



THE UNIVERSITY OF ARIZONA
COLLEGE OF SOCIAL & BEHAVIORAL SCIENCES

Southwest Institute for Research on Women



U-MATTER

Behavioral Health Staff and Co-responder
Focus Group Report - September 2020

SUBMITTED BY:

Josephine D. Korchmaros Ph.D., and Keith G. Bentele Ph.D.

University of Arizona

Southwest Institute for Research on Women

925 N. Tyndall Avenue

Tucson, AZ 85721

SEPTEMBER 2020

For additional information, contact Josephine Korchmaros at jkorch@email.arizona.edu.

Acknowledgements: The Southwest Institute for Research on Women (SIROW) wishes to acknowledge the contributions of CODAC behavioral health team members and co-responders to the focus group and this report.

Disclaimer: The development of this report is funded by SAMHSA grant 1H79TI081559. The views expressed here are the authors and do not represent the official policies or viewpoints of the funding agency; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Suggested reference: Korchmaros, J., & Bentele, K. (2020). *U-MATTER Behavioral Health Staff and Co-responder Focus Group Report*. Tucson, AZ: University of Arizona, Southwest Institute for Research on Women.



CONTENTS

| | |
|---|----|
| BACKGROUND AND METHODOLOGY..... | 4 |
| U-MATTER (Unified Medication Assisted Treatment Targeted Engagement Response) Project | 4 |
| U-MATTER Behavioral Health Staff and Co-responder Focus Groups..... | 5 |
| Protocol and Structure | 5 |
| Data Analysis..... | 5 |
| Results | 6 |
| General Strengths | 6 |
| General Challenges | 8 |
| Challenges Specific to Individuals Deflected by TPD and Those Referred by Pretrial Services..... | 11 |
| Recommended Changes | 12 |
| Specific Recommendations for Engaging Individuals Deflected by TPD or Referred by Pretrial Services | 13 |
| RECOMMENDATIONS BASED ON FINDINGS..... | 15 |



BACKGROUND AND METHODOLOGY

U-MATTER (Unified Medication Assisted Treatment Targeted Engagement Response) Project

U-MATTER is a collaboration between Pima County Administration, Criminal Justice Reform Unit; Tucson Police Department (TPD); CODAC Health, Recovery, and Wellness, Inc. (CODAC); and the University of Arizona's (UA) Southwest Institute for Research on Women (SIROW), partnering with Pretrial Services of Arizona Superior Court in Pima County. **U-MATTER** is focused on identifying, engaging, and retaining individuals with opioid use disorder (OUD) in comprehensive MAT and recovery support services and facilitating these individuals' long-term recovery. **U-MATTER** is enhancing and expanding access to MAT services for adults in Pima County, AZ with an OUD by increasing capacity and infrastructure to 1) identify and connect adults with OUD who are appropriate for MAT to existing comprehensive MAT and related recovery support services, including those of historically health disparate groups; and 2) provide ongoing peer support in the community to support retention and re-engagement in MAT.

U-MATTER engages in multiple strategies to reach these goals. **U-MATTER** supports the TPD Deflection Program, which aims to address misuse of opioids and other substances as well as related issues, such as criminality, by identifying individuals with substance misuse issues, encouraging them to get treatment, and immediately transporting them to a treatment provider. Under the Deflection Program, police officers and co-responding behavioral health peer support Outreach and Engagement Specialists (OES) identify and deflect individuals with substance use problems who are willing to consider treatment. That is, they transport them immediately to a partnering treatment provider in lieu of arresting them. The partnering provider, CODAC, is an integrated healthcare clinic with a 24/7 MAT clinic providing immediate initiation of treatment for OUD, other SUDs, and related health problems. The **U-MATTER** team has also developed a partnership with Pretrial Services of Arizona Superior Court in Pima County to further expand screening and active linkage to comprehensive MAT and recovery support services. **U-MATTER** also provides outreach to community members to promote **U-MATTER**, access to MAT, and to coordinate treatment referrals.

CODAC clinic staff assess the individuals and enroll them in appropriate treatment offered by the clinic or transport them to other service providers as needed. The clinic offers 24/7 MAT utilizing methadone, suboxone, and naltrexone with prescription and induction by psychiatric addiction specialists. It also provides comprehensive substance abuse treatment and recovery support services to adults with OUD. These services include, for example, evidence-based practices to address substance use (including tobacco use) and mental health issues; primary care services; an array of recovery support services; case management; HIV/AIDS testing and counseling; viral hepatitis testing and treatment, and linkages to other services (e.g., housing).

The **U-MATTER** project team utilizes ongoing monitoring and evaluation of **U-MATTER** to inform ongoing quality improvement of the project and its implementation.



U-MATTER Behavioral Health Staff and Co-responder Focus Groups

The **U-MATTER** SIROW evaluation team conducted focus groups with behavioral health staff to inform ongoing quality improvement of the project and its implementation. The specific goal of these focus groups was to assess successes, challenges, and areas for improvement in getting people identified through the Deflection Program or by referral from Pretrial Services engaged and retained in substance abuse treatment. The evaluation team conducted two focus groups, one comprised of behavioral health staff who work at CODAC's MAT integrated health clinic, and another with the team of behavioral health OES who co-respond with TPD officers.

Protocol and Structure

Participants

The target population for the first focus group were behavioral health staff at the 24/7 MAT clinic with a particular focus on staff who play a role in welcoming and receiving individuals at the clinic and guiding those individuals through the clinical intake procedure. Focus group participants included the Vice President for Clinical Services, the Director of Addiction Services, a nurse manager, a supervisor for the outreach team, an OES, a childcare specialist, and four recovery coaches. The second focus group was comprised of the four peer support OES that are embedded within TPD and co-respond with TPD officers who are members of TPD's Substance Use Resource Team (SURT). Each focus group lasted approximately 90 minutes and was conducted online using the Zoom platform, due to the COVID-19 pandemic. Participation was voluntary and the audio and video of the focus group discussions were recorded with the permission of the participants.

Facilitation

The SIROW **U-MATTER** evaluation team designed the focus group sessions to cultivate conversation, allow participants to express their views, and elicit in-depth feedback through open-ended questions. An experienced SIROW research evaluator moderated the sessions and a second SIROW **U-MATTER** evaluation team member assisted with note taking.

The facilitator began the session by providing background and context for the focus group itself and allowed participants to share their name and role at the clinic. The facilitator then guided participants in a discussion using a pre-planned script.

Data Analysis

To begin the data analysis process, the SIROW **U-MATTER** evaluation team reviewed the notes and recordings of the focus group sessions to identify themes and recommendations. The summary report below presents key identified strengths and challenges related to engaging and retaining people with substance use problems in treatment; challenges specific to engaging and retaining individuals who were deflected by TPD and those referred by Pretrial Services; and recommendations for **U-MATTER** project improvements.

RESULTS

General Strengths

Focus group participants were asked to reflect on their overall experiences in their respective positions and for examples of successful strategies employed to support clients in engaging and remaining in treatment.

A Whole Person Approach to Treatment

Multiple focus group participants emphasized the importance of treating the “entire person” and “meeting people where they’re at” in order to get people engaged in treatment. Treating the entire person refers to taking a global perspective on an individual’s situation and trying to identify and address their individual barriers to recovery, whether that be housing, transportation, health issues, etc. This is a guiding philosophy at CODAC and the MAT clinic, and was presented by some participants as critical to success with clients.

Involving Clients in their Own Recovery

A supervisor explained that respect for clients (referred to as “members” by CODAC staff) involves recognizing that, “the member is the expert on their own life more than we are the expert on a person’s life.” A recovery coach similarly emphasized the need to let clients identify their needs and goals and to help them work toward those outcomes as opposed to imposing goals on them. Multiple recovery coaches and an OES staff member identified the benefits of involving the client in the creation of their treatment plan. This involvement allows staff to build on what approaches clients say has worked for them in the past and encourages them to take responsibility for their own recovery. One OES stated, “having that agency is so important to guiding their recovery.”

“Follow up, Follow up, Follow up”

Multiple staff members emphasized the importance of following up repeatedly with clients. One recovery coach said that they try to make at least one contact a month, if not more, and to use these contacts to discuss with the client barriers to and potential strategies to support their recovery. Another recovery coach stated that “consistency is huge” in terms of following up with clients. It also supports successful engagement with treatment. Another recovery coach expressed that these follow up efforts are also a way to send a message to clients that, “there is somebody that cares about their recovery and cares if they live and have a high quality of life.” Multiple focus group participants emphasized the importance of communicating to clients that they acknowledge their value as a person and that they deserve to live. They try to accomplish this in different ways such as providing clients with Narcan¹ early in the intake process or encouraging clients to get help from a treatment provider, even if that provider is not CODAC.

¹ Narcan is an opioid antagonist used to reverse the symptoms of an opioid overdose.

Peer Support

Wide agreement was expressed that peer support and peer support training were extremely important elements contributing to the success of CODAC behavioral health programs. Recovery coaches expressed that it is extremely helpful that some of the coaches are in recovery themselves. Clients are more likely to trust coaches who “know what they are talking about” and this helps strengthen rapport with clients. One recovery coach stressed the importance of getting personal and building a real camaraderie with clients as opposed to just distributing curriculum or checking boxes in an impersonal manner.

The OES who co-respond with TPD officers—henceforth referred to as co-responders—similarly discussed the power of using their “own stories” to help others, and one stated that “rapport building is a huge part of the program.” Drawing an explicit contrast with the large caseloads of recovery coaches at CODAC, one co-responder offered that the really good thing about their positions is that they have ability to spend significant time with people and develop their relationships with them. Multiple co-responders also emphasized that these relationships are not just with the person experiencing addiction, but with their families as well. Describing this as a major positive component of TPD’s Deflection Program, multiple co-responders described specific situations where word-of-mouth recommendations led to individuals contacting them about services and treatment for family members and friends. Another co-responder also offered that their life experiences (with addiction and recovery) have been helpful in terms of understanding what is going on with particular individuals. They provided an example of appropriate treatment being provided for a person who was having a mental health episode that easily could have been misunderstood as a substance abuse issue.

Workplace Culture

Multiple recovery coaches attributed CODAC’s success in serving clients to a mutually supportive workplace culture. One coach stated that, “how we serve our members largely comes from how we serve each other.” This recovery coach referred to CODAC as a “well-oiled machine,” and noted that staff at CODAC do an excellent job of supporting one another in providing information, direction, and constructive criticism.

Co-responders similarly were extremely positive about the high level of camaraderie and mutual support between themselves, the TPD officers, and their counterparts who work on site at the CODAC MAT clinic. Multiple co-responders stressed their appreciation for the welcoming and cooperative nature of their co-workers. Co-responders provided multiple examples of how high trust and cooperation between the officers and co-responders allows them to plan specific approaches for different individuals and situations to increase successful engagement in treatment. One co-responder offered that working with the officers can often provide access to individuals who otherwise wouldn’t speak to a co-responder.

With law enforcement they see the authority there and it opens the door, and then the [co-responding OES] can share their stories and kind of open their hearts, if you would say, and then encourage them to change, hopefully, or give hope to their mom or dad or sister, brother that their sibling or daughter has other people trying to help them. (Co-responder)



In other situations, the TPD officers and co-responders may decide it makes more sense for the co-responder to initiate contact. But when asked if the presence of an officer was ever a barrier to treatment, all co-responders said that this has not been the case in their experiences. In fact, one co-responder said that the opposite is more often the case with SURT officers, with individuals expressing sincere gratitude for an officer's treatment of them.

Another benefit of the co-responder element of the deflection program mentioned by multiple co-responders is that it has let people working in behavioral health and law enforcement get to know one another and understand each other better. Co-responders argued that this familiarity and understanding helped their planning how to approach assisting individuals. In addition, one co-responder stated that the existence of this program has helped change the perspectives of the police officers themselves related to addiction and people experiencing addiction.

Getting Out in the Community

Co-responders accompany police officers with doing outreach in the community, visiting parks and other locations where people who use substances spend time to find people interested in treatment. Co-responders discussed the way this allows particular people to be reached who would normally never be outreached to regarding services. This engagement in the community also helps with building rapport with people who cannot be contacted in any other way, particularly people experiencing homelessness. Furthermore, multiple co-responders mentioned that the program has been influential in changing perceptions of the police and raising awareness about available treatment options. Multiple co-responders also mentioned how much they enjoyed working in the community and not being in an office all day.

General Challenges

Focus group participants were asked about challenges they face getting individuals to engage with and remain in treatment. They described general challenges that they encounter in their work. These challenges apply to individuals approaching CODAC through the Deflection Program and via a referral from Pretrial Services, but were not specific to these individuals.

Stigma

One recovery coach described stigma about MAT as a major challenge to successful engagement in treatment. That coach explained that there is a widely held view that methadone is just a substitute for heroin. Clients' family members' criticism or disapproval of MAT can be a powerful disincentive to engage in treatment. Other recovery coaches pointed out that stigma around MAT also can be a barrier to other services—many Narcotics Anonymous groups do not allow participation by clients engaged in MAT as they are not considered sober and some halfway houses and rehabilitation programs will not accept clients receiving MAT. Stigma was also cited as a barrier to re-engagement with treatment following a relapse. One recovery coach explained that relapsed clients' feelings of shame and guilt can cause them to avoid outreach efforts from staff. Lastly, it was offered that the stigma around MAT can cause clients to try to get off of medication too quickly, which can increase the risk of relapse.

One recovery coach said that coaches encourage clients to involve their family members in their recovery and to bring them to CODAC. This provides an opportunity to educate the family about the process and to reduce stigma. A focus group participant in a leadership position at the MAT clinic also stressed the need to educate family members and reduce stigma in the community more broadly. One recovery coach expressed that they have been encountering a great deal of stigma around MAT since the pandemic started and that this makes an uphill battle with addiction even more challenging. They expressed that highlighting success stories with MAT could be a way to reduce stigma stating, in regards to MAT, “the proof is in the pudding and we’re going to keep giving people proof.”

Lack of Contact Information and Identification

Multiple behavioral health staff voiced the difficulty of contacting and following up with clients that don’t have, or don’t have stable, phone numbers or addresses. In addition, clients often do not have identification. Currently, federal and state law requires that clients without identification obtain a government-issued ID within 30 days of beginning MAT. For clients for whom obtaining a birth certificate (required to get a state ID) is challenging, this is a major barrier to treatment. One staff member mentioned that this barrier can be profoundly disappointing for potential clients with high expectations about treatment who, in fact, cannot access services. Lastly, in the past, ID requirements were stricter and eligible clients have been denied treatment by staff not clear on the new policies. CODAC leadership is working to address this issue with additional staff training.

Transportation

Transportation was identified by multiple focus group participants as a huge issue for clients. Noting that “consistent dosing supports relapse prevention,” one recovery coach stated that lack of access to reliable transportation services is a huge barrier for some members. One of the transportation providers, VEYO, was specifically mentioned as unreliable and inconsistent. One recovery coach emphasized how consequential a missed ride can be, explaining that if a client misses a dose on a Saturday, they are at a higher risk of relapsing due to then needing to wait two days to dose the following Monday. One supervisor noted that routine transportation is expensive for insurance providers and they do not want to pay for these costs.

Homelessness

One recovery coach and one co-responder stated that the largest barrier they have encountered to successful engagement in treatment is chronic homelessness. Individuals experiencing chronic homelessness constitute a substantial proportion of CODAC behavioral health clients. The aforementioned issue of IDs is particularly acute for people experiencing homelessness as their IDs are often lost, stolen, or destroyed. One recovery coach pointed out that there are simply not enough resources (in terms of housing and other supportive services) to support these individuals. A recovery coach stated, “members have been homeless for two, five, twenty years. Trying to support recovery and substance absence in a homeless environment, you're fighting an uphill battle. I mean, and it is a steep uphill.”

The Nature of Addiction Itself

Multiple supervisors and recovery coaches made reference to the fact that addiction itself is a barrier to successful engagement in treatment. Given the way that substance use changes an individual's brain chemistry; the "primary focus is the next fix." Consequently, individuals experiencing addiction may avoid treatment because their brains don't want to stop using. One recovery coach stated that this "disease constantly fights us because this disease does not want to be cured." One co-responder offered that there is "no challenge in finding people who need help... ..the biggest thing is just getting them when they're ready to change."

Staffing Issues

A significant amount of time during the focus group was spent discussing issues resulting from a shortage of staff and the reasons for those shortages. One recovery coach offered that, in their opinion, there were issues with sufficient staff at all levels of the organization from the nursing staff down to the front desk staff. A supervisor, strongly agreeing that this is a major issue, explained that there is a broad shortage of qualified staff to fill positions, an issue that is especially acute with nursing, doctors of medicine (MD), and overnight positions. Nursing and MD staff are particularly overburdened, often needing to be on call and then having to come back to work soon after completing a shift. The supervisor went on to explain that the clinic can recruit for weeks without finding candidates and that the current demands for medical staff due to the pandemic has reduced the pool of applicants substantially. The same supervisor reported that there were currently 10 vacancies at CODAC overall, and that CODAC is currently short staffed by 4 nurses. In an effort to address some of these vacancies, the supervisor reported that CODAC is training internally to be able to fill peer support positions.

Focus group participants explained that the lack of sufficient staff creates multiple issues for CODAC and its clients. Being understaffed results in large caseloads for both recovery coaches and medical staff. A supervisor noted that some clients really need enormous amounts of time and attention, and that staff struggle to meet this need when they have a large caseload. One recovery coach stated that they are trying to,

meet [each member] where we're at. But at the same time. We've also got to meet the next member where they're at and the next member and the next member. And so we're just trying to get to everybody. Make sure, like I said, nobody falls through the cracks.
(Recovery coach)

Multiple recovery coaches referenced this specific tension between a desire to give each client the time and attention she or he needs and the need to serve all of the clients in their caseload.

Multiple recovery coaches raised the issue that a lack of staff can increase wait times for clients and that these long wait times can result in clients leaving. The shortage of medical staff can prevent some clients from receiving a nursing assessment in a timely manner, an assessment required for engagement in services. One recovery coach also mentioned that wait times can create a delicate situation when a client cannot receive a dose of medication until they see a recovery coach. Clients can become upset if they feel like they have been waiting for too long.

Multiple focus group participants mentioned that wait times are not solely an issue of staffing. Wait times lengthen and shorten depending on the influx of clients, which varies over time in unpredictable ways. This unpredictability of client load and, consequently, staffing need is something one supervisor offered as “endemic to a MAT clinic.”

Multiple focus group participants mentioned that while wait times can sometimes be long for clients, overall wait times for starting intakes have improved considerably over time. This was attributed to increasing flexibility in scheduling (allowing clients to do the different portions of the intake in any order based on the availability of specific staff) and the designation of a “cruise director” on the staff. The person in the cruise director position manages the flow of clients between segments of the intake procedure with the intent of reducing the gaps where the clients are waiting between appointments.

A supervisor also offered that some of these issues have been helped by legal changes resulting from the pandemic that have allowed more use of telehealth and Suboxone, a medication used in MAT that does not require clients to appear daily at the clinic to receive their MAT medication. Multiple recovery coaches reported having more clients keep their appointments over the phone and better attendance in their online outpatient groups compared to in-person appointments. The increased flexibility allowed by the telehealth option has been really helpful for some clients. A supervisor reported that pre-COVID the number of regular monthly contacts with clients averaged 4,000-5,000 a month. This has increased to 6,000-6,500 a month. The “no show” rate for providers has fallen in half, from an average of 120 to 60 a day.

Challenges Specific to Individuals Deflected by TPD and Those Referred by Pretrial Services

Chronic Homelessness

A supervisor offered that a substantially larger proportion of the individuals deflected by TPD to CODAC are experiencing homelessness compared to their clients overall. They reported that roughly 35-40% of deflected individuals are experiencing homelessness as compared to 8-10% of CODAC’s general client population. Individuals who are experiencing homelessness are more likely to have specific challenges that make engagement with treatment more difficult such as

- 1) Lack of the identification necessary to remain enrolled in MAT.
- 2) Lack of a stable address and phone number making follow up efforts difficult or impossible.
- 3) Lack of transportation challenging capability to come back to the clinic for MAT dosing or to complete the clinical intake procedure.
- 4) Need for healthcare from other providers. Many individuals experiencing homelessness require treatment for medical needs that cannot be addressed at the MAT integrated clinic and, consequently, are diverted to a hospital during the intake process. It can be difficult to connect with them after discharge from the hospital.
- 5) Additional existing medical conditions. Some individuals complete the clinical intake process, but do not receive medical clearance for MAT, or documentation that MAT medications are safe for that individual, due to existing health issues.

- 6) Many individuals experiencing homelessness are preoccupied with returning to and securing their property or pets before doing the clinical intake. Multiple focus group participants mentioned that this is a primary concern and that most of the people who leave for this reason do not return to complete the clinical intake.

Individuals Motivated by Avoiding Arrest as Opposed to Seeking Treatment

A supervisor stated bluntly, “to be really honest, there's a certain percentage of members that come in and have no intention of enrolling anyway, they're just avoiding going to jail.” Multiple participants in the focus group agreed with this statement. Another supervisor explained that, “word gets around that you can get snacks and water and AC for a few hours” as a result of deflection. They went on to say that even though some of these individuals have no interest in MAT, this is not necessarily a bad thing as the experience, “might plant a seed that helps them engage in recovery at a future date.”

Individuals Deflected by TPD are Often Currently or Recently Intoxicated

Multiple focus group participants raised the specific issue that some individuals brought to CODAC through deflection have used substances very recently or in some cases are very intoxicated when they arrive. One participant offered that this can raise issues with obtaining consent for treatment and in some cases medical concerns as the person could be at risk of overdosing. In addition, a supervisor emphasized that an individual who has used recently might begin experiencing withdrawal, at which point “they want out” and will usually not stay at the facility.

Staffing Issues

The staffing issues detailed on pages 10 and 11 were also cited as having specific impacts on engaging individuals deflected by TPD Deflection Program in treatment. For example, triage nurses who see individuals who are deflected are not always available. In addition, one OES mentioned that in the past they have been able to assist TPD officers with transporting individuals who have been deflected to a treatment provider. The OES reported that CODAC staff have not been able to do this as easily of late due to staff vacancies.

Recommended Changes

Focus group participants were asked about changes they would recommend to help clients better engage and remain in treatment.

General Recommendations for the MAT Clinic

There was widespread agreement that having more staff at all levels would be beneficial, in the word of one recovery coach, “to make sure everybody gets the quality and attention that they deserve in a timely manner.” Ideally there would be an MD on site 24/7 or at least nurse on staff overnight to address medical issues. In addition, it is important to have a person on staff who is dedicated to providing transportation as well as funding to support this non-billable service.

Another recommendation was to have the option to provide phones to clients who do not have one. This recommendation was enthusiastically supported by multiple participants of both focus groups who said this would be “amazing” and a huge help to their work.

One recovery coach suggested that having more laptops to help with staff mobility would be helpful.

One co-responder wondered if it would be possible for individuals to dose earlier in the clinical intake process in order to prevent people concerned about withdrawal from leaving.

Specific Recommendations for Engaging Individuals Deflected by TPD or Referred by Pretrial Services

Multiple focus group participants emphasized the difficulties created for individuals approaching the MAT clinic through via deflection or referral from Pretrial Services. One OES staff member stated that it's important to remember that "we're seeing them on their worst day." Coming to the MAT clinic after a long interaction with the police or a stay in jail can make it a challenge for an individual to then succeed in completing a time-consuming clinical intake process.

Support with Housing

Recognizing the improbability of being able to provide such support, one supervisor said that ideally she or he would like to have some type of support for a transitional/temporary living arrangement (like a hotel) for clients. Potential clients that are experiencing homelessness are often preoccupied with their sleeping arrangement. Having the reassurance of a safe place to go after completing the clinical intake would be helpful. Another supervisor offered that for individuals who were deflected who are currently using substances, temporary housing would give them "a place to sleep it off for a couple days" and return for the clinical intake when they're ready for it. Multiple co-responders similarly made the suggestion of some type of temporary housing option for individuals who are deflected. One co-responder described the frustration of sitting with someone who has agreed to treatment and then having to tell them there are no beds available at shelters. There was widespread agreement in both focus groups that having some type of housing available, even if temporary, would substantially improve engagement with treatment. One co-responder offered that this type of support is particularly critical in the first couple weeks of treatment when the medical staff are working on identifying the correct dose of medication for the individual.

More Support in Obtaining IDs

Multiple focus group participants mentioned how formidable the barrier of lack of identification can be. Lack of a state ID is a barrier to MAT after 30 days and to enrollment in programs providing housing and food support. This can be extremely frustrating and dispiriting for potential clients. More support for staff to help people obtain their IDs was suggested by one co-responder. A supervisor offered that this is a longstanding issue and CODAC has allocated a portion of their State Opioid Response grant to create a pool of funds to pay for identification cards. In addition, CODAC changed an internal policy to allow use of an expired identification or a paper jail identification for an additional 30 days to allow time for processing the official government issued cards.

Belongings and Pets

For those individuals experiencing homelessness, focus group participants suggested that having some arrangement that allowed them to pick up or secure their belongings would be extremely helpful. One recovery coach noted "that's everything they own, their entire life, and theft is common." Co-responders also mentioned the barriers created by concern for belongings and pets.

Focus group participants suggested that having some capacity to store people's belongings in storage bins or lockers was a possible solution.

More Locations in Town to Receive Medication Dosing for MAT

One co-responder offered that people who live on the east and south side of town are less likely to remain engaged in treatment due to longer distances to the MAT clinic. Another co-responder suggested the use of mini dosing locations, a model currently used by another local treatment provider.

Right People for the Job

One supervisor stressed the importance of having the "right officers in the job" for the Deflection Program and that this increases the likelihood of an individual engaging in treatment as a result of being deflected. Stressing that 95% of officers have been great, this supervisor said that a small percent of officers drop the person off and leave. Most officers call ahead to the MAT clinic to alert staff of their impending arrival and then wait with the individuals until they are received by clinic staff. Multiple staff reported that these actions have been particularly helpful as they allow the clinic staff to prepare for and receive the incoming individual.

Pretrial Services

A supervisor wondered if it would be possible to change when individuals involved in Pretrial Services are released. Currently, individuals receive a hearing in the afternoon and then are released around 6:00 or 7:00pm. Homeless services are not available at this time and many individuals want to return home or to use substances after being in jail. Releasing individuals earlier in the day might increase the chances of them completing the clinical intake. A co-responder offered that it might also be helpful for this specific population if more providers were able to provide medication dosing for MAT in jail. This co-responder suggested that providing this service could also help reduce the number of overdoses, the risk of which is relatively high following a period of incarceration. Lastly, given the issue of housing is a problem for many individuals referred by Pretrial Services, focus group participants again suggested that any type of temporary housing would be extremely helpful for these individuals.

Media Promotion/Marketing of the Deflection Program

Multiple co-responders suggested that the Deflection program should have more marketing. They suggested that marketing could help with community perceptions of the police and promote the availability of treatment services. Commenting on the current negative perceptions of the police held by some and demands for more social services in policing, one co-responder said, "we are doing what people are asking for, but they have no idea we're doing it."

Another Vehicle for the Co-responders

Multiple co-responders said that they would benefit substantially from having an additional agency vehicle to use in addition to the one vehicle they currently have. Now that the team has four co-responders, up from two previously, an additional vehicle would give them more flexibility in terms of going out in the field. Most importantly, it was suggested that an additional vehicle could help them transport individuals to treatment who are not willing to ride in the back of a police vehicle, a

ride that one co-responder noted can be traumatizing for some individuals. Another co-responder offered that multiple individuals have refused to be transported in a police vehicle and that the availability of the treatment provider agency vehicle in some cases makes all of the difference in terms of an individual engaging in treatment.

“Hand Holding” During the Transition to MAT Clinic Staff

One co-responder noted that there is sometimes a contrast between the individualized and sometimes extensive attention individuals who are deflected receive from the TPD officers and co-responders and the atmosphere upon arriving at the MAT clinic, especially if clinic staff are busy. They reported that some individuals can become frustrated or hopeless if they feel like they are “just a number to [staff].” They suggested that more explicit encouragement and “hand holding” be provided to these individuals as they transition into the sometimes lengthy clinical intake process.

Information Sharing

Multiple co-responders reported having difficulty coordinating services with providers and law enforcement, such as parole officers, who are not able to share information about individuals. A co-responder gave an example of speaking to someone in the community who said she or he is a client of a particular provider, but when the co-responder calls the provider, the provider is unable to provide any information on that community member. The co-responder expressed understanding of the need to respect the individual’s privacy, but expressed the resulting challenge to coordinating services for that individual. The co-responder wondered if there was a way to design a “blanket” release of information or something to that effect that would help them coordinate services for individuals.

Food

A supervisor suggested that it would be great if they could provide food to individuals during the clinical intake process. This supervisor explained that state and federal grant funds are highly restricted in terms of how much they can spend on food per client. Food is also not an allowable AHCCCS (AZ’s Medicaid agency) expenditure. The MAT clinic is able to provide light snacks to clients.

RECOMMENDATIONS BASED ON FINDINGS

Based on the feedback provided in these focus groups, a number of common barriers to successful engagement with treatment were identified as well as specific areas for growth and modification of existing practices.

Stigma

The marketing and promotion of success stories involving MAT and the Deflection Program could potentially help reduce stigma around MAT as well as promote the Deflection Program itself. The community education role already played by SURT officers and co-responders could potentially be bolstered with marketing materials and public events.

Lack of Identification

In addition to the current practices and funds allocated to helping individuals obtain identification, **U-MATTER** project partners might attempt to leverage additional existing city or county services/ supports that assist individuals in obtaining identification more intentionally as a component of the clinical intake process or of Pretrial Services.

Lack of Contact Information

Similarly, **U-MATTER** project partners might attempt to leverage existing city or county services/ supports that assist individuals in obtaining a phone more intentionally as a component of the clinical intake process or of Pretrial Services. Alternatively, grant funds might be secured to fund such phones.

Homelessness

Addressing the housing needs of individuals deflected by TPD or referred by Pretrial Services is an enormous task that **U-MATTER** project partners do not currently have the capacity to take on. However, a partnership with an existing housing support provider could help mitigate this challenge for some individuals. The housing assistance could take the form of temporary housing in a hotel or more substantive and longer-term housing assistance. One of the supervisors explained during the focus group that prior to the pandemic, CODAC had a partnership with a local housing support provider to have one bed available to use for up to 48 hours for individuals who had been deflected or referred from Pretrial Services. This support, though helpful, was insufficient to address the number of clinic clients in need of housing support. Currently, even this limited assistance is not available due to the pandemic. Pursuing similar types of partnership, ideally with larger capacity, could be very consequential for the likelihood of individuals engaging in treatment.

Transportation

Given how consequential transportation barriers can be and the substantially lower cost of this service when compared to supports such as providing housing, a focus on securing funding to support a staff position dedicated to transportation could be impactful. Alternatively, or in addition to, connecting individuals more intentionally with available transportation resources, such as by providing bus passes, could help mitigate this challenge.

Belongings and Pets

Given that the security of belongings and pets are a primary concern for people experiencing homelessness, it seems possible to review current practices to determine if there is a reasonable way for TPD officers or clinic staff to help individuals reduce these concerns. For example, clinic staff could potentially transport individuals to collect their belongings and provide them with a secure storage location.

Information Sharing

It could also be beneficial to explore whether information sharing agreements and releases of information could be developed to allow co-responders access to relevant information from providers and parole officers about individuals deflected by TPD with the individual's consent.

During the focus group, a supervisor explained that AHCCCS has been developing a Central Registry where any MAT program staff could check to see if a person was already enrolled with services at a provider located in the state of AZ. This registry will include basic information such as date of last MAT-related medication dose, the dose amount, and where the person receives services. When this registry is available, it will make for a very quick and simple means to check on where a person may or may not be getting services, as well as help avoid duplicative enrollment in multiple programs. AHCCCS is planning to start piloting this registry in October/November 2020.

Pretrial Services

Given the issues created with the current times at which individuals are released through Pretrial Services, it might be worthwhile to inquire as to whether this practice could be modified to allow individuals to be released earlier in the day.

