁷ Courts as well as local and state governments should dismantle this trap, eliminating fees where possible and ensuring that no one is ordered to pay more than they are able. The Department of Justice, the American Bar Association, and the Conference of State Court Administrators have all weighed in on how to do this.²¹⁸ Several states have made real progress on this front in recent years, but there is much more to do.²¹⁹

9. END BENCH WARRANTS FOR PEOPLE WHO FAIL TO APPEAR IN COURT FOR MINOR CHARGES OR FOR VALID REASONS.

Even minor misdemeanors that do not normally carry a jail sentence can lead to incarceration when a person misses a scheduled court appearance during what can be an 18-month process of misdemeanor prosecution.²²⁰ Many jurisdictions automatically issue a "bench warrant" when a person fails to appear in court, which many people do because they are in crisis, lack transportation or childcare, or fear losing their job – which could mean going without food, being evicted, or even losing custody of their children. If a person has a bench warrant, it means that any encounter with police could lead to them being booked into jail. Thus, bench warrants push people further to the margins and away from employment, housing, and stability. Courts should end the practice of issuing bench

warrants for failure to appear and should make it easier for people to attend court by providing reminder messages, transportation support, and/or options to attend virtually. In addition to reducing harms related to arrest and conviction, this will dramatically reduce pressure on courts overwhelmed with minor misdemeanors.²²¹

10. END THE INCARCERATION OF PEOPLE FOR NONCRIMINAL BEHAVIOR.

People under the supervision of a court or probation or parole officer are often incarcerated in jail for allegedly breaking a "rule" of supervision. This includes the failure to pay supervision fees, testing positive for drugs, and failure to report to an officer or a treatment program. Even short periods of incarceration are extremely disruptive, cut people off from their support systems, and seriously undermine their stability by threatening employment, housing, and child custody.²²²

11. REDUCE BARRIERS TO EXITING THE CRIMINAL LEGAL SYSTEM AND CONNECTING TO CARE.

Many people with outstanding arrest warrants understandably avoid police as well as other government systems. This keeps people on the margins of society, away from connections to care that could address root causes related to their justice system involvement. Local governments should work with trusted community partners to offer no-arrest events, where people with outstanding warrants can get their warrants cleared or a court date set, and where people can connect with services without fear of arrest.



PROGRAM SPOTLIGHT

OREGON VOTERS DECRIMINALIZED DRUGS UNDER MEASURE 110 IN 2020.

In November 2020, 58% of Oregon voters approved Measure 110, also known as the Drug Addiction Treatment and Recovery Act, making Oregon the first state in the U.S. to decriminalize low-level drug possession and greatly expand access to the full range of substance use disorder services.²²³ Two years later, public opinion research found that Oregon voters still overwhelmingly support the measure.²²⁴

MEASURE 110 FUNDS ADDICTION SERVICES THROUGH MARIJUANA TAX REVENUE AND LAW ENFORCEMENT COST SAVINGS.

Under Measure 110, people arrested for possession of a small amount of drugs – such as less than a gram of heroin or less than two grams of cocaine – face a civil \$100 fine, like a parking ticket, which is waived if they call a 24-hour addiction recovery center hotline and take a health assessment. Measure 110's funding for addiction services comes from redirected marijuana tax revenue and law enforcement cost savings from reduced arrest and adjudication of drug offenses.

MEASURE 110 PROVIDED \$300 MILLION+ TO ADDICTION SERVICES IN FIRST TWO YEARS.

In 2020, prior to Measure 110's implementation, Oregon had the second-highest substance use disorder rate in the nation and ranked 50th for providing access to substance use disorder treatment.²²⁵ Access to addiction services was particularly limited in rural parts of the state. Measure 110 addressed this gap by establishing behavioral health resource networks (BHRNs), which are providers collaborating to deliver addiction services *free of charge* to every county across the state.

During the earliest phases of implementation, when only a small portion of the funding was made available, Measure 110 provided critical services to more than 60,000 people in Oregon.²²⁶ More than \$300 million in BHRN funding has been awarded to all 36 Oregon counties and tribal organizations

60,000

people were provided critical services in Oregon through Measure 110 funding during the earliest phases of implementation.

for the 2021-23 budget biennium.²²⁷ Measure 110 funds cover a broad range of services tailored to fit people's individual needs, including low-barrier addiction services that are evidence-based, trauma-informed, culturally responsive, and patient-centered; peer support and recovery services designed to help people achieve and maintain their recovery; housing and employment support for people with substance use disorder; and overdose prevention, including access to naloxone and other drug education and outreach.

Although we will have to wait for outcome measures on the majority of Measure 110 funds allocated in 2021-23, the Oregon Health Authority has reported encouraging initial findings after an early distribution of \$31.4 million in 2021. Under that funding, which went to 67 organizations and 11 tribes and tribal organizations, more than 42,000 Oregonians accessed services.²²⁸

UNDER MEASURE 110, DRUG POSSESSION ARRESTS SIGNIFICANTLY DECREASED.

After Measure 110 took effect on February 1, 2021, drug possession arrests significantly decreased – even after average monthly drug possession arrests had already dropped by 50% during 2020, the first year of the Covid-19 pandemic. Once Measure 110 took effect, the monthly average fell by another 65% – with just 3,163 arrests in 2021, down from 14,934 in 2019 – a decrease that held steady in the first half of 2022.²²⁹

ANALYSIS SHOWS MEASURE 110 DID NOT NEGATIVELY IMPACT CRIME RATES.

To understand Measure 110's impact on crime, researchers compared trends in 911 calls in Portland

to comparable cities without decriminalization – Seattle, Washington; Sacramento, California; and Boise, Idaho – between January 2018 and July 2022, covering a period before and after Measure 110 was implemented. Analysis showed that trends in Portland were similar to those in the comparison cities, with “no significant increases in people calling 911” after Measure 110 took effect.²³⁰ Specifically, research found:

- Disorder calls (e.g., vagrancy, unwanted person, and disturbances) fell slightly in Portland and Sacramento, but increased in Seattle. Boise data was not available.²³¹
- Property crime calls showed seasonal increases in Portland and Seattle, while remaining flat in Sacramento and Boise. By July 2022, property crime calls in Portland were about the same as in July 2018, July 2019, and July 2020 – before Measure 110’s enactment.²³²
- Vice calls (e.g., calls related to drugs, alcohol, prostitution, gambling) fell slightly in Portland and Sacramento since Measure 110 took effect, with both cities experiencing far fewer vice calls than Seattle. Boise data was not available.²³³

Like many cities nationwide during the pandemic, Portland experienced a dramatic rise in gun homicides. However, there is no evidence linking that rise to Measure 110’s reforms. Portland Mayor Ted Wheeler believes that the rise in gun homicides in the city is “being driven by a very small percentage of our population.”²³⁴ Criminologists back up that belief. David Kennedy, a professor at the John Jay College of Criminal Justice in New York who worked with Portland police in the late 1990s, recently cautioned, “If the city doesn’t systematically understand and engage with the small world of

groups and group dynamics that drive homicide and gun violence, it will not be effective.”²³⁵

DRUG DECRIMINALIZATION IN COUNTRIES LIKE PORTUGAL SHOW DECREASE IN OVERDOSE, DISEASE, AND ARRESTS.

Oregon’s policy is new for the United States, but Portugal, the Netherlands, and the Czech Republic have treated drug possession as a public health issue instead of a criminal one for decades and all have much lower rates of addiction and overdose deaths than the U.S.²³⁶ Two decades after Portugal decriminalized all drugs in 2001 and dramatically expanded public health spending, the country’s rates of drug use, including among youth, have remained consistently below the European Union average.²³⁷ At the same time, arrests, incarceration, disease, overdose, and other harms are all down.²³⁸

ADDITIONAL RESOURCES

- [**Model State Legislation on 988 Implementation**](#)
- [**Coming Out of Concrete Closets**](#)
- [**End Fees, Discharge Debt, Fairly Fund Government**](#)

REALIZE THE VISION OF COMMUNITY-BASED MENTAL HEALTH CARE

CONTEXT

Everyone should have access to quality health care as access to health care improves health outcomes. Yet, health care remains unaffordable and out of reach for too many people in the US, especially those navigating mental health challenges.

MORE THAN 25 MILLION AMERICANS WHO EXPERIENCE MENTAL HEALTH ISSUES DID NOT RECEIVE TREATMENT – MOST COMMONLY BECAUSE THEY DO NOT HAVE HEALTH INSURANCE.

With the passage of the Mental Health & Addiction Equity Act in 2008²³⁹, the Affordable Care Act in 2010²⁴⁰, the 21st Century Cures Act in 2016²⁴¹, and the Consolidated Appropriations Act of 2021²⁴² (which ratified \$4.25 billion to state investments in mental health services), the federal government has made significant strides toward improving access to mental health care in recent years. However, there is still a long way to go to ensure access to quality care to all Americans who want it, especially given significant increases in mental health issues reported during the pandemic.²⁴³ According to the 2020 National Survey of Drug Use and Health (NSDUH), of the more than 50 million Americans who experienced a mental illness, more than half did not receive treatment – most commonly because they lacked insurance and/or could not afford it.²⁴⁴

PEOPLE WITH SERIOUS MENTAL HEALTH ISSUES ARE 10-20 TIMES MORE LIKELY TO EXPERIENCE HOUSELESSNESS THAN THE GENERAL POPULATION.

At the same time, cities must confront the reality that the greatest need is currently concentrated among the relatively small number of people who have serious mental illness (SMI).²⁴⁵ Serious mental illness is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.²⁴⁶ The 2020 NSDUH, which unfortunately does not include

50M

Americans have experienced a mental illness, but more than half did not receive treatment.

people living on the streets, in jails, or in hospitals, found that just over 14 million American adults experienced a serious mental illness.²⁴⁷ People with SMI are 10 to 20 times more likely to experience houselessness than the general population.²⁴⁸

LACK OF ACCESS TO MENTAL HEALTH CARE LEADS TO NEEDLESS INCARCERATION.

About one-third of people with SMI are unable to access care because of inadequate behavioral health crisis response, including someone to call, someone to respond, and somewhere to go; inadequate availability of home-based and community-based services; and the failure to connect people to the long-term supports and stable housing they need to live independently and successfully in their own community, including mobile crisis services, supported housing, supported employment, peer support services, and Assertive Community Treatment (ACT).²⁴⁹

TOO OFTEN, AN INDIVIDUAL IN MENTAL HEALTH CRISIS IS MET WITH DELAY, DETAINMENT, DENIAL OF SERVICE, OR VIOLENCE.²⁵⁰

The lack of access to mental health care leads to needless incarceration, burdens on ill-prepared hospital emergency departments, and worsening outcomes for people who fail to receive adequate or appropriate care.²⁵¹ Indeed, communities with a greater number of both mental health services and affordable services have significantly lower incarceration rates.²⁵²

POLICY SOLUTION

In 1963, President John F. Kennedy signed legislation designed to close the country's abysmal state psychiatric hospitals and replace them with a national network of community mental health centers. Unlike state hospitals, the centers would support people with mental health disabilities to live in their communities with as much dignity as possible. Only half of that vision was realized: The number of people housed in large psychiatric hospitals fell by 95% between the 1950s and the 1990s.²⁵³ But instead of moving into community-based care, people ended up unhoused and/or cycling through incarceration.²⁵⁴ It is long past time to realize the second half of Kennedy's vision by establishing a true community-based infrastructure for mental health care.

Appropriate behavioral health crisis care reduces overdependence on restrictive, longer-term hospital stays; hospital readmissions; use of law enforcement; and human tragedies that result from a lack of access to care.²⁵⁵ According to the Substance Abuse and Mental Health Services Administration, the three core components of a behavioral health crisis system are: a regional crisis call center, mobile crisis team response, and crisis receiving and stabilization facilities.²⁵⁶

Though essential, these crisis responses alone are insufficient. They must be fully incorporated within the broader system of care so seamless transitions evolve to connect people in crisis to care based on the assessed needs of the individual.²⁵⁷ When communities provide these services in sufficient quantities and ensure that mental health providers are at the fore (rather than law enforcement), they will dramatically reduce the damaging and costly cycling of people with mental health disabilities in and out of jails, emergency rooms, hospitals, and shelters.²⁵⁸

RECOMMENDATIONS

1. PROVIDE SERVICES RECOGNIZING PEOPLE'S HUMANITY, DIGNITY, AND AGENCY.

Everyone with a mental health condition – regardless of their citizenship status or involvement in the justice system – deserves to be treated with dignity and in a manner that is culturally appropriate, to maintain agency over their own treatment design, and to have their privacy protected. No one should be punished or institutionalized for so-called “noncompliance.” (See Box: Coercion is Not the Answer)

2. ESTABLISH A CRISIS CALL CENTER.

The recent implementation of a three-digit dialing code for the national behavioral health crisis line (9-8-8) gives jurisdictions the opportunity to focus on establishing a crisis call center that connects people in crisis directly with the support they need.²⁵⁹ At a minimum, these call centers should be open 24 hours a day, seven days a week, and every day of the year. They should be staffed with peers with lived experience and with clinicians overseeing clinical triage and have the resources to respond to all calls received (to minimize or eliminate law enforcement involvement). They should coordinate connections to mobile crisis team services. And they should connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.²⁶⁰

3. CREATE 24/7 MOBILE RESPONSE.

As described previously in this toolkit, civilian mobile crisis team services should offer community-based intervention to individuals in need wherever they are. These teams should be housed outside of law enforcement and include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation. They should respond where the person is (home,

work, park, etc.) and not restrict services to select locations within the region or particular days/times. They should connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations. The most effective community response teams incorporate peers within the mobile crisis team, respond without law enforcement accompaniment, are able to replace lost medications, and schedule outpatient follow-up appointments in a manner consistent with a warm hand-off in order to support connection to ongoing care.²⁶¹

4. DEVELOP AND FULLY FUND CRISIS RECEIVING AND STABILIZATION PROGRAMS.

Crisis receiving and stabilization services operate much like a hospital emergency department that accepts all walk-ins as well as ambulance, fire, and police drop-offs. These facilities must be staffed around the clock with qualified professionals and trained peers; accept all walk-ins, drop-offs, and referrals with no barriers (such as medical pre-clearance); and be designed to address mental health and substance use crises as well as minor medical issues. These facilities should also incorporate access to intensive support beds for individuals who need additional support and coordinate connection to ongoing care.²⁶²

5. ESTABLISH SHORT-TERM RESIDENTIAL AND PEER-OPERATED RESPITE FACILITIES.

Small, home-like short-term residential facilities should be a step-down option to support individuals who do not require inpatient care after their crisis episode. Although sometimes called crisis residential facilities, they are distinct from crisis receiving and stabilization programs, which have a no turn-away policy and require more intensive staffing. Another model of short-term facility-based care is peer-operated respite, which provides peer-staffed, restful, voluntary sanctuary for people in crisis. These facilities offer a low-cost, supportive step-down environment for individuals coming out of or working to avoid a crisis episode. Program activities focus on issues that have contributed to the escalation



in challenges facing the individual and/or their support system and the skills needed to succeed in the community.²⁶³ Excellent examples include Kiva Centers²⁶⁴ and Promise Resource Network.²⁶⁵

6. EXPAND SUPPORTIVE HOUSING.

Providing long-term housing along with supportive services – known as permanent supportive housing – to people with mental health disabilities dramatically improves outcomes. The research is clear that permanent supportive housing reduces emergency room visits and overall health care costs of previously unhoused people.²⁶⁶ Permanent supportive housing also significantly reduces criminal-legal involvement.²⁶⁷

7. EVALUATE NEED FOR LONG-TERM PSYCHIATRIC BEDS.

According to one often-cited estimate from the somewhat controversial Treatment Advocacy



Center, the psychiatric bed need in the U.S. is 40 to 60 beds per 100,000 population.²⁶⁸ But not all psychiatric beds are alike, ranging from acute psychiatric hospitals to community residential facilities and from acute to sub-acute and long-term care.²⁶⁹ It would be unwise to jump to the conclusion that an expansion of long-term psychiatric beds is of greater urgency than expanding community-based mental health services. Waiting lists for long-term psychiatric beds may reflect bottlenecks elsewhere in the system. For example, an acute inpatient hospital may be full because it is unable to transfer patients to a lower level of care that would be more appropriate because that lower level of care is also operating at capacity.²⁷⁰

It is essential that policymakers expand capacity along the full continuum of care, rather than enable a return to mass institutionalization. Just as

increased access to physical health clinics, health insurance, and preventative care decreases the use of emergency rooms and incidents of major physical health concerns, increasing home-based and community-based services will decrease the need for emergency rooms and inpatient settings for mental health.

8. INVEST IN COMMUNITY MENTAL HEALTH CENTERS AND COMMUNITY-BASED SUPPORT SERVICES.

A community or county mental health care center (CMHC) provides public mental health care services when a referral to a private doctor or therapist is not possible. Centers are operated by local governments to meet the needs of people with serious mental health disabilities. Some of the services a person might receive from a community or county mental health center include outpatient services, medication management, case management services, and intensive community treatment services. Some CMHCs use the Assertive Community Treatment (ACT) team-based care model to coordinate a client's care.²⁷¹

9. PROVIDE INDIVIDUALIZED SUPPORTIVE SERVICES TO PEOPLE IN THE COMMUNITY.

Assertive Community Treatment (ACT) is an individualized package of services and day-to-day supports that help people with the most significant mental health conditions and greatest needs living in the community.²⁷² Operating around the clock, ACT teams provide case management, assessments, psychiatric services, substance use disorder services, housing assistance, and supported employment in order to help people with mental health disabilities navigate the day-to-day demands of community living, including staying in treatment, maintaining stable housing, securing and maintaining employment, and engaging in community activities.²⁷³



PROGRAM SPOTLIGHT

PHOTO COURTESY OF MENTAL HEALTH SF

MENTAL HEALTH SAN FRANCISCO PROVIDES NEEDED SERVICES TO PEOPLE EXPERIENCING HOUSELESSNESS OR WHO ARE UNINSURED.

Passed unanimously by the San Francisco Board of Supervisors in December 2019, [Mental Health SF](#) is a program designed to provide access to mental health services, substance use treatment, and psychiatric medications to all adult residents of San Francisco with mental health issues and/or substance use disorders who are unhoused, uninsured, or enrolled in a government health insurance program (e.g., Medi-Cal or Healthy San Francisco).²⁷⁴ Funded through a business tax approved by 61% of voters in 2018,²⁷⁵ Mental Health SF is intended to overhaul service provision to unhoused residents with mental health disabilities and/or substance use disorders. Originally intended to be fully implemented in two years, implementation is ongoing, and challenges remain.

The program consists of four key components:

1. Office of Coordinated Care,
2. Street Crisis Response Team,
3. Mental Health Service Center, and
4. An expansion of new beds and facilities.

The Office of Coordinated Care, which opened in May 2022, is a centralized access point for patients who seek access to mental health and/or substance use treatment, psychiatric medications, and subsequent referral to longer-term care. Among other functions, the office is responsible for maintaining an up-to-date inventory of available openings in all City-operated and City-funded mental health and substance use programs (and, where possible, to include data on private, state, and federal facilities); assigning clients, as needed, with an appropriate level of case management; and coordinating with other public systems to ensure that all psychiatric emergency patients – including people who have been detained involuntarily – and people who are exiting the county jail system with a mental health diagnosis, receive a treatment plan and, if appropriate, are offered a case manager.

The Street Crisis Response Team is a city-wide crisis team led by the Department of Public Health that operates 24 hours per day, seven days per

week, to intervene with people on the street who are experiencing a substance use or mental health crisis, with the goal of engaging them in a system of treatment and coordinated care. By April 2022, there were six teams providing 24/7 citywide coverage with a seventh team planned. By the end of the first year, the teams had taken more than 5,000 calls, engaged with nearly 3,000 people in crisis, and taken 61% of calls to law enforcement reporting a person experiencing a behavioral health-related crisis on the street.²⁷⁶

The Mental Health Service Center is intended to be located in one or more buildings that are open 24 hours a day, seven days a week, to provide a range of services, including assessment of immediate need; psychiatric assessment, diagnosis, case management, and treatment; pharmacy services; mental health urgent care; accompanied transportation to off-site support services; and a drug sobering center. Until that site is selected, San Francisco has expanded hours at its existing Behavioral Health Access Center. There is a 24-hour phone line, but drop-ins are only available Monday to Friday, 8 am to 5 pm.

Expansion of New Beds and Facilities. Critically, Mental Health SF acknowledges that “housing is as important as health care and treatment services” and directs the county to prioritize Mental Health SF clients who are experiencing both houselessness and a serious mental health disabilities or substance use disorder for wraparound services and appropriate housing.

ADDITIONAL RESOURCES

- [Legislation creating Mental Health SF](#)
- [Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration](#)
- [Mental Health SF Ordinance](#)

EXPAND ACCESS TO AND QUALITY OF ADDICTION AND RECOVERY SERVICES

CONTEXT

Not everyone who uses substances needs or wants treatment. For those who do, we at the Drug Policy Alliance are dedicated to ensuring on-demand access to effective substance use disorder (SUD) treatment based on science, human rights, and compassion.

“Substance use disorder” is a medical diagnosis that is met “when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.”²⁷⁷ A number of criteria must be met for this diagnosis to be made, and the level of severity may be mild, moderate, or severe, depending on the number of diagnostic criteria met by an individual. Not everyone who consumes alcohol or other substances does so problematically²⁷⁸, which is why criminalization of drug consumers – with disproportionate enforcement against people of color, especially Black people – is ill-conceived and demonstrably harmful to individuals, families, and whole communities.²⁷⁹

PEOPLE RECOVER FROM SUBSTANCE USE DISORDER IN DIFFERENT WAYS; TREATMENT IS ONE OPTION.

Substance use disorder, or addiction, can devastate the lives of individuals and whole families. People struggling with addiction deserve support, not criminalization. The good news is that people recover from substance use disorders every day – and in many different ways. Around 10% of American adults report ever having had a substance use disorder, with about 75% of them in recovery.²⁸⁰ About half of people who have overcome a substance use disorder did so without accessing treatment or self-help recovery supports.²⁸¹ Of those who did access supports, 30% participated in some form of treatment and another 45% utilized self-help groups. People with more severe past substance use disorder, especially those with a co-

10%

Around 10% of American adults report ever having had a substance use disorder, with about 75% of them in recovery.²⁸⁰

occurring mental health diagnosis, were more likely to have participated in addiction services as part of their recovery journey.²⁸²

HOW TREATMENT IS DELIVERED MATTERS: PEOPLE EXPERIENCING HOUSELESSNESS REPORTED THAT THE WAY SERVICES ARE DELIVERED IS MORE IMPORTANT THAN THE TYPE OF SERVICES PROVIDED.

The persistent and false puritanical belief that addiction is a moral failing – rather than a manageable health condition – has led to pervasive criminalization and societal exclusion of people who use drugs. It also discourages people from seeking help.²⁸³ In one study, people experiencing houselessness reported that the way services are delivered is more important than the *type* of services provided.²⁸⁴ Stigma must be countered with widespread education campaigns targeting not just the public, but also the medical field²⁸⁵, law enforcement²⁸⁶, and elected officials²⁸⁷. This has particular implications for Black people with substance use disorder, who are more likely to be treated as a “criminal” than as a “patient” by health care personnel.²⁸⁸

POLICY SOLUTION

Not everyone with a substance use disorder will need or desire help, but anyone who does seek help should be able to access evidence-backed addiction and recovery services that work for them *when they want it*. In one large recent survey, the median number of serious

attempts at recovery before remission was just two – and did not differ by primary substance (e.g., opioids vs. alcohol).²⁸⁹ This may be fewer attempts than even informed professionals would expect, especially with substance use disorder increasingly described as a chronic, relapsing condition. Of course, some people will make many more attempts; they should be allowed to continue trying as many times as they wish.

In addition to dramatically expanding evidence-based addiction and recovery services to meet the need, public policy should aim to remove barriers to services. Unfortunately, many people with substance use disorders who might otherwise want to access treatment do not seek care due to the stigma associated with addiction.²⁹⁰ Others do not have access to effective treatment due to lack of insurance or limited insurance coverage, lack of nearby facilities or reliable transportation, or long waitlists for available services.²⁹¹

WHERE PEOPLE CAN ACCESS TREATMENT, THE QUALITY OF CARE VARIES WIDELY, WITH SOME TREATMENT CENTERS OFFERING EVIDENCE-BASED PRACTICES (INCLUDING MEDICATION FOR OPIOID USE DISORDER AND HARM REDUCTION SERVICES) AND OTHERS PROVIDING INEFFECTIVE OR EVEN HARMFUL TREATMENTS.²⁹²

And even within addiction service programs, people can experience discrimination or shame. All these problems must be addressed to ensure on-demand access to quality addiction and recovery services in every community.

RECOMMENDATIONS

I. EXPAND ACCESS TO NON-COERCIVE ADDICTION SERVICES.

Forcing someone into addiction services flies in the face of public health principles – and encourages resistance, rather than cooperation, from the manipulated party – because it strips an individual of agency over themselves and their own lives.²⁹³

Research on mandated drug treatment does not suggest improved outcomes over voluntary engagement, and some studies suggest potential harms.²⁹⁴ In countries where compulsory treatment is common, research shows higher rates of relapse compared to voluntary community-based treatment services; avoidance of health care in response to stigma and shame; higher rates of infectious disease and bloodborne virus transmission; and inadequate medication and staffing.²⁹⁵

2. MAKE ADDICTION SERVICES AVAILABLE ON DEMAND.

Public health systems should strive to expand addiction services until waiting lists have been eliminated and care is available on demand – without time-consuming bureaucracy or pre-conditions (including abstinence, absence of a mental health diagnosis, ability to pay, or surrendering a beloved pet). Policymakers should also increase the number and types of access points to addiction services, including within syringe exchange programs; as part of overdose response; within schools, houseless shelters, faith-based institutions, and other community-based supports; and as part of routine medical screenings. While behind bars, incarcerated people should have on-demand access to the full range of addiction services (including medications for opioid use disorder) but must not be required to participate.

3. EXPAND EVIDENCE-BASED TREATMENT FOR OPIOID USE DISORDERS.

Medications for opioid use disorder (MOUD) – including methadone and buprenorphine – are the gold-standard of treatment for people with opioid use disorder.²⁹⁶ However, only a fraction of people who could benefit from this treatment ever receive it, with Black patients much less likely to gain access.²⁹⁷ Some lack access to these critical therapies simply due to where they live or what health insurance they have.²⁹⁸ Only federally designated opioid treatment programs (OTPs) are authorized to offer patients all three forms of medication, but, while most provide methadone, too many fail to offer buprenorphine (which is less

harshly regulated than methadone).²⁹⁹ Policymakers must work to ensure increased access to these lifesaving medications in every community as well as for the many people with substance use disorder who are behind bars.³⁰⁰

4. EXPAND EVIDENCE-BASED TREATMENT FOR STIMULANT USE DISORDERS.

Overdose deaths involving stimulants, including methamphetamine, are increasing across the U.S. and demand urgent action.³⁰¹ While there are currently no medications shown to address stimulant use disorders, contingency management (CM) – which consists of behavioral health interventions that positively reinforce desired outcomes – is a proven non-medication approach.³⁰² Typically, participants are rewarded with prizes or vouchers exchangeable for goods and services each time they return a toxicology test that is negative for the presence of a particular substance. The goal is to reduce consumption of substances that may be contributing to a substance use disorder for the duration of the treatment course. After participation in CM, other types of interventions are provided with the goal of preventing relapse in the long term. In late 2022, California began the nation's largest CM pilot (See Program Spotlight).

5. EXPLICITLY ADDRESS ACCESS TO EVIDENCE-BASED ADDICTION SERVICES FOR PEOPLE OF COLOR, ESPECIALLY BLACK PEOPLE.

Research shows that white and Black people consume drugs at similar rates; however, the legal consequences, access to quality treatment, and levels of stigma are quite different.³⁰³ For example, a Black woman who lives on the street, has a mental health issue, and uses drugs faces significantly more stigma (as well as likelihood of violence, illness, and incarceration) and far less access to high-quality addiction services than a housed white woman who uses drugs and/or has a mental health issue. The results are deadly: one recent study showed a 40% increase in the opioid overdose death rate for Black individuals relative to non-Hispanic white individuals.³⁰⁴

Major barriers to quality addiction services are similar for Black people as for other ethnic and racial groups: the stigma associated with medications for opioid use disorder (MOUD); the high costs of addiction services; red tape payer policies such as prior authorization; the stigmatizing attitudes of clinical professionals; the lack of treatment options for individuals with co-occurring disorders; and the complexity of navigating the substance use disorder care system.³⁰⁵ Addressing these barriers for all individuals is critical, but Black people's access to addiction services must be explicitly addressed. In 2023, the American Society of Addiction Medicine (ASAM) called for significant reforms to address the "structural racism and stigma" that impact access to addiction services and urged investments in advocacy infrastructures and organizations that can advance racial justice in addiction care.³⁰⁶

6. END PRACTICE OF PUNISHING PEOPLE BY DENYING SERVICES FOR NONCOMPLIANCE.

People receiving addiction services are not always willing or able to abstain from drug use. Addiction services must not be denied to anyone in response to continued or relapsed drug use. Nor should a person who is on pretrial release or probation or parole supervision be incarcerated for their drug use while engaged in addiction services.

7. SIGNIFICANTLY EXPAND MUTUAL AID RECOVERY SUPPORT SERVICES.

Research – and many people's personal experiences – strongly support the utility of mutual aid groups (also called self-help groups) in supporting recovery and preventing relapse among people with substance use disorders, including those who choose not to engage in formal addiction services.³⁰⁷ Some evidence suggests that mutual aid groups may even be more effective than other established treatments for increasing abstinence.³⁰⁸ The most common mutual aid groups include 12-step programs, like Alcoholics Anonymous and Narcotics Anonymous, and are structured programs with behavioral, spiritual, and cognitive components.



Other options include SMART (Self-Management and Recovery Training) Recovery³⁰⁹ and the RECOVER Project³¹⁰ of Franklin County, Massachusetts. Proliferation of mutual aid groups, both online and in-person, is a critical part of building a robust recovery community, which can help individuals reach and sustain recovery.

8. GROW THE ADDICTION SERVICES WORKFORCE, INCLUDING PEOPLE WITH DRUG USE HISTORIES.

To meet demand, addiction services need to expand dramatically across the country. This will only be possible with an equally expanded trained workforce. Policymakers and practitioners should incentivize the training of future employees in the addiction services sector. These programs should prioritize inclusion of people with a history of incarceration and drug use, who will share personal experience with future patients, making them more trustworthy messengers and guides.³¹¹ Critically, to foster a stable and expert workforce, all employees should be compensated fairly and properly, including with a living wage and robust health and retirement benefits.

9. CREATE A SAFER SUPPLY OF CONTROLLED SUBSTANCES.

The current overdose crisis is now driven by a toxic supply: Our loved ones are dying at alarming rates because of an unregulated system where people do not know the purity, amount, or potency of the drugs they are taking. By establishing legal regulations for the creation and distribution of drugs, legalization or “safer supply” would create a legally regulated way for people to access all drugs so that people do not need to buy illicit forms of drugs that are often contaminated with multiple toxic additives. Safer supply would ensure that people who use drugs know exactly what they are getting. Under legal regulation, drugs would be held to procedures similar to government-regulated consumer goods (i.e., sealed, packaged, and meet rigorous quality-controlled requirements). Legal regulation also puts in place safeguards and protections (e.g., age restrictions and quality of supply).



PROGRAM SPOTLIGHT

RECOVERY INCENTIVES: CALIFORNIA'S CONTINGENCY MANAGEMENT PROGRAM

In late 2022, California became the first state in the nation to cover contingency management (CM) as a Medicaid benefit.³¹² The "Recovery Incentives: California's Contingency Management Program" promises to not only significantly expand access to behavioral incentives – the gold-standard in addiction services for stimulant-related substance use disorder – but it will also allow for evaluation of CM's effectiveness at scale in one of the country's most populous states. To make this program possible, California's Department of Health Care Services (DHCS) requested and received authorization through a Medicaid waiver from the federal Centers for Medicare and Medicaid Services to include CM as a Medi-Cal covered service.

California will roll out its program in stages. Seven counties were approved to roll out the program in the first wave, with a total of 24 counties included in the pilot phase, running from 2022 through March 2024. DHCS expects to publish a final report on the two phases of the pilot program in July 2024. If successful, the program will be expanded to include all 37 counties (home to 96% of the state population) that have opted into the state's Drug Medi-Cal Organized Delivery System (DMC-ODS) program.

Under the program, all Medi-Cal enrollees will be eligible for CM services if they have been diagnosed with a qualifying stimulant use disorder and an assessment has determined that CM is medically appropriate. To be eligible to participate, Medi-Cal enrollees must reside in a county that has opted into the pilot, have completed an American Society of Addiction Medicine (ASAM) assessment indicating they can appropriately be treated in an outpatient setting, not be enrolled in another CM program for their substance use disorder, *and* not be receiving residential DMC-ODS services. Eligibility is not dependent on participation in any other addiction services.

PARTICIPANTS RECEIVE INCENTIVES FOR NOT USING DRUGS BUT ARE NOT PUNISHED FOR USING.

Eligible Medi-Cal enrollees will participate in a 24-week course of CM treatment followed by six or more months of recovery support services. For the first 12 weeks, participants will be asked to visit a drug testing site twice a week. For the remainder of the program, testing frequency drops to once a week. Incentives begin at \$10 per negative drug test and increase over time. At least initially, incentives will be gift cards from retail stores, grocery stores, and gas stations. (Later, the state hopes to provide access to incentives through mobile devices.) In the event of a test positive for stimulants, the participant receives no incentive but regains eligibility for the incentives as soon as they provide a subsequent negative test. Across all 24 weeks of the program, the maximum aggregate incentive amount per participant is \$599.

ADDITIONAL RESOURCES

- [Over-Jailed and Un-Treated](#)
- [Face & Voices of Recovery Mutual Aid Resources](#)

FORCED OR COERCIVE TREATMENT IS NOT THE ANSWER. ETHICAL AND EFFECTIVE ALTERNATIVES ARE AVAILABLE.

The vast majority of people who meet the diagnostic criteria for a substance use disorder do not believe they need addiction services.³¹³ While many of these people will ultimately recover without accessing formal addiction services³¹⁴, others could potentially benefit from some type of intervention. It is tempting to believe that mandating addiction services could break through to some people in this group. But while that might be the case in some limited instances, experience and research are clear: A policy of compulsory drug treatment does more harm than good. Ethical and effective alternatives are available.

WHAT IS FORCED OR COERCIVE TREATMENT?

Coercion refers to the practice of forcing individuals into addiction services against their will. While the intention may be to help an individual recover from a substance use disorder, the reality is that coercion flies in the face of public health principles by robbing people of agency over their own lives and subverting their wishes to those of the state and individuals empowered by the state. Research on compulsory drug treatment does not suggest improved outcomes over voluntary engagement, and some studies suggest potential harms.³¹⁵ Mandating addiction services may lead to higher rates of relapse compared to voluntary community-based treatment services; avoidance of health care in response to stigma and shame; and higher rates of infectious disease and bloodborne virus transmission.³¹⁶

COERCIVE TREATMENT LEADS TO INCREASED INCARCERATION AND OTHER HARMS.

Coerced treatment is a well-known feature of the U.S. criminal legal system. A concept first developed in the 1980s, “drug courts” – a catch-all term that encompasses a wide variety of criminal court-based programs that mandate participation in

activities or services intended to address addiction – are now prolific, with nearly 3,800 nationwide.³¹⁷ While there are plenty of people who credit drug courts with their recovery success, the programs have been shown to have significant negative consequences, including *increased* incarceration, inadequate or inappropriate provision of addiction services, and racially disparate increases in drug arrests.³¹⁸ As the American Society of Addiction Medicine has recently acknowledged,

“THE CRIMINAL LEGAL SYSTEM SHOULD NOT BE USED TO INTERFERE WITH, OR INFLUENCE, THE ASSESSMENT, DIAGNOSIS, OR TREATMENT DECISIONS OF THOSE WITH [SUBSTANCE USE DISORDER]. GIVEN THAT THE CRIMINAL LEGAL SYSTEM HAS HAD INEQUITABLY DETRIMENTAL EFFECTS ON [BLACK AND INDIGENOUS PEOPLE AND OTHER PEOPLE OF COLOR], REFORMS WITHIN THIS SYSTEM ARE PARTICULARLY NEEDED TO ACHIEVE RACIAL JUSTICE.”³¹⁹

FORCED TREATMENT IN SOME STATES CAN INCLUDE RESTRAINT, FORCED MEDICATION, AND SURGERY.

At the same time that awareness of the negative consequences of criminal court-mandated treatment is increasing, policymakers and addiction professionals are showing increased interest in civil commitment.³²⁰ At least 37 states and Washington, D.C., authorize some form of involuntary commitment procedure specifically for substance use.³²¹ Though involuntary commitment laws vary widely across jurisdictions, they generally authorize designated facilities to hold an individual without their consent for a period of time ranging from three days to a year. Laws in 16 states go so far as to authorize various forms of forced treatment, including restraint, forced medication, and even surgery. Empowering facilities and their

practitioners to make such significant, life-altering decisions on behalf of individuals placed in their care presents significant risk. Historically, similar institutional systems have been prone to abuse – with the most vulnerable and marginalized suffering most grievously.³²²

Civil commitment proceedings are usually initiated based on the individual's substance use presenting a danger to themselves or others, causing the individual to be gravely disabled, or impairing or eliminating their self-control.³²³ Court clinicians help courts determine whether individuals meet statutory requirements for commitment. In a rare survey of court clinicians, however, many reported having endorsed commitment on one or more occasions in the absence of statutory criteria being satisfied.³²⁴ This troubling finding suggests that, despite policymakers' efforts to protect the rights of the involuntarily committed, these rights may not be robustly protected in practice.

INVOLUNTARY CIVIL COMMITMENT CAN INCREASE RISK OF SEVERE WITHDRAWAL, RELAPSE, AND OPIOID-INVOLVED DEATH.

Involuntary commitment may also increase certain risks without minimizing others. While civil commitment often succeeds in providing short-term protection from overdose, for example, research suggests that it may be associated with long-term harms, including heightened risk of severe withdrawal, relapse, and opioid-involved mortality, particularly in the immediate aftermath of the period of involuntary commitment.³²⁵ And, despite being an effort to reduce the criminalization of people with substance use disorders, involuntary commitment may not reduce the likelihood of future incarceration.³²⁶

FORCED TREATMENT REMOVES PEOPLE'S RIGHTS OVER THEIR OWN BODIES.

Forced treatment can undermine an individual's autonomy and sense of control and can create feelings of resentment and mistrust. This can make it difficult for an individual to engage in treatment or therapy and can undermine the therapeutic relationship. Additionally, coercion can



perpetuate the stigma associated with addiction and substance use disorders and can further marginalize individuals and make it harder for them to seek help and support.

INSTEAD OF BEING COERCED INTO ADDICTION SERVICES, PEOPLE SHOULD BE OFFERED A RANGE OF OPTIONS AND SUPPORT – AND EMPOWERED TO MAKE DECISIONS ABOUT THEIR OWN CARE.³²⁷

Motivational Interviewing (MI) is a client-centered counseling approach aimed at helping people resolve ambivalence about making changes to their behavior. In the context of addiction services, MI can be an effective way to help individuals who do not believe they have a problem to realize the benefits of seeking help.³²⁸ The goal of MI is to enhance the individual's own motivation to change, rather than impose change from the outside.

Instead of coercion, a harm reduction and person-centered approach to addiction services may be more likely to be effective in promoting lasting change.³²⁹ This means empowering individuals to make their own decisions about their care and offering them a range of options and support. Regardless of their current openness to treatment, everyone should have the option to participate in addiction services that are a good fit for them when and if they want it.

EXPAND ACCESS TO AFFORDABLE AND SUPPORTIVE HOUSING

CONTEXT

Everyone deserves to have a place to call home and a roof over their heads, regardless of their relationship to drugs. In fact, the toxic stress of being unhoused can lead to or exacerbate problematic drug use.

LACK OF AFFORDABLE HOUSING IS INCREASING HOUSELESSNESS.

Houselessness is increasing across the U.S. thanks to a lack of affordable housing, economic inequality, and inadequate support systems for people experiencing houselessness.³³⁰ As housing and other costs of living rise, many people have little financial savings to weather a job loss, unexpected medical costs, or another rent increase.³³¹ And as pandemic-era eviction protections expire, eviction rates are increasing.³³² Meanwhile, scores of people are released each year from incarceration and hospitalization directly to the streets.³³³

CONGREGATE SHELTER RESIDENTS REPORT FEELING UNSAFE AND UNWELCOME AND NOT HAVING PRIVACY.

Congregate shelters can provide a temporary stopgap for people experiencing houselessness, but they are insufficient and often undesirable. People report avoiding shelters for several reasons, including fear for their safety³³⁴, feeling unwelcome³³⁵, the lack of privacy³³⁶, strict rules³³⁷, constant surveillance³³⁸, and having to navigate a complex shelter bureaucracy³³⁹. Shelters typically stigmatize and criminalize drug use, including confiscating supplies people need to use drugs (which drives up transmission of HIV and HCV) and discharging people who overdose. Shelters also fail to address the underlying causes of houselessness, with many people exiting shelters to return to bed down in public spaces.³⁴⁰ While the unsheltered houseless population rose by 30% across the country in 2015–2020, the population *in shelters* actually fell.

30%

While the unsheltered houseless population rose by 30% across the country in 2015–2020, the population in shelters actually fell.³⁴¹

VOTERS ARE CONCERNED ABOUT HOUSELESSNESS, BUT POLICYMAKERS MAKE INEFFECTIVE DECISIONS AIMED AT DISAPPEARING – RATHER THAN HELPING – PEOPLE LIVING ON THE STREET.

The increased visibility of houselessness is creating pressure on local and state governments to act. In early 2022, more Americans reported worrying a great deal about houselessness compared with the years before the pandemic.³⁴² People also reported that having unhoused individuals in their neighborhood makes them feel unsafe.³⁴³ While houseless encampments can be unsafe as well as troubling reminders of nationwide systemic policy failures, removing them does not end houselessness. Instead, raids of encampments (so-called “sweeps”) damage health, well-being, and connections to care; compromise personal safety and civic trust; undermine paths to housing and financial stability; and create unnecessary costs for local communities.³⁴⁴ They may also substantially increase morbidity due to loss of medication, including overdose-reversing naloxone.³⁴⁵

PEOPLE WHO CHRONICALLY EXPERIENCE HOUSELESSNESS HAVE HIGHER PHYSICAL AND MENTAL HEALTH MORBIDITY AND INCREASED MORTALITY RATES.

Though some local officials have already responded punitively, it is a terrible mistake to respond by further criminalizing people living on the street, as they are already struggling. People

who experience chronic homelessness have higher physical and mental health morbidity and increased mortality rates.³⁴⁶ Housing instability is also associated with health problems among youth, including increased risks of early drug use, depression, and teen pregnancy.³⁴⁷ Among people who use drugs, homelessness is associated with increased drug-related harms, including overdose and syringe sharing.³⁴⁸

POLICY SOLUTION

What people in unstable living conditions – including people living on the streets – need is support, not punishment. First and foremost, they need affordable housing, which they deserve to experience in a way that preserves their safety, dignity, and agency.³⁴⁹ Rigorous research shows that the vast majority of people who struggle with even the most severe challenges can maintain tenancies if they are given access to permanent housing with non-coercive supportive services.³⁵⁰

To be clear, everyone deserves to have a safe place to live. Developing enough affordable housing for all community residents who need it should be an urgent priority of every level of government. There are a number of strategies for increasing the housing supply, including zoning changes, land use reform, and creating incentives for developers and requirements around new housing developments.³⁵¹ These efforts are critical and also take time. This section focuses on recommendations for more urgent action to meet the emergency need for housing, while those longer-term strategies work toward changing the broader context to one where housing costs are more within reach of low-income people.

RECOMMENDATIONS

I. PROTECT PEOPLE FROM ENTERING HOMELESSNESS IN THE FIRST PLACE.

People and families at risk of homelessness should be supported to stay in their homes. According to the Center for Evidence-Based Homelessness Prevention, key strategies include:

a. *Permanent, deep rental housing subsidies*, which provide financial assistance that helps individuals and families cover housing costs;

b. *Eviction prevention programs*, which can include financial assistance, legal representation, or mediation services to prevent displacement from rental units;

c. *Community-based services*, which link clients to an array of supportive services that help them maintain stable housing – including eviction prevention and short-term financial assistance, education, job placement assistance, benefits enrollment, and childcare assistance;

d. *Critical time intervention*, which provides comprehensive case management to connect individuals with mental health disabilities who are being discharged from a psychiatric facility with community-based supports; and

e. *Proactive screening of populations at heightened risk of homelessness* with follow-up services and targeted support to help individuals and families maintain stable housing.³⁵²

2. RECOGNIZE THE DIGNITY OF UNHOUSED PEOPLE.

One persistent myth is that people living on the streets want to be there. In fact, many individuals experiencing homelessness opt out of homeless services because of how they are treated and because what is offered does not meet their needs and may actually be harmful.³⁵³ To successfully engage people in services aimed at getting them into housing, cities should ensure that service providers are able to offer real, tangible benefits to people experiencing homelessness and do so in a way that preserves their safety, dignity, and agency.³⁵⁴

3. EXPLICITLY CONSIDER RACE WHEN TRIAGING FOR SERVICES.

Systemic racism continues to push a higher rate of people of color into homelessness and keep them there, compared to their white counterparts.³⁵⁵ Homeless services that do not explicitly account

for the added barriers disproportionately experienced by people of color reinforce these disparities.³⁵⁶ For example, recent research suggests that the most commonly used tool to evaluate vulnerability during houselessness (the Vulnerability Index, Service Prioritization Decision Assistance Tool, or the VI-SPDAT) is racially biased, producing higher scores for white women than for Black women, despite high rates of trauma for both.³⁵⁷

4. CREATE ALTERNATIVES TO CONGREGATE SHELTERS.

Many people avoid large shelters for reasons of safety, privacy, and self-respect (because they are treated poorly at shelters and are required to adhere to strict rules).³⁵⁸ Intentionally designed smaller, non-congregate shelter facilities or private rented rooms (aka stabilization beds) can mitigate these barriers by having more flexible rules, offering more privacy, and having a higher ratio of staff to residents.³⁵⁹ These short-term, non-congregate shelter options should be significantly expanded, particularly in locations where people go often to manage their health and other needs (for example, by a clinic or a place of employment) and they should include hands-on case managers who work with people to connect them to an appropriate type of permanent housing. However, they must be seen as a part of the system, not the only solution. To be effective, shelter must be coupled with prevention and connection to housing to ensure bed turnover and temporary stays.

5. EXPAND PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing is a type of long-term housing program that provides individuals and families who have experienced houselessness with not only a place to live, but also a range of services and support to help them maintain their housing and improve their overall well-being. In these settings, an intensive case manager helps link people to services like job training, mental health counseling, and addiction services. The goal of permanent supportive housing is to help people overcome any challenges that may have

contributed to their houselessness and to prevent them from becoming unhoused again in the future. The research is clear that permanent supportive housing reduces emergency room visits and overall health care costs of previously unhoused people.³⁶⁰ Permanent supportive housing also significantly reduces criminal-legal involvement.³⁶¹

6. ADOPT A HOUSING FIRST APPROACH.

The Housing First approach is a method that quickly and successfully connects people experiencing chronic houselessness with permanent housing – without preconditions such as abstinence, enrollment in treatment, or service participation – along with ongoing supports and treatment.³⁶² A true Housing First approach does not set preconditions for attaining housing. When implemented as intended, the model employs harm reduction practices to reduce the risks associated with psychiatric or addiction-related behavior.³⁶³ There is strong evidence that Housing First policies reduce houselessness and hospital use for populations with behavioral health issues, including persistent mental health disabilities, problematic drug use, and addiction.³⁶⁴ Housing First policies reduce health disparities, improve housing stability, advance mental health and well-being, and facilitate access to treatment for substance use disorder.³⁶⁵ Housing First policies decrease costs to shelters and reduce emergency room use and costs.³⁶⁶ Unfortunately, not all self-proclaimed Housing First programs have authentically adopted the harm reduction ethic. This failure should be addressed through careful program design and evaluation as well as through anti-stigma trainings and harm reduction trainings.

7. INVEST IN RAPID RE-HOUSING.

Rapid re-housing programs usually include housing identification, rent and moving assistance, and case-management services.³⁶⁷ Rapid re-housing programs decrease rates of houselessness, decrease the length of time families and individuals remain unhoused, and increase access to social services.³⁶⁸ Participation in a rapid re-housing program may also lead to increased food security,



improved physical and mental health, and increased income.³⁶⁹ Evaluations of rapid re-housing programs targeted to military veterans and their families show that more than 80% of participants have permanent housing after exiting the program.³⁷⁰ A pilot evaluation showed that the rapid re-housing component of Housing First policies can reduce costs associated with acute care services for individuals with persistent mental health diagnoses and substance use disorder, including reduced hospital admissions and jail bookings.³⁷¹

8. ALLOW UNRELATED ADULTS TO SHARE HOUSING.

In many jurisdictions, zoning rules limit how many unrelated adults can live together, limiting opportunities for communal living, an otherwise affordable option for those unable to afford their own home.³⁷² Some have further restrictions against “transitional housing” and “sober living,” targeting people exiting homelessness and/or incarceration and people in recovery from addiction.³⁷³ (Transitional housing and sober living situations can be problematic, for example, where they require adherence to strict rules; but the

point here is that local zoning laws should not be allowed to prohibit already vulnerable people from accessing safe housing.) The benefits to ending these zoning restrictions would be felt across the board: increased housing access for people with lower incomes, reduced homelessness, diversifying neighborhoods, encouraging community, and meeting the needs of people with diverse definitions of “family.”

9. FIGHT DISCRIMINATION AGAINST THOSE WITH CRIMINAL CONVICTIONS AND DRUG USE HISTORIES.

“Not in my backyard,” or NIMBY, attitudes stymie the development of transitional and supportive housing, especially for formerly incarcerated people.³⁷⁴ NIMBY forces are especially strong in opposing housing explicitly intended for people in recovery from substance use disorder.³⁷⁵ Even where a person may have the means to afford an apartment, landlords routinely conduct criminal background checks on prospective tenants and often discriminate against people who are formerly incarcerated.³⁷⁶



PROGRAM SPOTLIGHTS

PHOTO COURTESY OF ANWOL

PROGRAM SPOTLIGHT #1: DENVER SUPPORTIVE HOUSING SOCIAL IMPACT BOND INITIATIVE (DENVER SIB)

Launched in 2016 by the City and County of Denver, the Denver Supportive Housing Social Impact Bond Initiative (Denver SIB) was a five-year pilot program intended to increase housing stability and decrease jail stays among people who were experiencing chronic homelessness and who had frequent interactions with the criminal legal and emergency health systems.³⁷⁷ Employing a Housing First approach, the Denver SIB provided a permanent housing subsidy and intensive services to help participants stay housed. The initiative was funded using a combination of financing from private investors and public dollars leveraged through Medicaid and housing assistance programs. (see next page for Supportive Housing Logic Model).

To be eligible for the program, an individual needed to have had eight or more arrests over three years and to have lacked a permanent address during at least three of those arrests. Eligible individuals were then randomly assigned to either the treatment group (which was offered supportive housing services as part of Denver SIB) or to the control group (which received services as usual in the community). The project evaluation included 724 people: 363 in the treatment group and 361 in the control group.³⁷⁸

Denver SIB participants were located, engaged, and housed through two local service providers: Colorado Coalition for the Homeless (CCH) and the Mental Health Center of Denver (MHOD). Participants received intensive wraparound services, including subsidized housing, a modified assertive community treatment (ACT) team, behavioral health services, links to community resources, and transportation assistance and referrals.

By every measure, people who were referred to the Denver SIB supportive housing program had clearly improved outcomes over the control group:

- An average of 560 more days in permanent housing (with 77% of people provided supports through Denver SIB still in housing after three years).

- An average of 8 fewer police contacts and 4 fewer arrests, representing a 34% reduction in police contacts and a 40% percent reduction in arrests.
- An average of 2 fewer jail stays and an average of 38 fewer days in jail, representing a 30% reduction in unique jail stays and a 27% reduction in total jail days.
- An average of 127 fewer unique shelter visits and 95 fewer days with any shelter stays, representing a 40% reduction in shelter visits and a 35% reduction in days with any shelter stays.
- An average of 6 fewer emergency department (ED) visits and 8 more office-based health care visits with a psychiatric diagnosis, representing a 40% decrease in ED visits and a 155% increase in office-based visits (i.e., better connection to non-emergency care).
- An average of 4 fewer visits to a detoxification facility, representing a 65% reduction in the use of detoxification facilities that aren't equipped to provide follow-up treatment.

Denver SIB participants had \$6,876 less in total annual, per person costs associated with other emergency public services compared with the control group, with some of the biggest cost avoidances in jail, ambulance, and emergency department costs. About half of the total per person annual cost of the Denver SIB was offset by cost avoidances in other public services.

The goal of financing the pilot through a social impact bond was to demonstrate its effectiveness and build support for local government to directly fund supportive housing services. This has happened to a limited degree: Denver has moved to continue to house and support people remaining in the program. However, scaling the program to serve all 1,209 people experiencing chronic homelessness in the county of Denver would require \$5 million to \$7 million in new state and federal housing assistance per year dedicated to supportive housing for this population.³⁷⁹

(continued on page 71)

SUPPORTIVE HOUSING LOGIC MODEL

INTERVENTION

HOUSING SUBSIDY

Provide rental assistance in a housing unit that is safe, sustainable, functional, and conducive to tenant stability

SUPPORTIVE SERVICES

- Develop a treatment plan
- Facilitate access to benefits
- Provide referrals
- Coordinate care

IMMEDIATE OUTCOMES

INCREASE HOUSING STABILITY

- Reduce homelessness
- Increase days in safe and healthy permanent housing

DECREASE CRIMES ASSOCIATED WITH HOMELESSNESS

Decrease, for example, trespassing and panhandling

INCREASE ACCESS TO HEALTH CARE

- Connect to mental and physical health care and substance use disorder treatment
- Increase continuity of care

LONG-TERM OUTCOMES

DECREASE INVOLVEMENT WITH THE CRIMINAL SYSTEM

- Decrease arrests
- Decrease jail days

DECREASE CRIMES ASSOCIATED WITH HOMELESSNESS

Decrease avoidable emergency room and hospital visits

INCREASE ACCESS TO HEALTH CARE

- Improve mental health
- Improve physical health

Source: Mary Cunningham, Mike Pergamit, Sarah Gillespie, Devlin Hanson, and Shiva Kooragayala. *Denver Support Housing Social Impact Bond Initiative: Evaluation and Research Design* (Washington, DC: Urban Institute, 2016).

Building on already extensive research, the outcomes of the Denver SIB continue to show that supportive housing through a Housing First approach not only ends chronic homelessness and helps people find stability, but also reduces jail days and lowers public costs.

PROGRAM SPOTLIGHT #2: A NEW WAY OF LIFE REENTRY PROJECT (ANWOL)

A New Way of Life Reentry Project (ANWOL) has been providing housing for women exiting incarceration in Los Angeles County since 1998. For less than half the cost of incarceration, women are housed and provided with wraparound supports to heal from the trauma of incarceration, become self-sufficient, and reunite with their children. Since the organization's founding, more than 1,600 women have found safety and support in ANWOL's reentry homes, and more than 400 have reunited with their children. On average, more than 80% of the residents meet benchmarks identified as crucial for successful reentry. In its 25th year of operation, the organization now operates 12 homes in Los Angeles County.

ANWOL's approach to women's reentry was developed by formerly incarcerated women for formerly incarcerated women – and provides gender-specific supports (including family reunification) that most other reentry programs do not. Unlike "transitional housing" or "halfway homes," which often look and feel like extensions of prison, ANWOL homes look and feel like family homes. And while halfway house staff focus on surveillance and control, ANWOL staff focus on meeting the needs of each unique woman that comes through the doors. Each woman sets her own goals, and ANWOL staff support her in achieving those goals. The motto is: "linking promise with opportunity." Critically, the ANWOL approach is supportive and loving, freeing residents from the constant surveillance and control they experienced during incarceration. Residents are held accountable by people who want to see them succeed.

In 2018, ANWOL created the [SAFE \(Sisterhood Alliance for Freedom & Equality\) Housing Network](#) in order to support the replication of ANWOL's model throughout the U.S. and beyond. Since then, more than 260 individuals have been trained on ANWOL's unique and effective model for women's reentry. Thirty-one groups have been invited to become authorized members of the SAFE Housing Network, which now operates 39 homes across 18 states and four countries (Kenya, Nigeria, Uganda, and the U.S.). In 2022, the SAFE Housing Network housed more than 270 formerly incarcerated women and LGBTQ+ individuals and provided other reentry services to more than 5,800 formerly incarcerated people.

ADDITIONAL RESOURCES

- [**In Our Backyard: Overcoming Community Resistance to Reentry Housing \(A NIMBY Toolkit\)**](#)
- [**Housing as a Platform for Formerly Incarcerated Persons**](#)

FUNDING: WHERE WILL IT COME FROM? HERE ARE FIVE FUNDING STREAMS.

This toolkit provides a range of options for communities working to improve their policy responses to behavioral health crises and homelessness. No matter what proposal a community pursues, a central question will be: "Where will the funding come from?" As advocates work with governments at the city, county, and state levels, a basic understanding of budget options will be helpful for those discussions. This section lays out several key sources of funding and includes links to additional guidance on leveraging a range of revenue streams to resource new and expanded programs.

I. THE GENERAL FUND

Largely made up of tax revenue and fees for services like parking or utilities, the general fund – at the city, county, or state level – is a flexible funding source that can be used to support general government functions.³⁹⁰ At each level of government, advocates and elected officials can build political will to change budget allocations to increase funding for community-based services. To do so, however, they may need to advocate for a reduction in spending on other priorities – each of which has its own political constituency that will fight to maintain its share of the pie, as we saw with municipal policing budgets even after the George Floyd protests in 2020 and nationwide calls to "defund the police."³⁹¹ One place that might be ripe for reduced local spending is incarceration.

2. DEDICATED TAX REVENUE

All states limit local jurisdictions' ability to impose new taxes, though some local governments' powers are more limited than others.³⁹² Some local governments may impose taxes only where the change is approved by voters. Regardless of whether public approval of a new tax is required, local elected officials are understandably sensitive to the voting public's general antipathy for increased taxes.³⁹³ Unlike public support for taxes in

general, however, public opinion research as well as successful campaigns around the country suggest that a majority of voters generally favor increasing funding for services that address underlying causes of homelessness, mental health disabilities, and addiction – especially when the wealthy or corporations are being asked to pay their fair share.³⁹⁴ Another successful strategy is to direct existing tax funds, including, as Oregon has done, allocating tax revenue from legal cannabis sales, to greatly expand access to substance use disorder services.³⁹⁵

3. FEDERAL FUNDING

States and local governments can tap into a variety of federal funds, including:

a. Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA provides grants for a wide range of behavioral health programs, including those aimed at treating addiction and mental health disabilities.

b. Health and Human Services (HHS): HHS offers funding through various programs, including the Substance Abuse Prevention and Treatment Block Grant, to support the expansion of behavioral health services.

c. Department of Housing and Urban Development (HUD): HUD provides funding for permanent supportive housing for individuals with behavioral health conditions, through programs such as the Continuum of Care and the Section 811 Supportive Housing for Persons with Disabilities program.

d. Centers for Medicare & Medicaid Services (CMS): CMS provides funding for a range of behavioral health programs through Medicaid, including those aimed at expanding access to care for people with addiction and mental health disabilities. In 2021, CMS issued guidance for reimbursement of qualifying community-based mobile crisis intervention services authorized by the American Rescue Plan

Act, which authorizes a state option to provide such services for up to five years, ending March 31, 2027.³⁸⁶

e. Department of Veterans Affairs (VA): The VA provides funding for behavioral health services for veterans, including those aimed at addressing addiction and homelessness.

f. Community Development Block Grants (CDBG): Cities and counties can use CDBG funds to support a wide range of programs aimed at improving the health and well-being of communities, including those aimed at addressing behavioral health and homelessness.

It is important to note that these federal funding sources have specific eligibility requirements, and the process for accessing funding can be competitive and complex. Cities and counties should consult with their state and local governments to determine the best way to access these funding sources.

4. OPIOID SETTLEMENT FUNDING

A series of settlements from lawsuits related to the opioid crisis have so far produced settlement funds of around \$54 billion dollars, with nearly half of the money coming from a \$26 billion 2022 settlement with drug manufacturers and distributors, and more funds expected from ongoing legal battles.³⁸⁷ These funds – which will be distributed over nearly two decades – present a unique opportunity for the U.S. to address substance use disorder and the overdose epidemic. States are required to spend 85% of their settlement funds on opioid remediation, with 70% of that allocated to future remediation.³⁸⁸ Most states have passed legislation and/or created advisory boards to make recommendations on the best way to allocate the available funds. To find out what funds are available in your state, visit the [Opioid Settlement Tracker](#).³⁸⁹

5. PRIVATE PHILANTHROPY

Private foundations and philanthropic organizations can provide direct funding to cities to support the expansion of behavioral health services. They can also make grants to non-profit organizations

working to address behavioral health issues in cities, provide technical assistance to cities and nonprofit organizations to help them develop and implement effective programs for addressing behavioral health issues, and collaborate with cities and other stakeholders to establish public-private partnerships aimed at expanding access to behavioral health services. Private philanthropy can also play a role in raising awareness of behavioral health issues and promoting evidence-based solutions through public education and advocacy efforts.

ADDITIONAL RESOURCES

- [Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services](#)
- [Financing Community Responder Programs](#)
- [Reform/Transform: Creating a Community Responder Program](#)
- [Funding Housing Solutions to Reduce Jail Incarceration](#)
- [What Jails Cost: A Look at Spending in America's Large Cities](#)
- [OpioidSettlementTracker.com](#)
- [Strategies for Effectively Allocating Opioid Settlement Funds](#)

CONCLUSION: INVEST IN COMMUNITIES WITH EVIDENCE-BASED, HEALTH-CENTERED APPROACHES

The challenges facing communities across the United States are serious and multifaceted. Long-term underinvestment in public health systems, the dismantling of the social safety net, the criminalization of social issues, and the systemic segregation and marginalization of people of color and particularly Black people have all contributed to worsening health outcomes and increasing poverty and homelessness.

However, we have the evidence and knowledge needed to address these issues in productive and positive ways. Elected officials, advocates, and community organizations must come together at all levels of government to develop health-centered approaches that address root causes and systemic challenges to ensure healthy, safe communities for all residents.

The recommendations put forth in this toolkit provide advocates with informed perspectives on recent trends, original public opinion research and effective messages, and recommendations on health-centered policy responses to address these intertwined crises, as well as how to fund them. As described throughout this toolkit, communities have a wide range of evidence-based strategies they can use to respond using a health-centered approach.

WE MUST WORK TOWARDS A FUTURE WHERE EVERY INDIVIDUAL HAS ACCESS TO THE CARE AND SUPPORT THEY NEED TO THRIVE, FREE FROM STIGMA, DISCRIMINATION, AND CRIMINALIZATION.

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