



Comprehensive Human Services Needs Assessment

2021

Prepared for Tempe Community Council



2021 COMPREHENSIVE TEMPE HUMAN SERVICES COMMUNITY NEEDS ASSESSMENT

Prepared for Tempe Community Council



IN PARTNERSHIP

This needs assessment was conducted in partnership with Tempe Community Council Staff, the Needs Assessment Advisory Team, key leaders and staff at human service organizations throughout the city.

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| Tempe Community Council | Corona Insights |
|--|---|
| <p>Tempe Community Council ("TCC") was founded in 1972 and in 1976 became a 501(c)(3) nonprofit corporation committed to involving a broad base of volunteer citizens and staff in addressing immediate and long-term human service needs in the city of Tempe, Arizona.</p> <p>As a nonpartisan organization, TCC works through a volunteer citizen board to: identify and plan for needed human service programs in the community, to mobilize and educate the community regarding human service issues and needs, to conduct a funding review and recommendation process, and to inspire the community to donate time and resources to address human service needs.</p> | <p>Corona Insights is a Denver-based research, evaluation, and consulting firm with a mission to Illuminate Pathways to Greater Impact. We provide accurate information and thoughtful consul to decision makers. Corona Insights would like to thank TCC for entrusting us with shepherding this needs assessment.</p> |

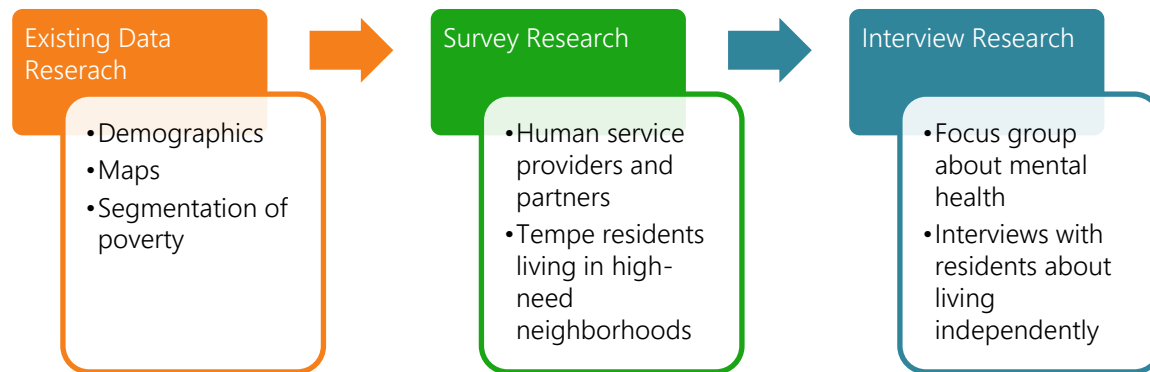
CONTENTS

| | |
|--|-----|
| Executive Summary..... | 1 |
| Section 1: Exploring Demographics and Community <i>Analysis of Secondary Data</i> | 8 |
| Section 2: Providing Human Services <i>Survey of Human Service Providers & Partners</i> | 40 |
| Section 3: Personal Resources, Challenges, and Human Service Needs <i>Statically Valid Survey of Households in High-Need Neighborhoods</i> | 51 |
| Section 4: Mental Health Complexities and Opportunities <i>Group Discussion with Mental Health Providers, Experts, and Community Leaders</i> | 68 |
| Section 5: Aging and Independent Living <i>In-depth Interviews with Residents</i> | 75 |
| Section 6: Prioritization of Needs & Resources <i>Prioritization Summit</i> | 81 |
| Section 7: Promising Programs <i>Model Program Search</i> | 86 |
| Appendix A: Methodology Existing Data Sources and Analysis..... | 102 |
| Appendix B: Methodology Survey of Human Service Providers and Partners | 103 |
| Appendix C: Methodology Statistically Valid Survey of Residents Living in High Need Neighborhoods | 104 |
| Appendix D: Methodology Focus Group Discussion with Mental Health Experts.... | 107 |
| Appendix E: Methodology In-Depth Interviews with Residents | 108 |
| Appendix F: Potential Outcomes Tracking Tools Individual Needs, Mental Health, and Substance Use.. | 109 |

EXECUTIVE SUMMARY

As a nonpartisan organization, Tempe Community Council (TCC) works through a volunteer citizen board to identify and plan for needed human service programs in the community; mobilize and educate the community regarding human service issues and needs; conduct a funding review and recommendation process; and inspire the community to donate time and resources to address human service needs.

In 2021, the TCC hired [Corona Insights](#), a Denver-based research and consulting firm, to conduct a comprehensive human services needs assessment. This report summarizes the needs assessment process and the most notable outcomes, including key findings and insights garnered from a robust progression of research phases.



Additionally, an open link to a questionnaire was available for anyone to provide their input into the needs assessment process. Data from this open-link survey were kept separate from the statistically valid resident survey.

KEY INSIGHTS

COMMUNITY

Transportation



- > 87% of surveyed residents have a reliable car and car insurance, and 84% usually drive themselves to get around the community. Additionally, about 27% usually walk, 17% take public transit, and 9% have others drive them to get around town. Only 4% need help or more help getting to places, such as to the store.
- > However, for older adults that were interviewed, transportation was a top-of-mind challenge, and they expressed concerns over the rising amount of traffic and lack of reliable access to transportation and parking.
- > 7% of Tempe residents who drove or carpoled to work lived below the poverty level, compared to 30% of residents who took public transportation to work. Public transportation users were also more likely to be home renters (86%) than homeowners (14%). These figures generally remained steady over the past 10 years.

- > Tempe is a labor importer. Over 166,000 private sector primary jobs (i.e., highest paying) located in Tempe were held by people who lived outside Tempe, as of 2018. This figure dwarfed the number of people who lived in Tempe but worked elsewhere (about 51,000) plus the number of people who lived and worked in Tempe (over 16,000).
- > 67% of females with young children were employed in 2019, up from 54% in 2010. Older adults (age 65-74) were slightly more likely to be in the workforce by 2019, which may be a sign of inability to afford retirement.

Employment



- > Tempe residents who worked fewer than 30 hours per week had a 50% likelihood of having low incomes, while those working full time had only a 9% likelihood of having low incomes, according to census data.
- > Unemployment rates decreased for most populations between 2010 and 2019, especially for people with a diploma or less education. Unemployment trended higher around the university, but also in pockets throughout Tempe. The July 2021 unemployment rate in the Phoenix Metro area was 5.7%.
- > 25% of surveyed residents (or someone in their home) lost a job in the last year, and about that many looked for a job but did not get one. Many residents described “jobs and work” as a common challenge of the last year.
- > 47% of human service organizations provide job services or training, and 70% of them have ability to serve more people who are looking for a job.
- > Although providing job services is common, 41% of service providers rated job services or training as a top area for action in the next five years, which was the third highest among 19 priority areas tested.

Social and Community



- > 38% of surveyed residents felt lonely some of the time or often, while 40% felt lonely hardly ever or never. Respondents who are homeless, renters, or who had smaller household incomes reported higher levels of loneliness.
- > 68% of surveyed residents reported having family or friends living close by that could help if needed.
- > 26% of service providers mentioned social isolation when describing COVID-19's impact on the people they serve.

HOUSEHOLDS

Finances



- > American Community Survey data showed the median income of all households in Tempe neared \$66,000 in 2019, which was up \$21,000 compared to 2010, a 47% increase. Households with a White householder had the highest income in 2019 at \$74,800. However, median household incomes among homes with Hispanic householders grew at a faster rate (i.e., 78%) compared to households with a White householder (47%).
- > People living in neighborhoods in Northeast Tempe have the most socioeconomic vulnerability, according to Social Vulnerability Index data. The median household income in the southern neighborhoods of Tempe tended to be between \$115,000 and \$150,000, much higher than the \$20,000 to \$50,000 range in the northern neighborhoods.
- > 19% of surveyed residents rated their personal finances as bad or very bad, while 47% rated them as good or very good. 91% said they have a checking account at a bank, 80% have a credit card, 72% have a savings account with more than \$100, and 66% have a retirement savings account.
- > About one third of surveyed residents said a \$400 emergency expense would prevent them from paying other bills. Additionally, nearly 40% could not pay off what they owe on their credit card if they wanted to.
- > 10% of service providers ranked financial education as a top action area.

Household Makeup



- > Neighborhoods with higher proportions of single parent households were spread throughout Central and Southern Tempe, which is generally where children live.
 - > Children living with single-parents, and especially with single mothers, were much more likely than other children to be living in poverty. Indeed, about half of children who live with a single mother live in poverty.
 - > 33% of service providers believed helping parents access childcare would take an extreme or strong intervention, which ranked second lowest among 22 issues tested. Relatedly, 6% of surveyed residents needed help or more help paying for childcare, while very few were currently getting help paying for childcare. 5% needed help finding childcare to match work schedules.
 - > 11% of surveyed residents experienced a divorce, separation, or breakup in the past year.
-

Housing



- > 24% of rented households were paying \$1,500 or more per month on rent in 2019, up from 9% in 2010, according to the American Community Survey. Additionally, only 1.4% of rented households were paying less than \$500 in rent, down from 4% in 2010. However, the percentage of rented households that were housing burden (i.e., paying 30%+ of income on housing) decreased slightly, from 54% to 49% during that time. Nonetheless, this means nearly half of all rented households were spending much of their income on housing.
- > Housing situations are more likely to be good than bad. 69% of surveyed residents rated their current housing situation as good or very good, while 4% rated it bad or very bad.
- > 22% of surveyed residents need help or more help finding a home they can afford, 11% need help paying rent or making housing payments, and 11% need help paying utility bills. Positively, 8% of residents are currently getting help paying utility bills and 6% are getting help paying for rent or making housing payments.
- > 17% of surveyed residents worried a lot about needing to move from their home or being forced to move, and 5% were evicted or forced to move in the past year.
- > Almost half of service providers said housing and homelessness was the greatest community-wide challenge, when considering the number of people affected and the severity of the challenge. This was far greater than any other challenge. 32% of service providers said their organizations are over capacity to help more residents pay for housing, and only 24% have ability to serve more people.
- > 37% of service providers believe Tempe's *homeless* residents are served "not so well" or "not well at all," making them the second worst-served population.
- > 73% of service providers rated housing as a top area for action in the next five years, which was more than any other priority area tested.

PEOPLE

Race and Ethnicity



- > 25% of service providers said that all or almost all of their programming is focused on increasing access to services or resources for members or underrepresented racial or ethnic groups.
- > Unemployment rates decreased for most populations of color between 2010 and 2019, but especially for Black/African Americans (9-percentage point decrease) and people in the American Indian and Alaska Native population (6-percentage point decrease), according to the American Community Survey.
- > People of color are almost universally more likely to have low incomes than their White counterparts; in particular, Asian residents are twice as likely to have low incomes. As a result of higher likelihoods of having low incomes, people of color make up more than half of the low-income population, according to data from the U.S. Census Bureau.

Ability



- > About 13% of all Tempe civilians living in non-group homes reported having a disability on the American Community Survey, and 17% of the American Indian and Alaska Native population reported having a disability. Ambulatory difficulty, hearing difficulty, and independent living difficulty were all much more common in residents 65 or older.
- > Among surveyed residents, about 18% reported that a disability, handicap, or chronic disease kept them or someone in their household from fully participating in typical activities, and 8% said they need help or need more help overcoming a disability.
- > Service providers rated *"supporting people who are disabled to live independently"* as the challenge most likely to require extreme or strong intervention, among 22 different challenges listed. Relatedly, almost all service providers who support disabled residents said they have ability to serve more.
- > Tempe residents with a disability were 28% more likely than other residents to have lower incomes, according to census data.

Youth



- > 55% of human service organizations that were surveyed provide or address youth development or support, which was more than any other service included on the survey. However, only 24% of human service organizations address childcare.
- > Youth having issues at school and at home were challenges that likely need strong intervention, and local organizations providing that help are more likely to be over capacity.
- > Relatively few service providers believed school-aged children or infants and toddlers were not well served in Tempe. 4% mentioned youth and education as the greatest community-wide challenge.
- > 7% of surveyed residents said they need help or more help for problems their kids were having.

Seniors



- > Although seniors are more likely to be on fixed incomes, they are less likely than other Tempe residents to be in poverty, according to census data. Nonetheless, some interviewed seniors expressed considerable anxiety over their ability to pay bills in the future.
- > 6% of surveyed residents need help or more help living independently as they age, and 7% need help or more help caring for an older family member.
- > Ambulatory difficulty, hearing difficulty, and independent living difficulty are all much more common in residents 65 or older than in younger residents, according to the American Community Survey.
- > The percentage of Tempe's seniors who are renting increased from 21% in 2010 to 27% in 2019.
- > 53% of organizations that serve seniors have at least some capacity to serve more seniors wanting to age in place, according to human service providers.
- > Most seniors who were interviewed wish to maintain their independence, are reluctant to commit to a full-time assisted living situation, and currently rely on family and friends for support. Interviewed residents who are providing help to older family members feel overwhelmed by the sheer multitude of responsibilities that are required.

HEALTH

Health and Trauma



- > Most surveyed residents consider themselves healthy: 75% rated their health, in general, as good or very good while only 3% rated their health as bad and 0% said very bad. 92% had health insurance and 20% received Medicare or Medicaid.
- > Illness, injury, and death was the third most common significant challenge of the past year for surveyed residents. 27% had a serious health problem, illness, or injury, which was the second most common stressful experience, and 22% experienced the death of a close friend or family member. 8% witnessed violent or aggressive behavior in their home, such as domestic abuse.
- > 11% of surveyed residents need help or more help getting health insurance, finding or going to a doctor, or paying for medical bills.
- > 76% of service providers indicated child abuse survivors and domestic abuse survivors would typically need extreme or strong interventions and support; this was the third highest among the 22 issues that were rated. Generally, organizations that support this population had the ability to serve more.
- > 29% of service providers rated trauma as a top action area for the next five years, which was the seventh highest among 19 priority area tested. 20% rated medical healthcare as a top action area, and 12% rated health insurance as a top action area.

Mental Health



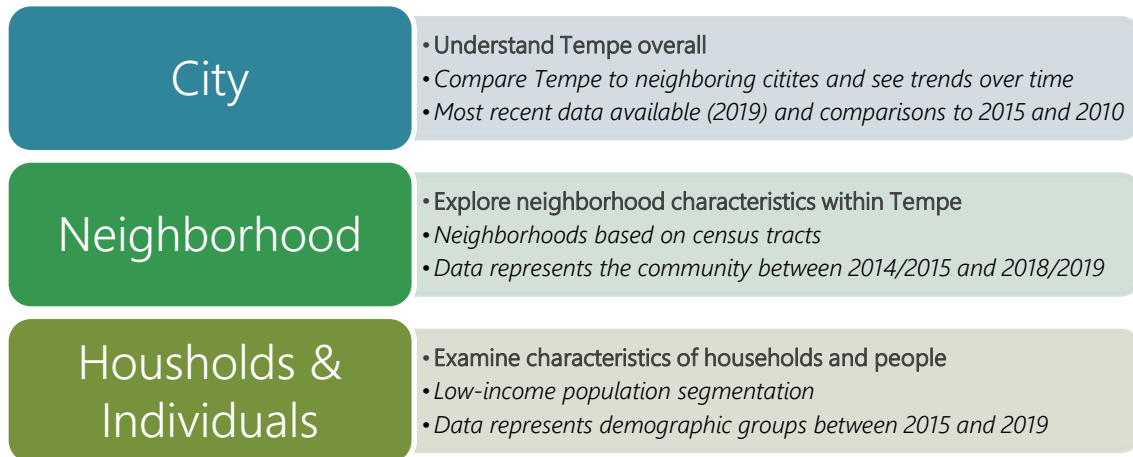
- > 46% of surveyed residents had a day when their mental health was NOT good in the past month, yet only 8% of those surveyed were getting the help they needed to access mental health care.
- > 45% of service providers said their organizations are over capacity to help more residents address alcohol or drug abuse, while 36% have ability to serve more people. 37% of service providers said their organizations are over capacity to help more residents access mental health care, while 47% can serve more.
- > Mentally ill residents are arguably the worst-served vulnerable population in Tempe; 38% of service providers believe Tempe's mentally ill residents are served "not so well" or "not well at all," higher than other populations tested.
- > The focus group discussion highlighted that mental healthcare should be addressed by a broader population than licensed therapists or professionals. Peer-support programs can be used throughout the crisis system to encourage individuals to seek or continue to get the mental health care and services they need.
- > Mental health problems and awareness was a notable outcome of COVID: 26% of service providers mentioned mental health problems when describing COVID's impact on the people they serve.
- > 11% of service providers said mental health was the greatest community-wide challenge, when considering the number of people effected and the severity of the challenge. This was more common than most other challenges, but far less common than housing. A lack of knowledge about available resources is a key mental health care problem, according to providers and experts.
- > 59% of service providers rated mental healthcare as a top action area for the next five years, making it the second highest ranked priority area.

SECTION 1:
EXPLORING DEMOGRAPHICS AND COMMUNITY
ANALYSIS OF SECONDARY DATA

INTRODUCTION

Government agencies, local non-profits, and other organizations all collect information about communities, neighborhoods, households, and people living in Tempe. We begin the needs assessment by exploring trustworthy existing data to establish facts, begin to reveal insights, and look at community and neighborhood demographic trends over time.

The data presented in this section can be categorized into three levels of analysis: city, neighborhood, and households & individuals. We leveraged the advantages of each analysis level to provide an in-depth profile of the Tempe community.



DATA SOURCES

The primary data source accessed for the existing data review was the American Community Survey (ACS), which is administered annually by the U.S. Census Bureau. The ACS provides a wealth of knowledge and insights at all three levels of analysis described above, and it is trusted as one of the most accurate, reliable, and consistent sources of community demographic information. All data in this section were derived from the ACS except for commuting patterns and job locations, which were collected from the Longitudinal-Employer Household Dynamics (LEHD) Program at the U.S. Census Bureau's Center for Economic Studies. The social vulnerability index is provided by the U.S. Center for Disease Control, but it is based completely upon analysis of ACS data.

A description of the methodology is found in [Appendix A](#), and more information about these data sources is available online:

American Community Survey

- <https://www.census.gov/programs-surveys/acs>

LEHD Origin-Destination Employment Statistics

- <https://lehd.ces.census.gov/doc/help/onthemap/OnTheMapDataOverview.pdf>

Social Vulnerability Index

- https://www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2018.html

KEY INSIGHTS | DEMOGRAPHICS

The following key findings summarize the results of the existing data review and analysis.

CITY AND NEIGHBORHOOD PROFILES

1. **Some neighborhoods have more social vulnerability than others.** Social vulnerability in Tempe, as measured by a suite of socioeconomic, demographic, and household characteristics, were higher in Northeast and West-Central neighborhoods than elsewhere. The specific socioeconomic factors that primarily drove vulnerability were low-income, poverty status, and lack of high school education. Specific housing and transportation factors that primarily drove vulnerability were crowded housing and lack of vehicles.
2. **Home renters are common.** A majority (59%) of housing units in Tempe were rented (much higher than the 35% statewide), and rental costs have increased notably over the past decade. The median contract rent, for all rented units, in Tempe was about \$900 in 2010 and climbed to about \$1,200 by 2019, a 31% increase over nine years. As of 2019, one-quarter of renters were paying \$1,500 or more per month. In tandem, household crowding (i.e., more than one occupant per bedroom, on average) climbed slightly, and the percentage of older adults renting also increased.
 - a. Although rental costs increased, so too did income. Therefore, the percentage of renters who were housing burdened (i.e., paying more than 30% of their income on housing costs) decreased slightly from 54% in 2010 to 49% in 2019.
3. **Increasing incomes.** Median annual household income in Tempe increased 47% between 2010 and 2019, from near \$45,000 to near \$66,000. As of 2019, household incomes among Hispanic householders were lower than among white householders, even though incomes within Hispanic households grew at a faster rate (78% vs. 47%) since 2010.
4. **Falling unemployment.** Income increases in Tempe correlated with generally increasing employment to population ratios and decreasing unemployment across most demographic groups. As of 2018, jobs within Tempe tended to be located on the west side of the city or downtown, and job location concentration varied only slightly by job pay range. Key job producing industries included educational services; healthcare and social assistance; professional, scientific, and technical services; finance and insurance; real estate and rental/leasing; and retail.
5. **Tempe is a labor importer.** In 2018, over 166,000 private sector primary jobs (i.e., highest paying) located in Tempe were held by people who lived outside Tempe. This figure dwarfed the number of people who lived in Tempe but worked elsewhere (about 51,000) plus the number of people who lived and worked in Tempe (over 16,000).

LOW INCOME SEGMENTATION

Four key populations that tend to have lower incomes are listed below:

6. **Single-parent households** – These are primarily single mothers with children, but single fathers are not uncommon. Both single-mother and single-father households are more likely than average to have low incomes, but single-mothers are particularly highly likely to have low incomes because women tend to earn less than men overall. Further, single-mothers care for more children, on average, than do single-fathers, according to the U.S. Census. While the total number of single-parent households are not large relative to other populations with low incomes, they are more vulnerable than average.
7. **Persons of Asian ancestry or born in Asia** – People of Asian origin were far more likely to have low incomes than the average Tempe resident, and they are present in large enough numbers to be a notable proportion of the low-income population. A strong majority of low-income persons of Asian ancestry or Asian birth are college students.

8. **College students** – College students are obviously a very large population that is also highly likely to have low incomes. While some college students have need for assistance or services, many students have additional income in the form of grants, loans, parental support, scholarships, or other aid that may not be accounted for in census data. While this is a population of interest, the statistics presented here also likely overestimate the extent of need.
9. **Part-time workers** – Approximately one-third of people with low incomes worked part-time. Given the large college population, some part-time workers are likely college students who are working and attending school. But it is worth considering how to help part-time workers who may be unable to work more hours but want to. Solutions may include increasing childcare availability or providing job transition training.

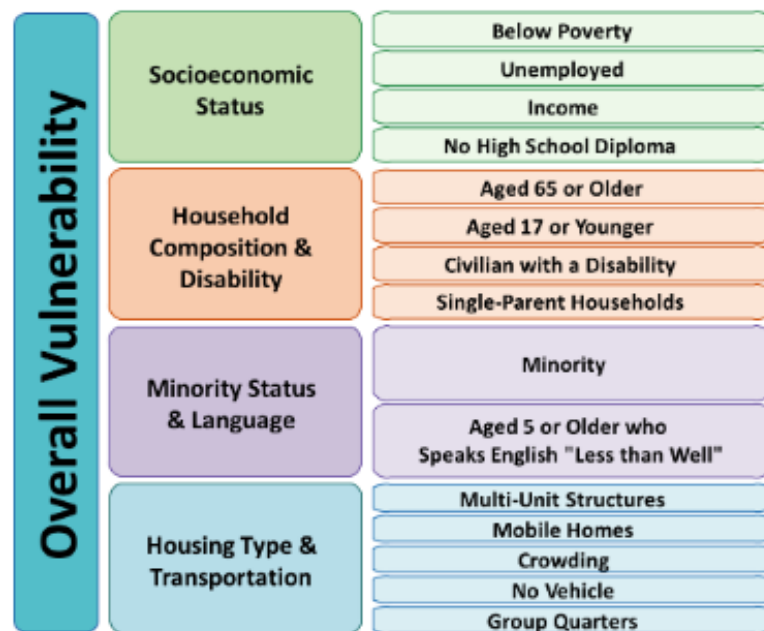
CITY AND NEIGHBORHOOD PROFILES

SOCIAL VULNERABILITY

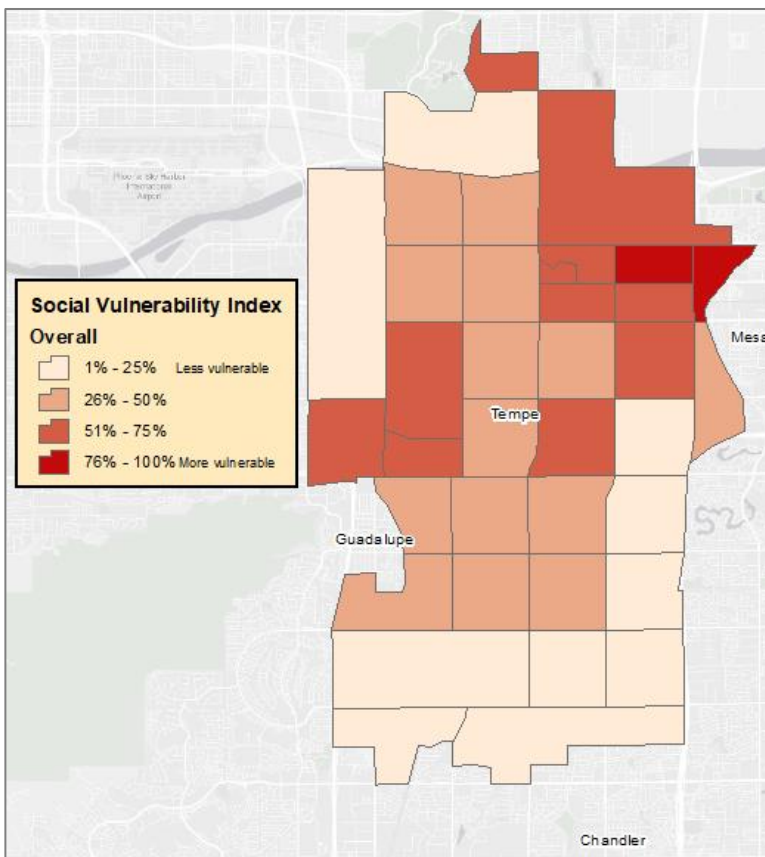
Human services can benefit people living in communities that are vulnerable to negative external pressures, such as disease outbreaks, economic recessions, natural or human caused hazards, and unjust public policy and structural racism. It is well documented that community factors, such as employment, social capital, and just democratic structures can reduce the impact of negative events and help these communities bounce back faster.

To identify neighborhoods that are more vulnerable to negative events and unjust structures, the Center for Disease Control's developed a social vulnerability index (SVI). The index ranks neighborhoods (based on census tracts) on a vulnerability scale comprised of fifteen community measurements that are collected by the U.S. Census Bureau. Measurements fall within four themes: socioeconomic; household composition and disability; racial and ethnic minority status and language; and housing and transportation. By mapping the ranked results overall and by theme, we can see what neighborhoods in Tempe may have fewer resources and less capacity to maintain physical health and economic vitality in the face of negative stressors. People living in these neighborhoods may benefit the most from the successful delivery of human services.

Maps on the following pages show Tempe's neighborhoods as defined by census tracts. The colors represent the percentile ranking of that neighborhood on the social vulnerability index relative to the nation overall. Values can range from 0% to 100%, and higher ranking (e.g., 75% to 100%) represent greater vulnerability.



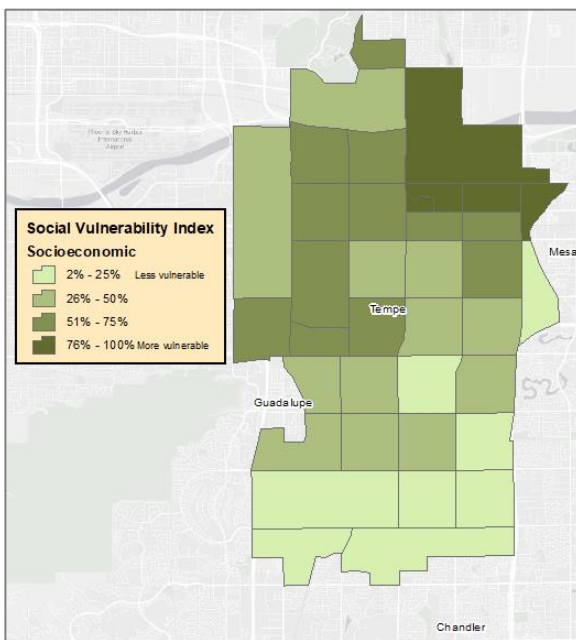
Factors Comprising the Social Vulnerability Index (SVI)



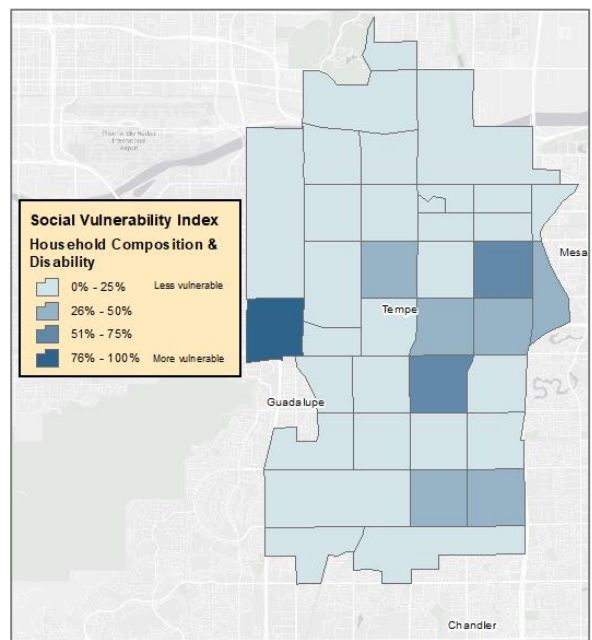
Neighborhoods in Northeast Tempe and West-Central Tempe have the most vulnerability overall. The primary drivers for vulnerability in these neighborhoods are socioeconomic and housing and transportation. The specific socioeconomic factors driving vulnerability are low-income, poverty status, and lack of high school education. The specific housing and transportation factors driving vulnerability are crowded housing and lack of a vehicle.

Social Vulnerability Index (SVI) – Overall

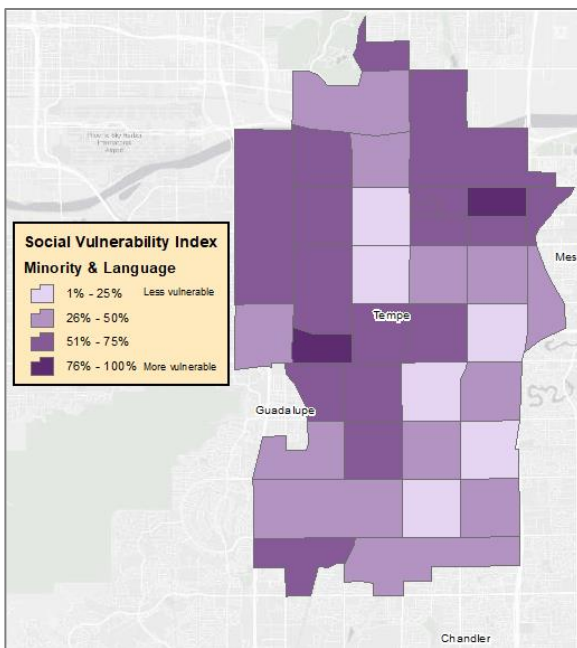
The following four maps show the percentile ranking of neighborhoods based on the four major themes of the SVI.



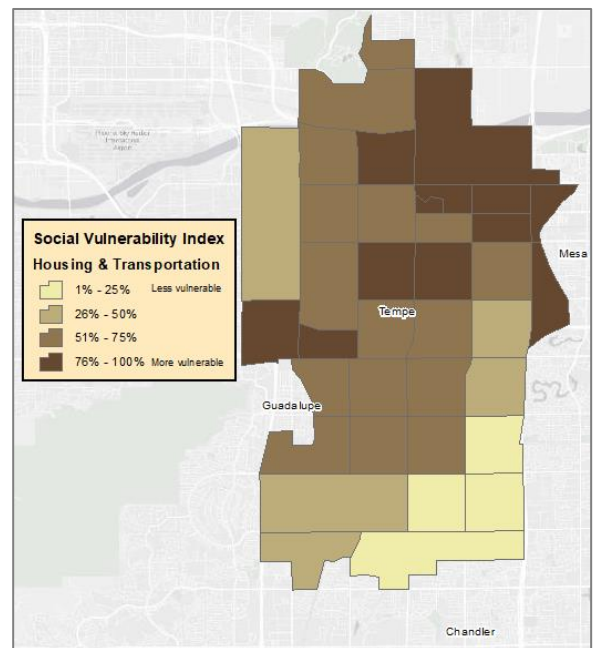
SVI – Socioeconomic: The neighborhoods in Northeast Tempe have the most socioeconomic vulnerability.



SVI – Household Composition and Disability: The pattern of vulnerability is less obvious for this theme.



SVI – Minority Status & Language: Compared to the rest of the country, Tempe has more racial and ethnic minority residents and more residents with limited English-speaking ability. These populations are dispersed in Tempe.



SVI – Housing Type and Transportation: The neighborhoods in Northeast Tempe tend to have the most housing and transportation vulnerability.

HOUSING

To support the needs assessment, we explored the following housing questions: How many households are housing burdened (i.e., paying more than 30% of income on housing), and has that changed over time? How has the cost of rent changed over time, and how does that relate to household income among renters (i.e., if rent has increased, has household income increased proportionately?) How many older adults are renting?

PAYING FOR RENTAL HOUSING

Between 2010 and 2019, the proportion of all occupied housing units that were renter-occupied increased from 53% to 59%, and about 9,000 more homes were renter-occupied in 2019 compared to 2010. Although rental housing costs clearly increased throughout the 2010's, including a 22% increase in median rent costs, the percentage of households paying more than 30% of income on rent slightly decreased from 54% to 49%, which is a good sign. However, about half of all renters are still considered housing burdened.

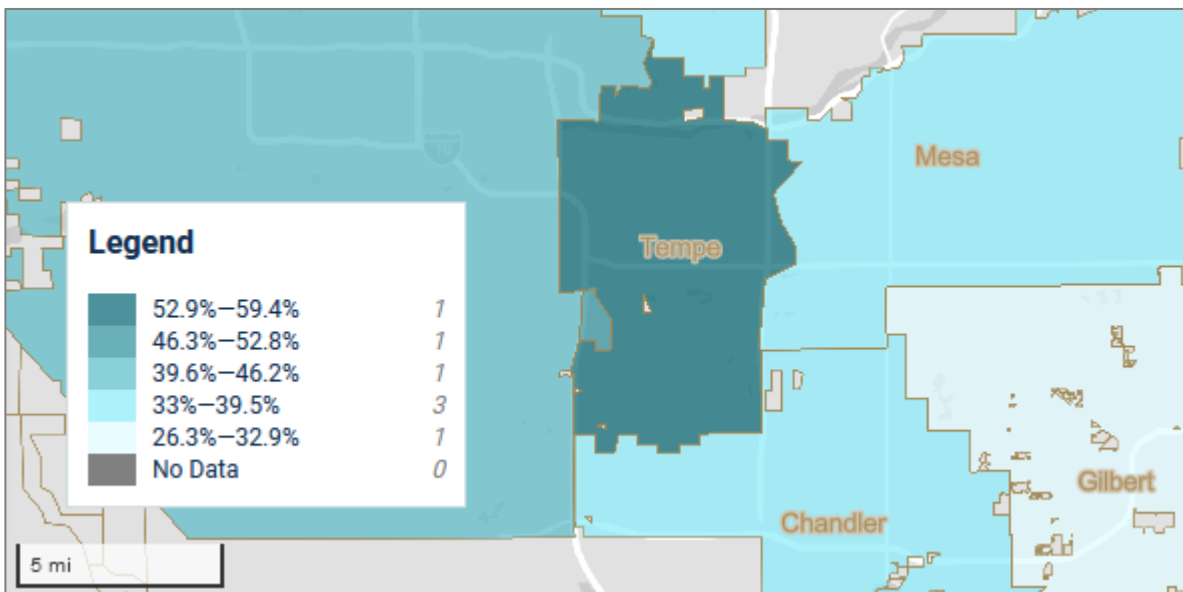
The slight decrease in housing burden during this time may be partially explained by a trend of greater occupant density per housing unit. That is, there were more households with more than one occupant per room in 2019 than in 2010, which may translate to more renters contributing to the total rent payment.

Lastly, the population of older adult (i.e., age 55 or older) renters is of concern because they may have less ability to afford rent increases. Also, losing secure housing may have more negative spillover effects such as negatively impacting their health and wellbeing. There was a 29% increase in the percentage of all older adult householders that were renting between 2010 and 2019, equating to about 2,500 more older-adult renters in 2019 compared to 2010.

| | Trend | 2010 | 2015 | 2019 |
|--|-------|--------|---------------------|------------------------|
| Rented housing units | ↑ | 34,213 | 37,745 | 43,380 |
| | | 53% | 58% | 59% |
| Households paying less than \$500 in rent | ↓ | 4% | 3.1% | 1.4% |
| Households paying \$1,500 or more in rent | ↑ | 9.1% | 12% | 24% |
| Median rent | ↑ | \$886 | \$954 +8% / 2010 | \$1,164 +22% / 2015 |
| Housing burden (>30% of income spent on rent) | ↓ | 54% | 50% | 49% |
| More than 1 occupant per room | ↑ | 3.1% | 4.7% | 5.3% |
| Percentage of older adult householders who are renting | ↑ | 21% | 26% | 27% |

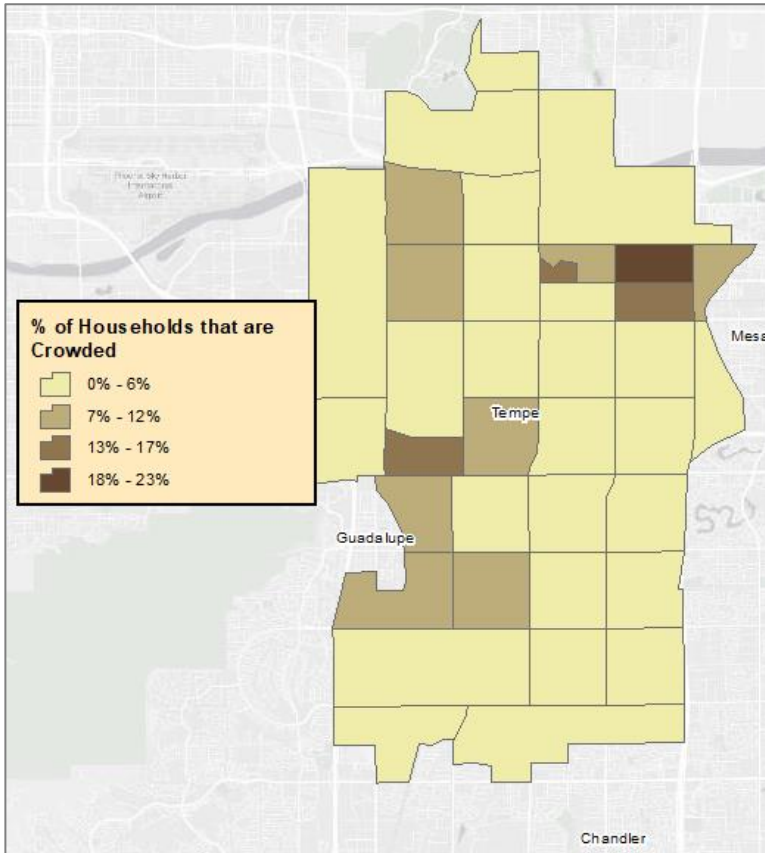
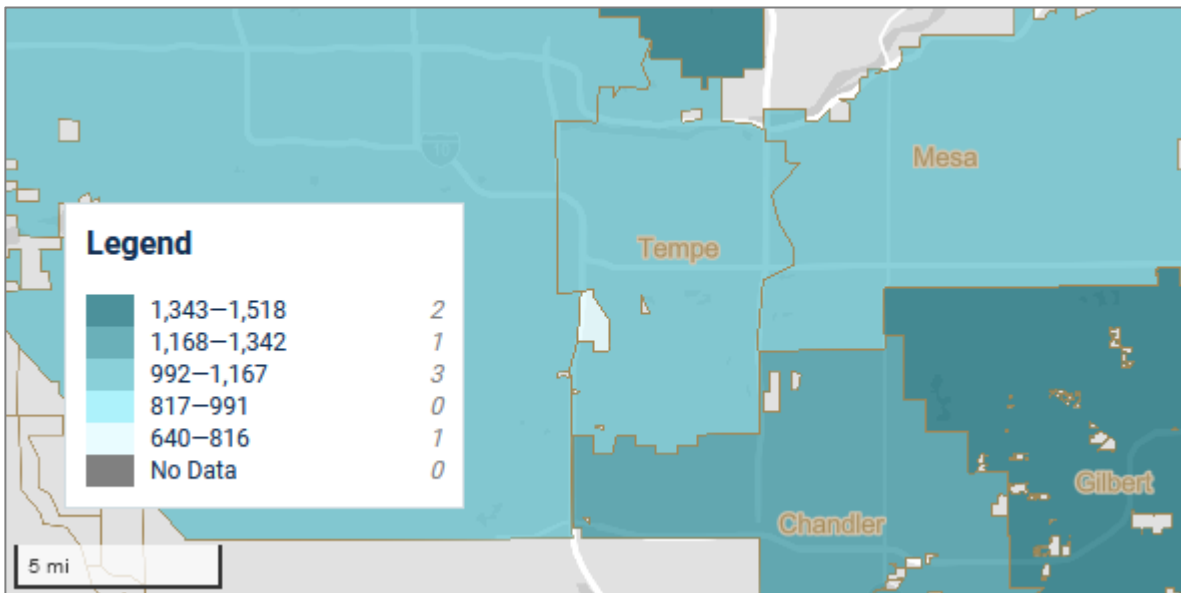
Percentage of all Housing Units that are Renter Occupied (2019)

Tempe has a much higher proportion of rented housing units than neighboring communities.



Median Gross Rent in Dollars (2019)

Although housing rental costs have been growing in Tempe, rental costs in 2019 were generally in line with neighboring communities. Note, however, that the percentage of lower-cost rent options (units under \$1,000 per month) varied dramatically throughout the metro area: 13% of all rental units in Gilbert were under \$1,000 compared to 32% in Tempe, 45% in Mesa and Phoenix, and 86% in Guadalupe (data not shown here).



% of homes with more people than rooms:

Throughout most of Tempe, few occupied housing units have more people living in them than bedrooms. However, there are pockets of crowded housing, especially around the University and Central Tempe.

FINANCIAL STABILITY

We explored the following financial stability questions, which predominately related to employment and income:

What is the median household income and how does that differ across the community? What is the unemployment rate? What are the major employment industries?

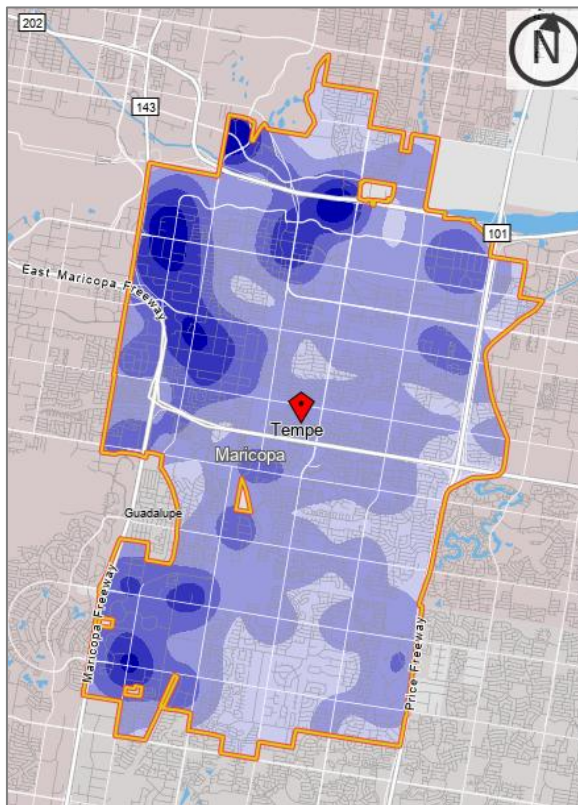
EMPLOYMENT

Since 2010, the employment/population ratio remained relatively steady for the population between age 25 and 64. Likewise, the unemployment rate remained similar across the decade, with a slight decrease recently. There were, however, some notable trends by segment. Specifically, older adults (age 65 to 74) became slightly more likely to be in the workforce, which may be a sign of inadequate ability to afford retirement. Also, females with children younger than six years old were more likely to participate in the workforce in 2019 than 2010. This may have human service implications because there may be an increasing demand for childcare. Alternatively, there may be more children younger than six who are being cared for by a relative, friend, or acquaintance when parents are working.

The unemployment rate dropped slightly between 2010 and 2019 for people age 25 to 64 (of any race or ethnicity), for people who are white and not Hispanic, and people who are Asian. The unemployment rate decreased notably for people with less education and for people who are Black or African American or American Indian/Alaska Native.

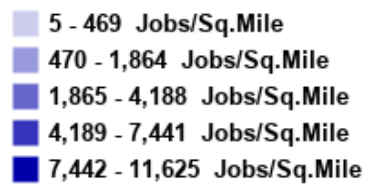
| | | Trend | 2010 | 2015 | 2019 |
|--|--|-------|------|------|------|
| Employed (employment/ population ratio) | Age 25 to 64 | — | 77% | 77% | 79% |
| | Age 16 to 19 | — | 38% | 38% | 36% |
| | Age 65 to 74 | ↑ | 25% | 25% | 29% |
| | Females with children under 6 | ↑ | 54% | 65% | 67% |
| Unemployment rate | Age 25 to 64 | — | 6% | 6% | 4% |
| | No high school diploma | ↓ | 14% | 6% | 4% |
| | High school graduate (or GED) | ↓ | 11% | 8% | 6% |
| | White alone, not Hispanic or Latino | — | 7% | 7% | 5% |
| | Hispanic or Latino origin (of any race) | ↓ | 8% | 6% | 5% |
| | Asian alone | — | 7% | 6% | 6% |
| | Black or African American | ↓ | 16% | 12% | 7% |
| | American Indian and Alaska Native | ↓ | 11% | 15% | 5% |

JOBS BY LOCATION



According to the most recent estimates from the Center for Economic Studies at the U.S. Census Bureau (2018), most private-sector primary jobs are located in Northwest Tempe (west of Priest Dr.), Downtown, and in Southwest Tempe.

Legend:



JOBS BY INDUSTRY

We explored jobs by industry for the full-time, year-round civilian employed population that is 16 years or older. Perhaps not surprisingly, the industry supporting the most jobs was “educational services, and health care and social assistance,” which was split about evenly between educational services (12%) and healthcare and social assistance (13%). Other industries supporting many jobs in Tempe included “professional, scientific, and technical services” (12%), “finance and insurance, and real estate and rental and leasing” (12%), and “retail” (11%). Women were much more likely than men to work in education services and health care services industry, whereas men were nearly twice as likely to work in professional, scientific, and technical service industry.

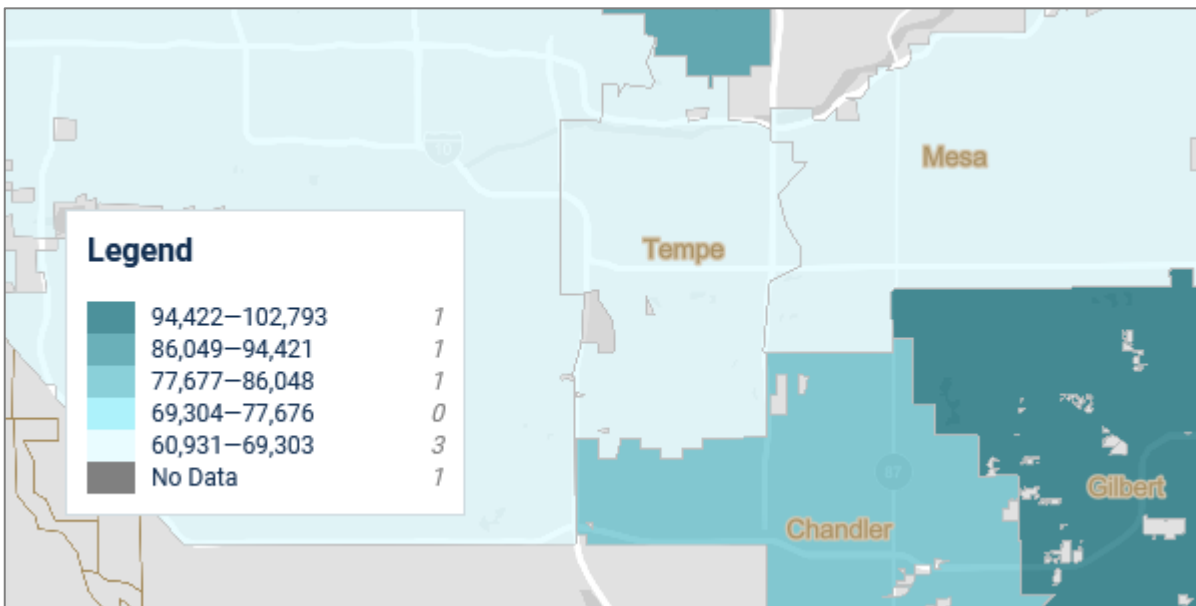
MEDIAN HOUSEHOLD INCOME

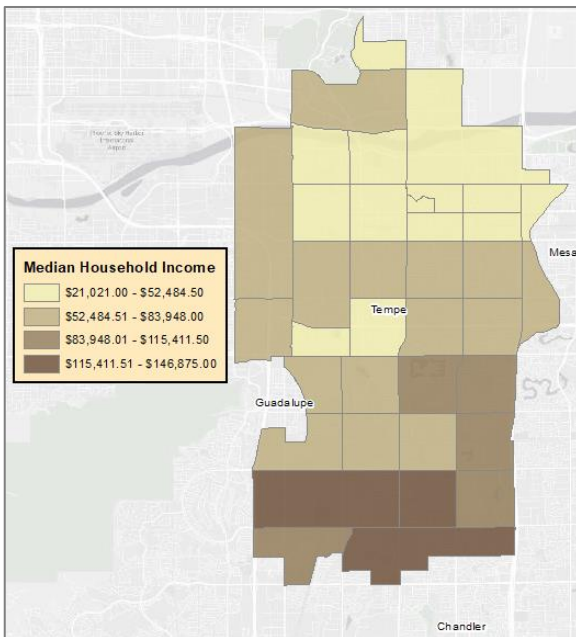
The median income of all households in Tempe was just over \$66,000 in 2019, which was up \$21,000 compared to 2010, a 47% increase. Household income trends did differ by race and ethnicity. Households with a White householder had the highest household income in 2019 at \$74,800. However, median household incomes among Hispanic householders grew at a faster rate (i.e., 78%) compared to households with a White householder (47%). The difference in median incomes between White and Hispanic householders was \$13,500, down slightly from \$16,000 in 2010.

| | Trend | 2010 | 2015 | 2019 |
|---|-------|----------|------------------------|------------------------|
| All households | ↓ | \$45,200 | \$51,700 14% growth | \$66,300 28% growth |
| Householder: White alone, not Hispanic | ↑ | \$50,500 | \$57,500 14% growth | \$74,800 30% growth |
| Householder: Hispanic or Latino (of any race) | ↑ | \$34,500 | \$49,700 44% growth | \$61,300 23% growth |

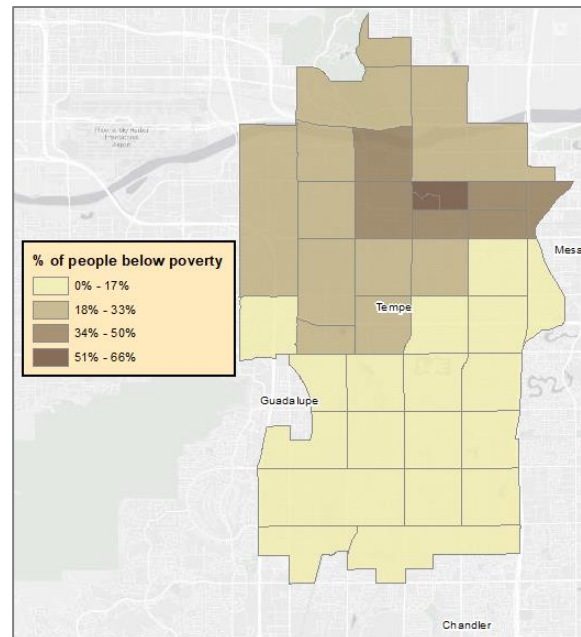
Median Household Income (2019)

Tempe's median household income in 2019 was near \$66,300, which was a bit higher than Phoenix and Mesa, but lower than Gilbert, Chandler, and Scottsdale.

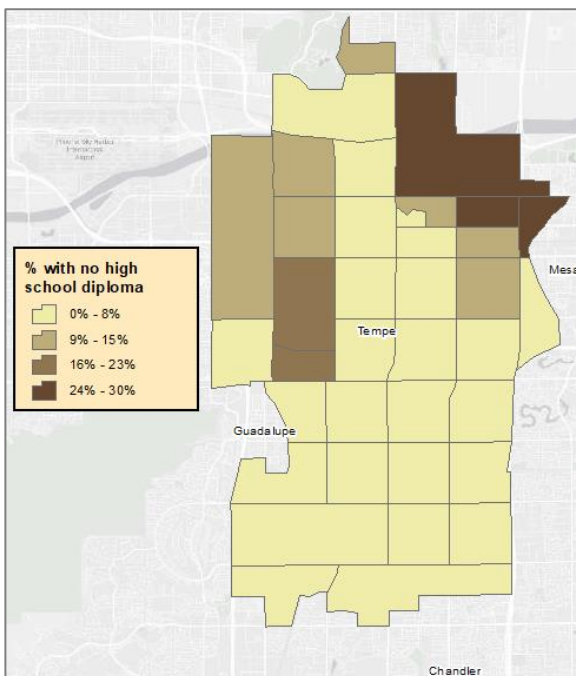




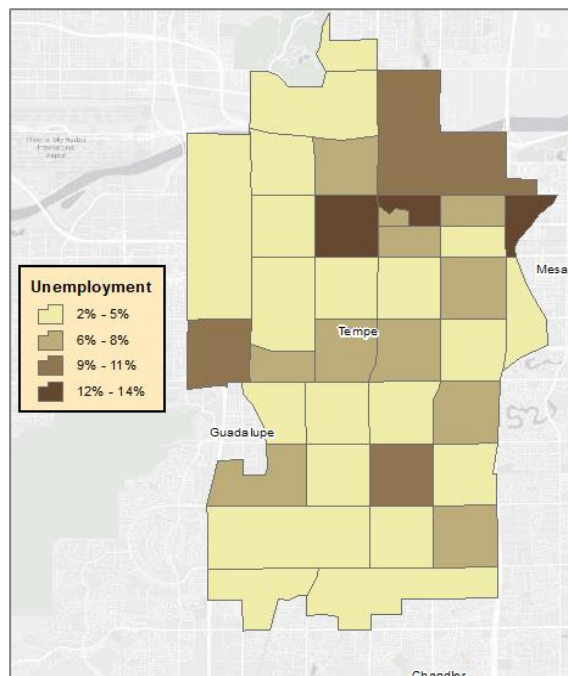
Median household income: The median household income in the southern neighborhoods of Tempe tended to be between \$115,000 and \$150,000, much higher than the \$20,000 to \$50,000 range in the northern neighborhoods, including around the Arizona State University campus.



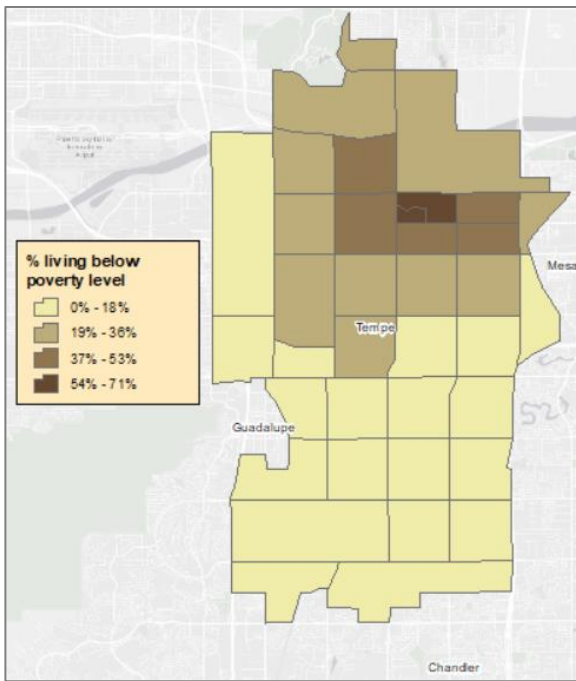
% of people living below poverty: People living in the Northern half of Tempe were much more likely to be experiencing poverty than those in Southern Tempe. The college student population in Tempe is likely a driver of higher poverty levels in this area.



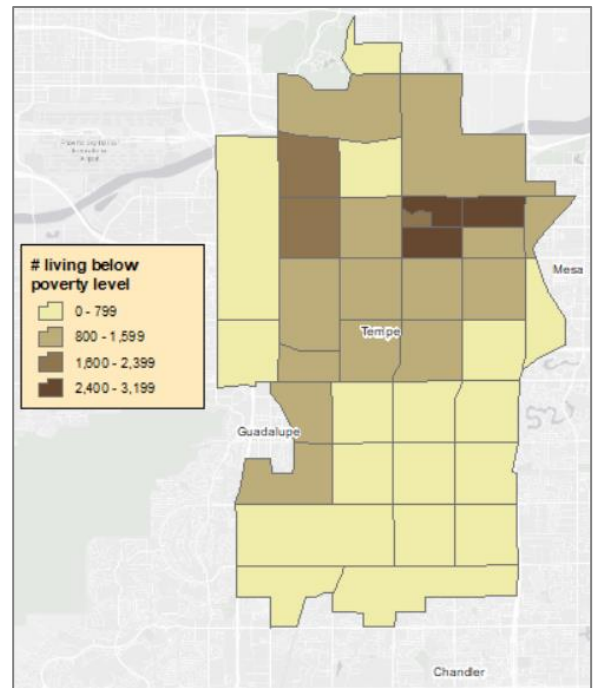
% who do not have a high school diploma: Residents without a high school diploma are concentrated in Northeast Tempe.



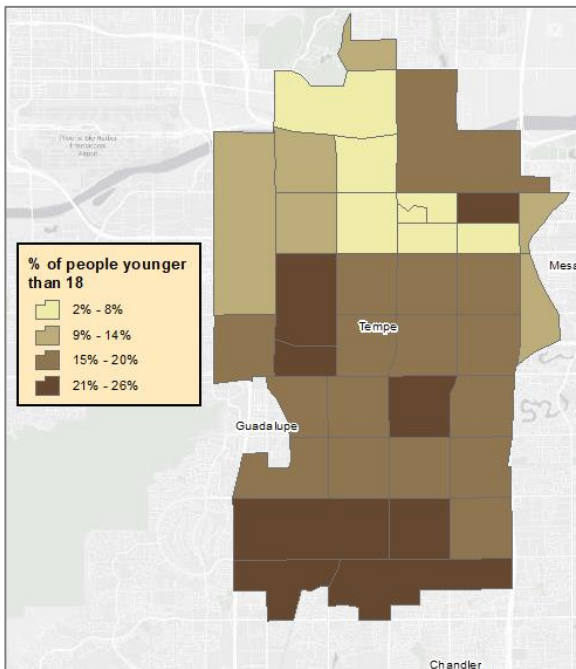
% of people (age 16+ and in labor force) unemployed: Unemployment trended higher around the university, but also in pockets throughout Tempe. *Unless they are working or seeking employment, college students are not classified as in the labor force.*



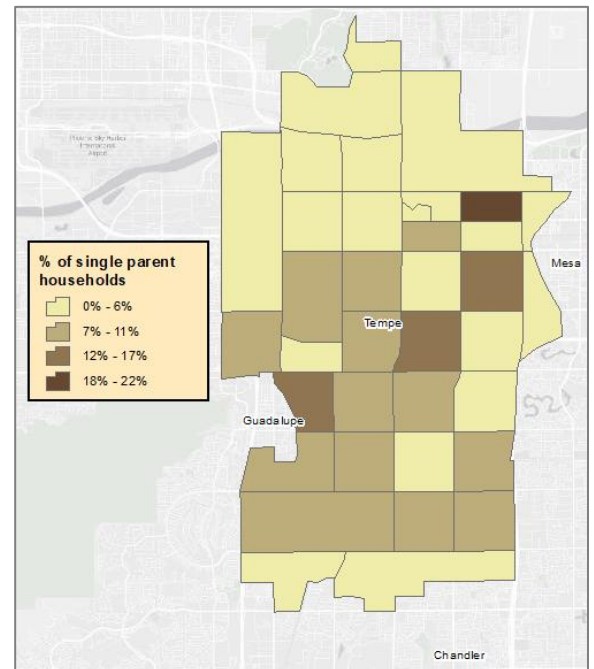
% of people living below 100% of poverty level:
The highest concentrations of people experiencing poverty are in northern Tempe, especially the neighborhoods near and west of the university.



of people living below 100% of poverty level:
Some neighborhoods, such as east of Guadalupe, have relatively lower concentrations of poverty, but still notable numbers of people experiencing poverty.



% of all residents who are younger than 18:
Residents younger than 18 were spread throughout Tempe, except for the area around the university.



% of single parent households: Neighborhoods with higher proportions of single parent households (with children younger than 18) were spread throughout central and southern Tempe.

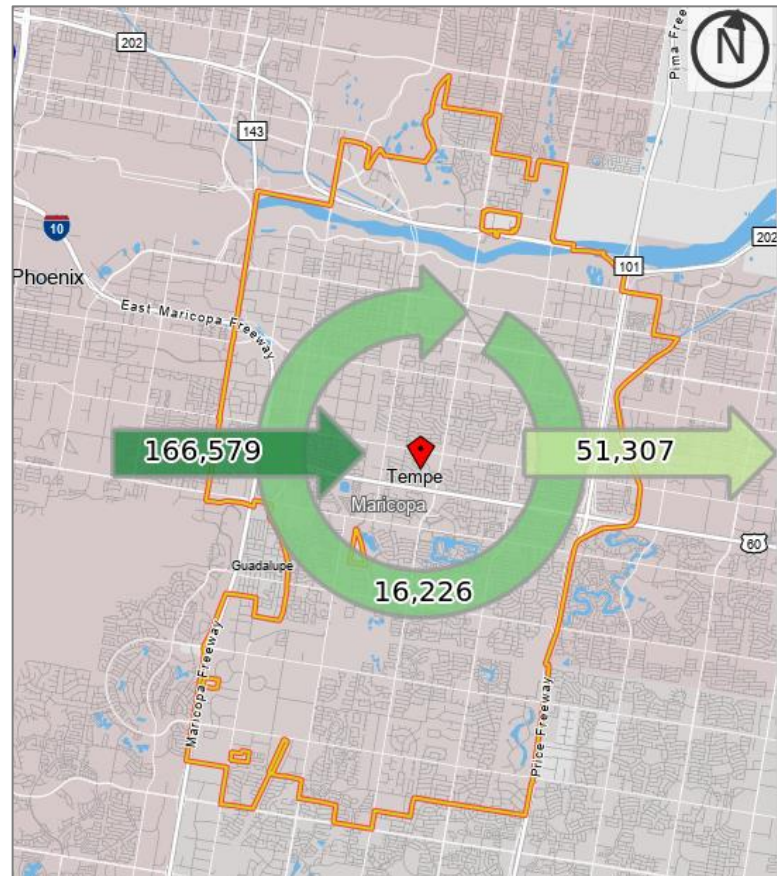
TRANSPORTATION

Transportation is closely related to job access and overall quality of life. Questions answered in this analysis include: How many people are commuting into and out of Tempe and where are they commuting from and to? How many low-income households commute to work by bus and has that changed over time?

COMMUTING PATTERNS

According to estimates from the Center for Economic Studies at the U.S. Census Bureau, Tempe is a labor importer. Over 166,000 private sector primary jobs (i.e., highest paying) located in Tempe are held by people who live outside Tempe, as of 2018. This figure dwarfs the number of people who live in Tempe but work elsewhere (about 51,000) plus the number of people who live and work in Tempe (over 16,000).

We explored the extent that home and work location dynamics were related to pay rate. There was a very slight trend: people who live and work in Tempe were more likely to make less than \$40,000 annually than people who work in Tempe but live elsewhere (58% compared to 51%). Residents who live and work in Tempe may not have resources to find or hold better paying jobs outside of Tempe, or they may simply prefer to work in Tempe regardless of pay.



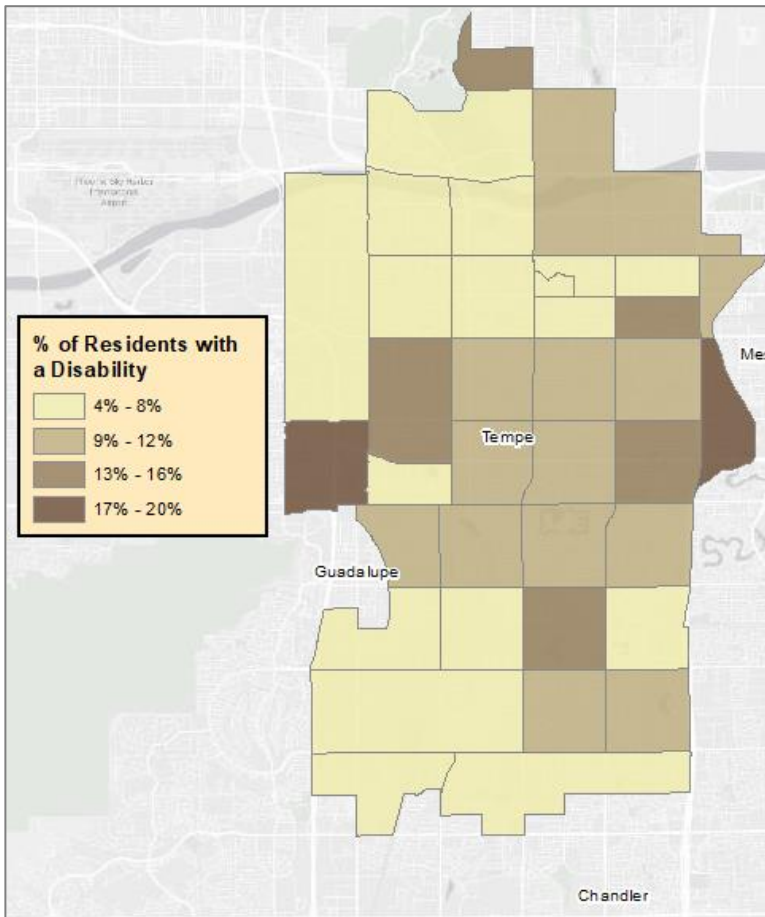
Most workers who commute into Tempe arrive from Phoenix, Mesa, Chandler, Gilbert, and Scottsdale. Conversely, among the 60,000 Tempe residents who commute out of town, they are most likely to work in Phoenix, Scottsdale, Chandler, Mesa, and Gilbert. Tempe residents are more likely to commute to jobs in Scottsdale than Scottsdale residents are likely to commute to Tempe.

TRANSPORTATION MODES

How one gets to work is clearly related to household income, as people who were experiencing poverty were much more likely to take public transportation to work than people not in poverty. Indeed, 7% of Tempe residents who drove or carpooled to work lived below the poverty level, compared to 30% of residents who took public transportation to work. Public transportation users were also more likely to be home renters (86%) than homeowners (14%). These figures generally remained steady over the past 10 years.

ABILITY

Finally, we explored how many people have various disabilities, as reported in the American Community Survey. About 13% of all civilians living in non-group homes reported having a disability. Those in the American Indian and Alaska Native population were more likely than others to report a disability. Nearly 5% of the population in Tempe experience cognitive difficulty, and 5% have an ambulatory difficulty. About 4% have independent-living difficulty, 3% have a hearing difficulty, and 2% have self-care difficulty or vision difficulty. Ambulatory difficulty, hearing difficulty, and independent living difficulty are all much more common in residents 65 or older than in younger residents.



% of residents living with a disability: People living with a disability are somewhat concentrated in central Tempe, with fewer living near the university or in Southwest Tempe.

SUMMARY OF LOW-INCOME SEGMENTATION

If a goal of a needs assessment is to help people with low incomes to thrive, it is useful to explore and understand the circumstances related to low incomes. This understanding can lead to recommendations and strategies on how to leverage resources and best assist this population.

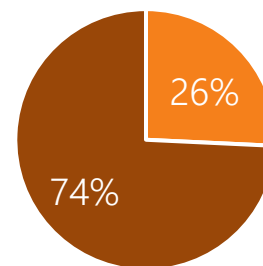
This section of the report examines the population in Tempe that has incomes of 150 percent of the poverty level or lower, which for the purposes of this examination will be called “low-income people.” We examine potential contributing factors and descriptive characteristics among this population.

The specific source used for this data is based on individual anonymized responses to the American Community Survey, which includes Tempe and the nearby small community of Guadalupe, whose residents interact with various Tempe services. The geographic boundaries described by the data differ somewhat from the exact city boundaries, but with certain statistical adjustments, the differences were minimized. The population examined in this chapter totals 196,066 people, which is within 1% of the combined population of Tempe and Guadalupe. The universe of data also includes another 10,690 people for whom income information is not determined, and therefore were excluded from all analyses. More detail about the segmentation methodology can be found in [Appendix A](#).

OVERVIEW OF PEOPLE WITH LOW-INCOMES

Low-income people comprise slightly more than one-quarter of the population of Tempe, or approximately 50,500 people. Because the poverty level varies by the size of the household, people experiencing poverty may live at differing levels of income in households of varying sizes.

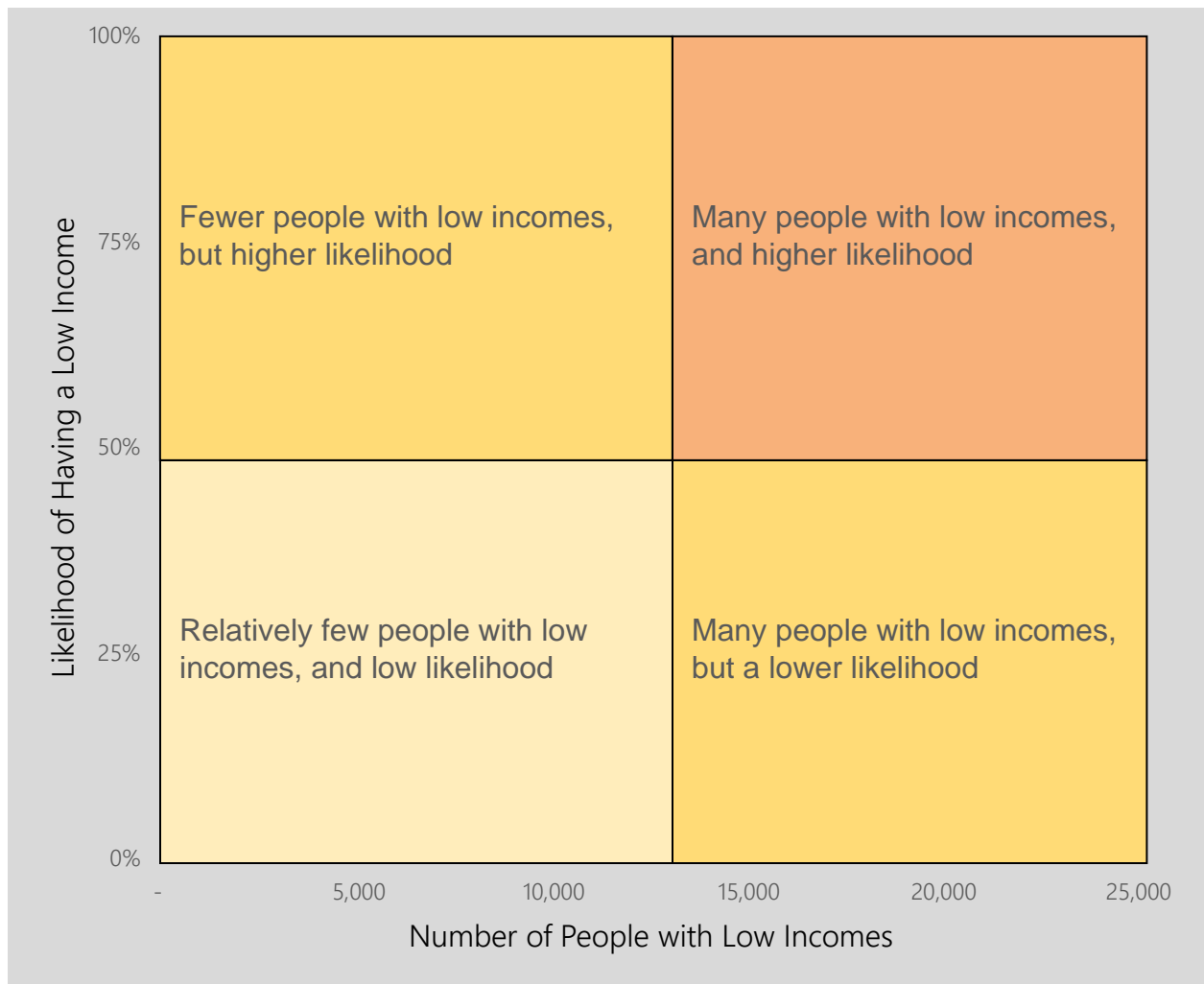
Low-income households are most common among small households, with 64% being 1- or 2-person households. Most also have incomes below \$20,000 per year, constituting 67% of low-income households.



- Below 150% of Poverty Level
- 150+ % of Poverty Level

DEMOGRAPHIC FACTORS THAT CORRELATE WITH LOW INCOMES

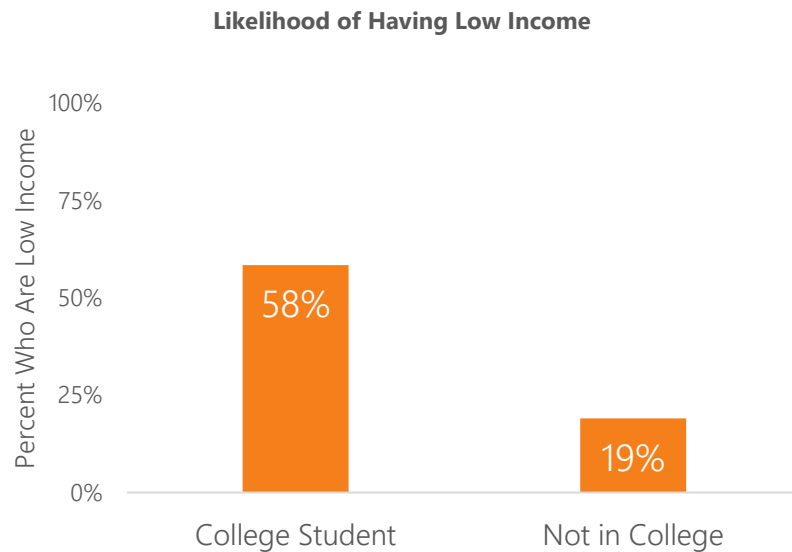
We examined several demographic characteristics of Tempe residents (e.g., college enrolment, work status, primary language, region of birth, etc.) to determine what correlated with and might contribute to low incomes. We are interested in examining two different dimensions: how large the low-income population is within a demographic group, and how prevalent low incomes are within a demographic group, as illustrated below.



For each demographic characteristic described below, we provide these two measures: likelihood of having a low income and number of people in each category with a low income. After presenting each characteristic individually, we combine them to compare.

College Enrollment

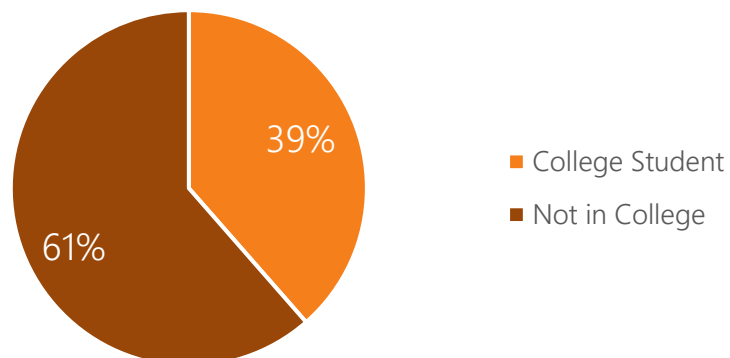
College enrollment is highly correlated with being a low-income person. Whereas 19% of non-college students are low-income, 58% of college students fall into that category.



This high propensity means that a large proportion of low-income people in the community are college students – 39%, or approximately 19,500 people.

It should be noted, though, that some college students likely receive financial support from parents, so these figures may overestimate the number of people who have low incomes on a practical basis.

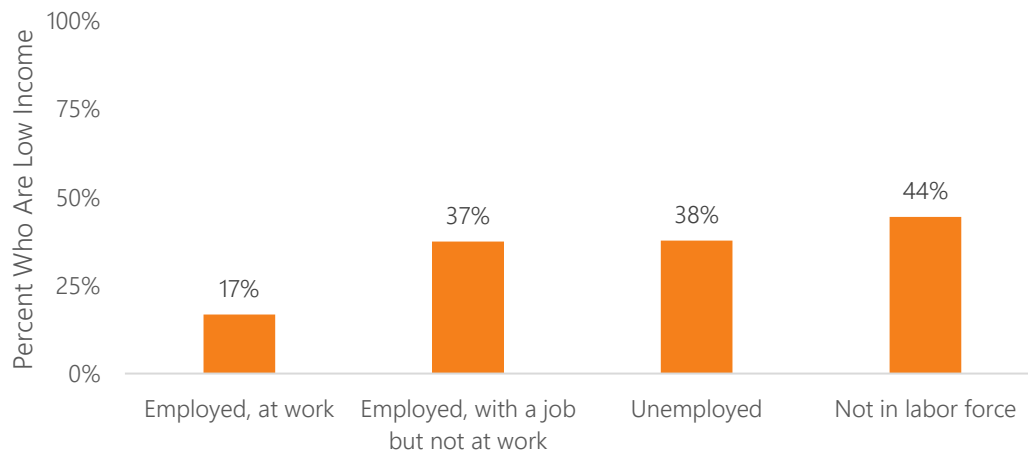
Segment's Proportion Among All People with Low Incomes



Work Status

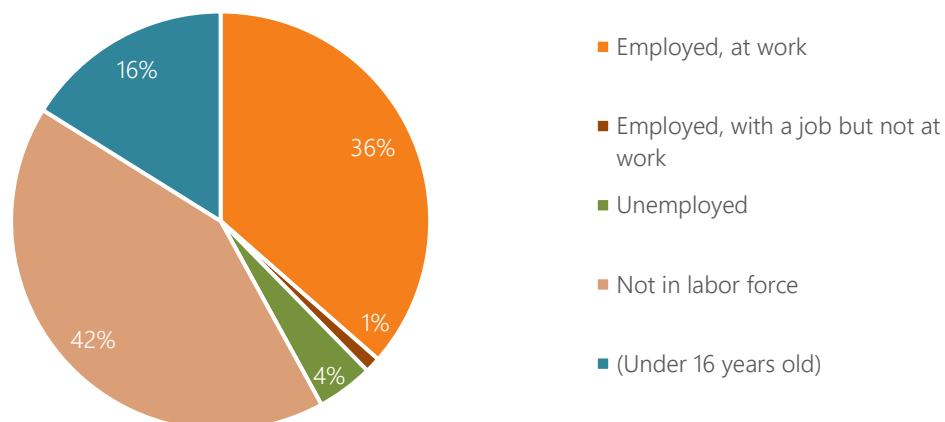
Having a job and actively working is a key way to avoid having a low income, albeit not a guarantee. Seventeen percent of those who are working are still low-income, but that is less than half the rate of alternatives. Factors that result in not working, whether being out of the labor force, being unemployed and looking for work, and having a job but not currently working, all bear a 37% to 44% likelihood of being low income.

Likelihood of Having Low Income



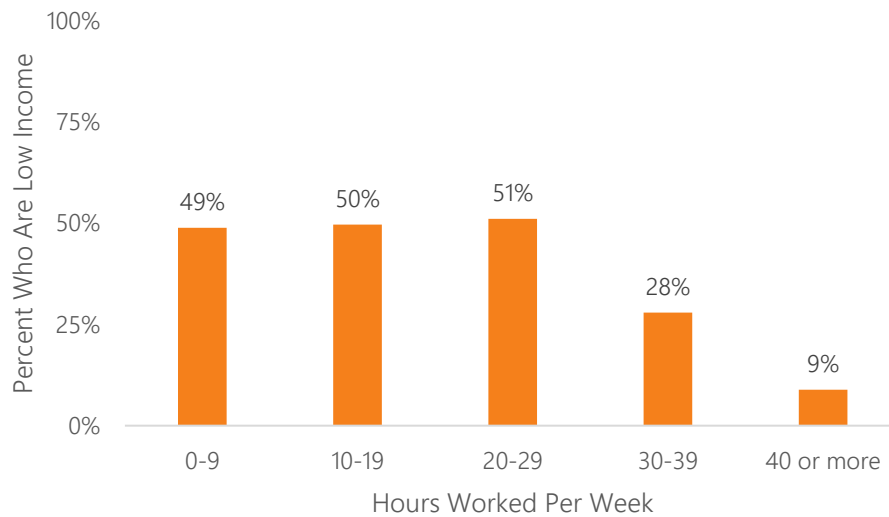
While having a job is a good prevention measure, people with jobs still constitute 36% of low-income people (i.e., roughly 18,400 people), just because it is very common to have a job. Nonetheless, people not in the labor force make up the largest percentage of low-income people at 42% (21,200 people). Despite a high likelihood of having a low income, unemployed people and people working sporadically make up very low proportions of the low-income population because their overall numbers in the population are not large. People younger than 16 do not have an assigned work status.

Segment's Proportion Among All People with Low Incomes



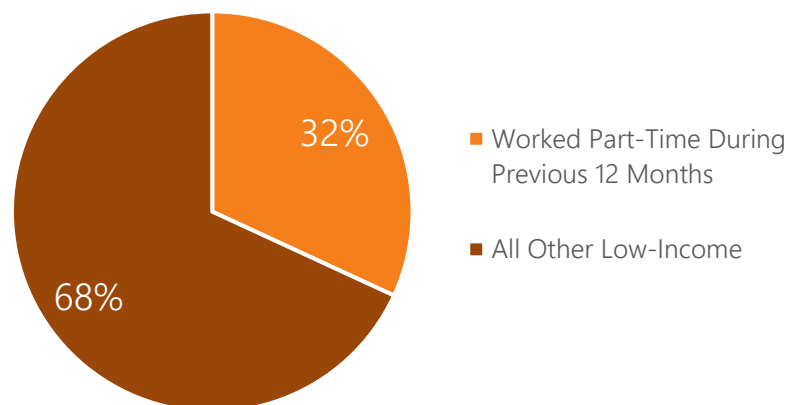
Those who are working, though, also fall into two categories: working full-time and working part-time. Those who work fewer than 30 hours per week have a 50% likelihood of being low income, while those working full time have only a 9% likelihood.

Likelihood of Having Low Income



Overall, those who had worked part-time during the past 12 months made up nearly one-third of low-income people, or 16,100 people (note that this measure includes all who worked at least part-time at some point during the past 12 months, so the figures are not directly comparable to the current work status shown earlier).

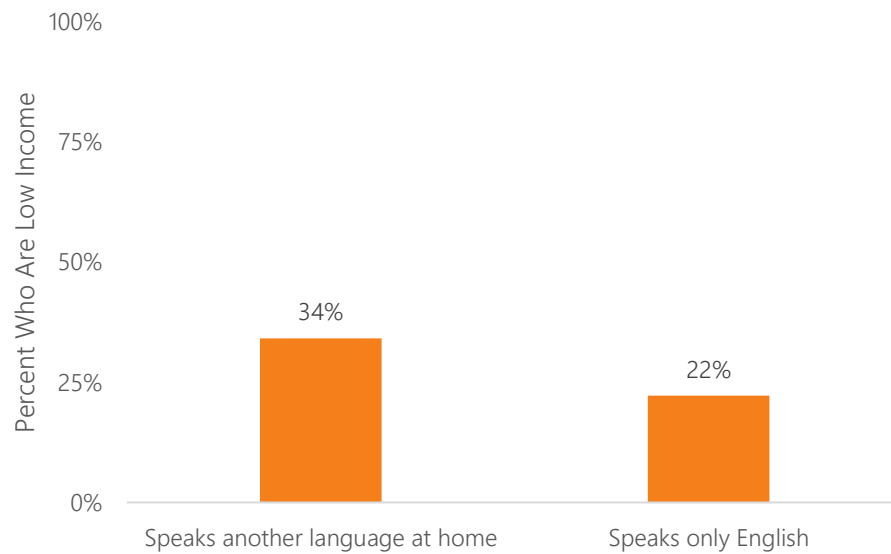
Segment's Proportion Among All People with Low Incomes



Primary Language

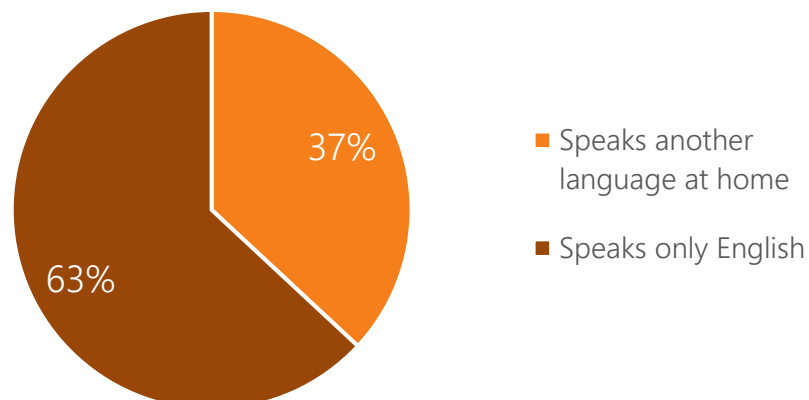
Thirty-four percent of residents who speak a non-English language at home have low incomes, compared to 22% of those who speak only English at home.

Likelihood of Having Low Income



Speaking non-English languages at home is relatively common in Tempe, and people who do so make up 37% of low-income people in the city, or 17,500 people.

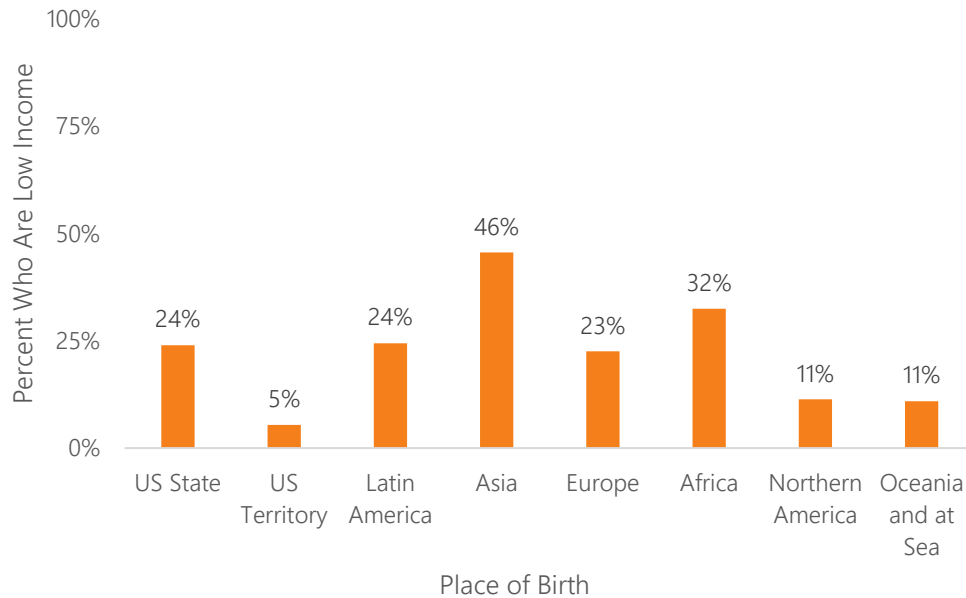
Segment's Proportion Among All People with Low Incomes



Region of Birth

Closely related to language is the region of birth. People who were born in the United States have a 24% likelihood of having low incomes, similar to the overall average. Resident immigrants who are most likely to have low incomes were born in Asia (46% likelihood) and Africa (32% likelihood).

Likelihood of Having Low Income



If we convert these to numbers of low-income people, we nonetheless find that US-born residents comprise the largest population of low-income people (38,600, or 76% of low-income people) due to their larger presence in the population. The Asian-born population is second-largest with 15% of low-income people (7,700 people), followed by people born in Latin America (2,700 people, or 5%).

Segment's Proportion Among All People with Low Incomes

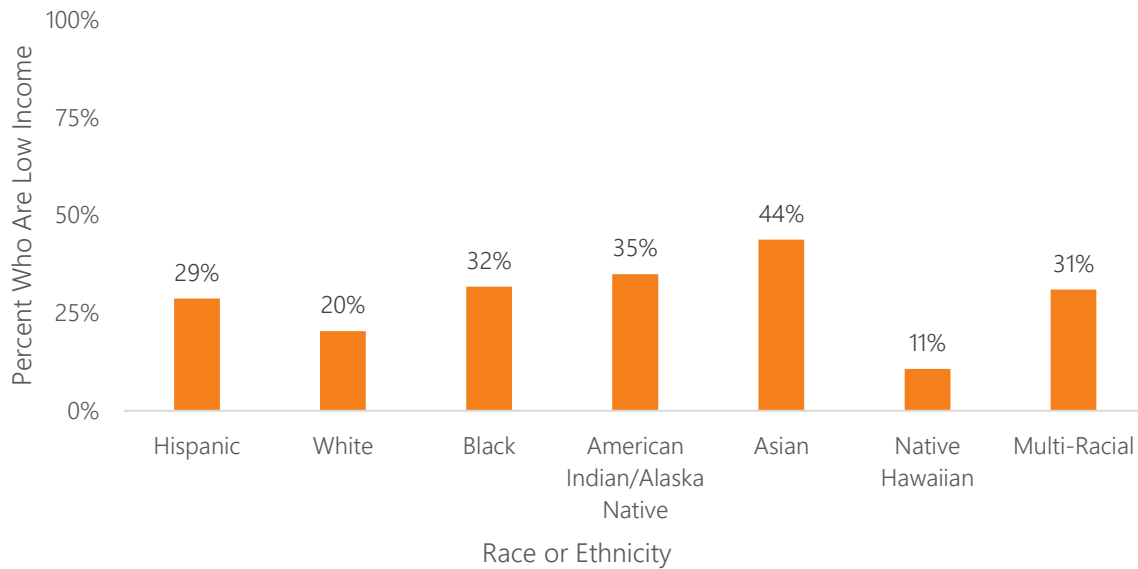
Place of Birth



Race and Ethnicity

Regardless of immigration history or language, race and ethnicity are also an issue to consider. As shown below, people of color are almost universally more likely to have low incomes than their white counterparts. The only exception is the Native Hawaiian population, although relatively few people who are Native Hawaiian live in the Tempe area.

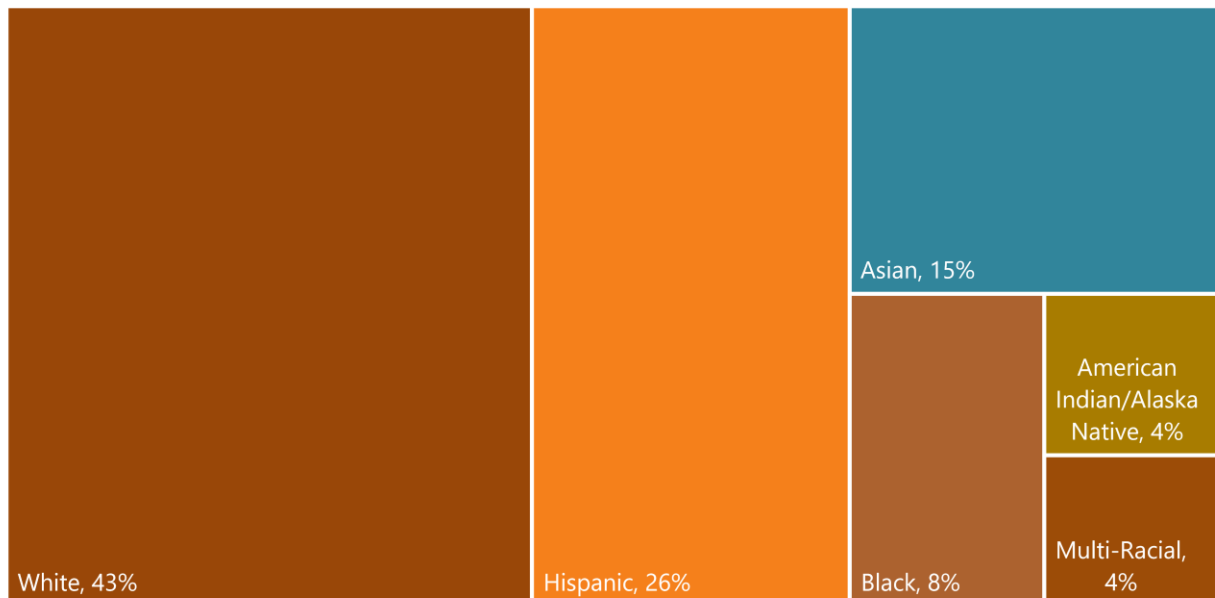
Likelihood of Having Low Income



As a result of higher likelihoods of having low incomes, people of color make up more than half of the low-income population.

Segment's Proportion Among All People with Low Incomes

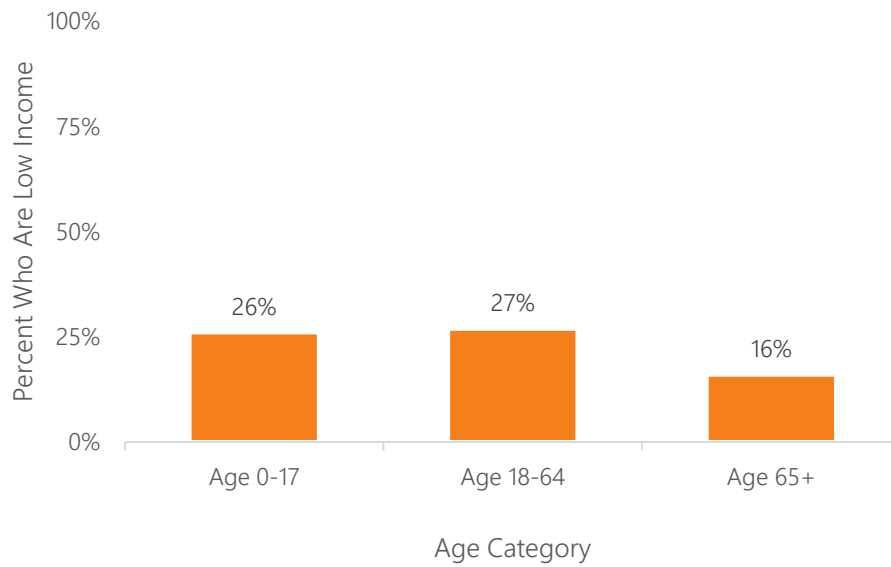
Race or Ethnicity



Age – Children, Seniors, and Other Adults

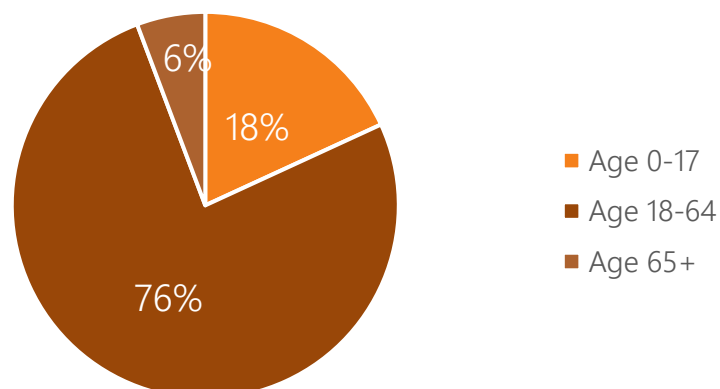
Children and seniors are often populations of interest when considering issues of income. In Tempe, people most likely to have low income are working age (i.e., 18 to 64), which is likely driven by the high number of college-age students who are low income. Children are low income at approximately the same rate as working age residents, while seniors are notably less likely to have low incomes.

Likelihood of Having Low Income



When analyzed as the number of people in poverty, seniors represent approximately 6% of low-income residents (2,900 people), while children represent approximately 18% (9,200 people). The vast majority (76%, or 38,500 people) of low-income residents are between 18 and 64.

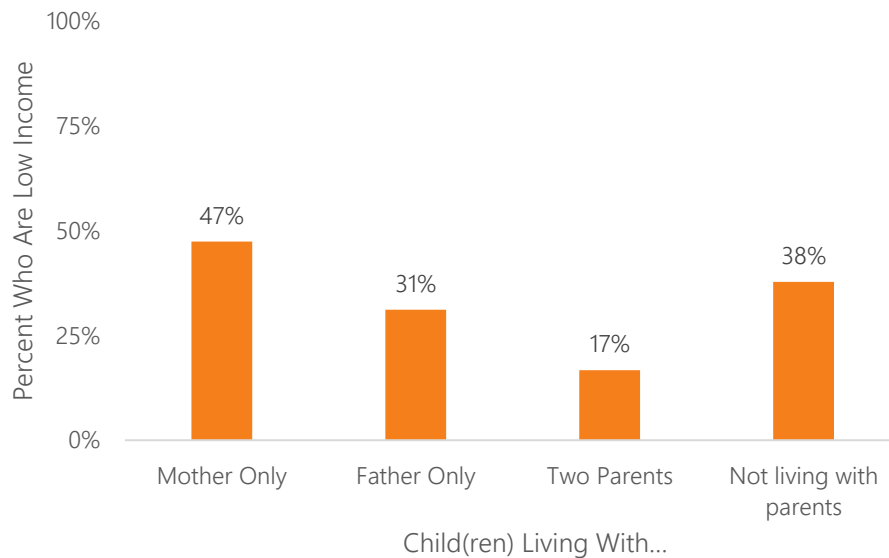
Segment's Proportion Among All People with Low Incomes



Children, Families, and the Work Force

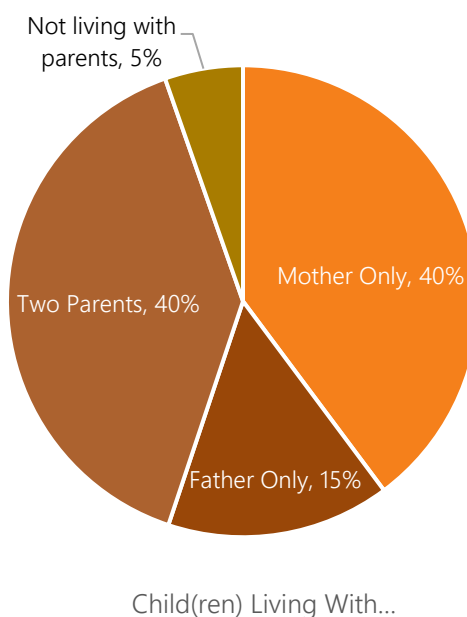
Children have little or no ability to generate income, and thus do not control their financial status. However, we can examine their likelihood of living in a household with low incomes in relation to their parental situation. Children living with one parent or not living with parents are much more likely to live in a low-income home than children living with two parents.

Likelihood of Having Low Income



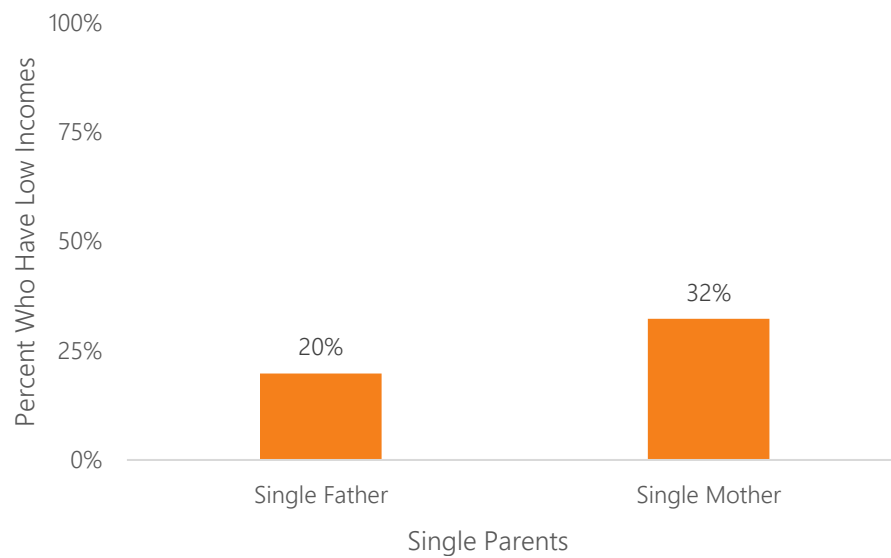
While a plurality of children live with two parents, the increased financial vulnerability of single-parent households, particularly single mothers, means that a majority of children with low incomes live in single-parent households.

Segment's Proportion Among All Children with Low Incomes



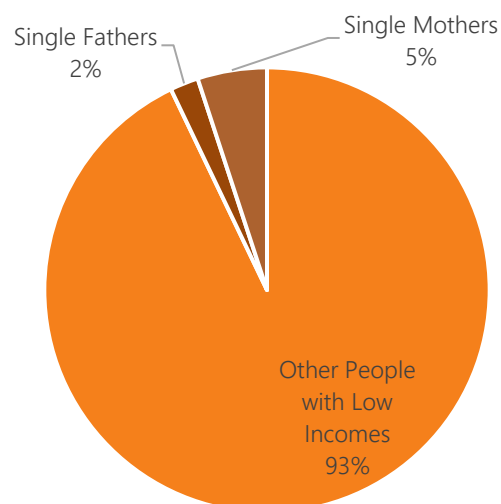
A similar dynamic pertains to the mothers in single-parent families. Nearly one-third of single mothers have low incomes, while single fathers actually are less likely than the average Tempe resident to have a low income.

Likelihood of Having Low Income



Because they represent a relatively small proportion of the community, single parents represent fewer than 10% of people with low incomes (1,000 men and 2,500 women)

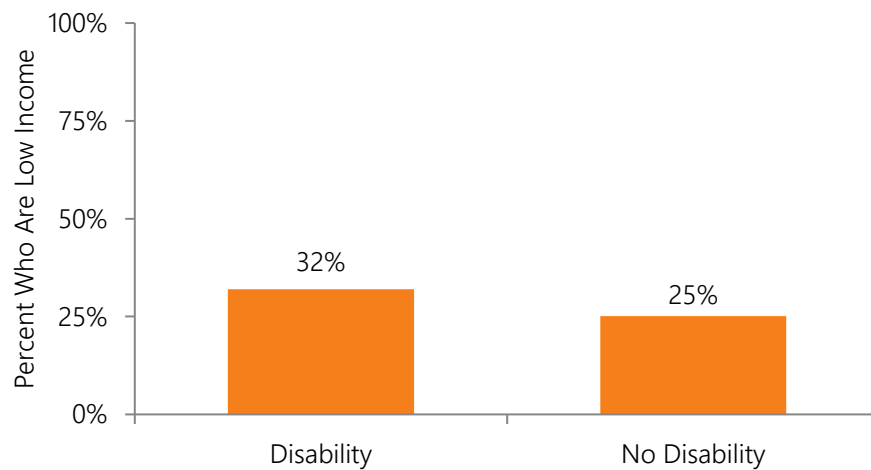
Segment's Proportion Among All People with Low Incomes



Disability

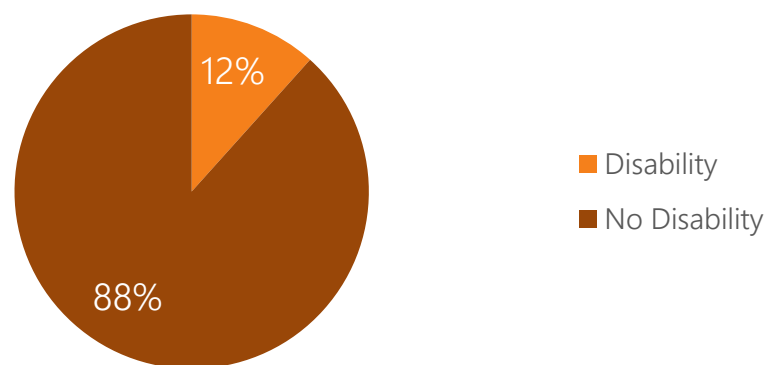
People with a disability are notably more likely to have low incomes compared to those without a disability. Disabilities are defined as any one or more of the following: self-care (age 5 or older), vision, hearing, living independently (age 15 or older), or mobility (age 5 or older). In certain categories, people under various ages were excluded from consideration, so the incidence rate totals differ slightly from that of the overall population.

Likelihood of Having Low Income



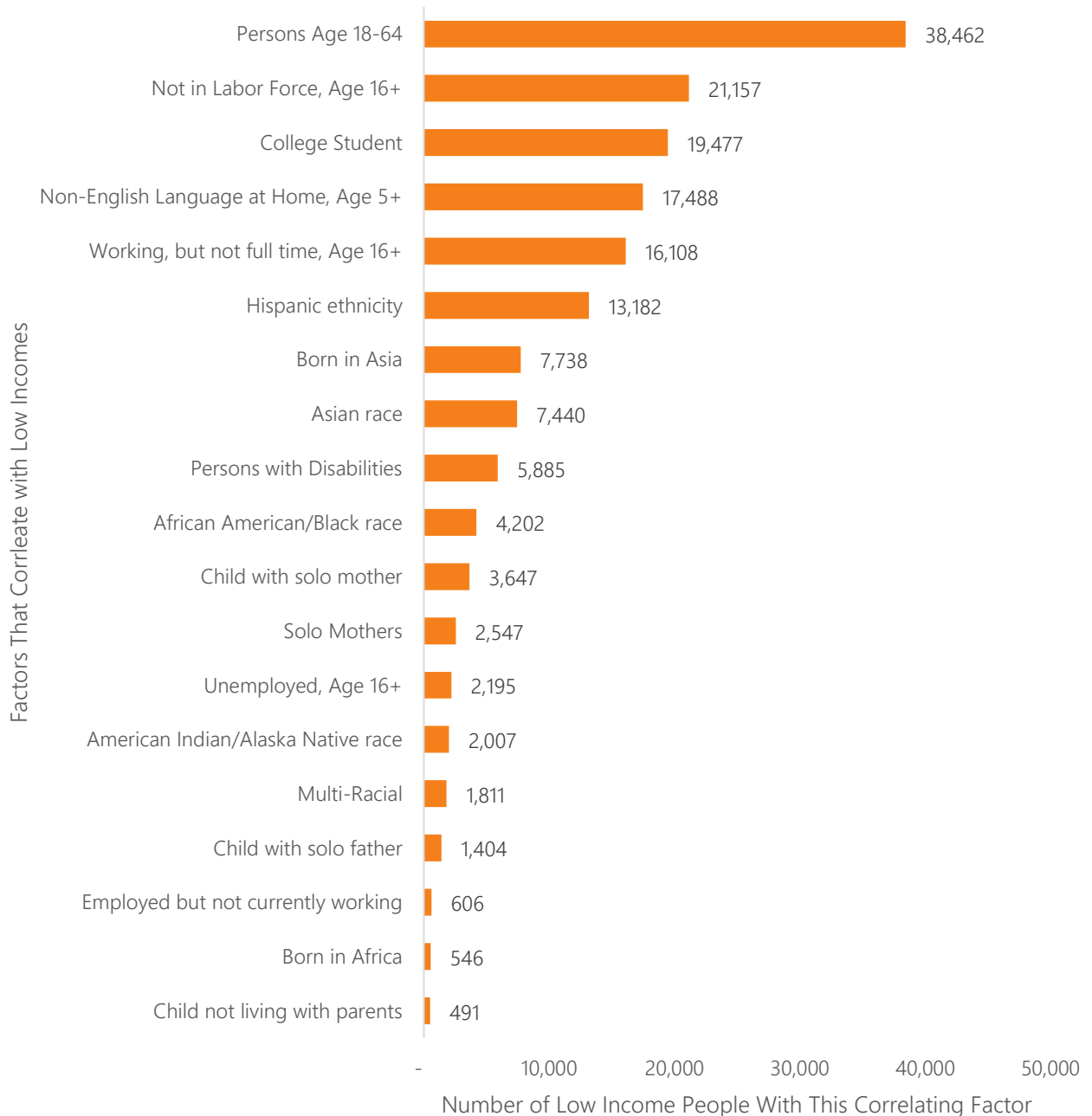
While people with disabilities were more likely to have low incomes than those without disabilities, they were much less common in the population and therefore comprise a small proportion of people with low incomes.

Segment's Proportion Among All People with Low Incomes

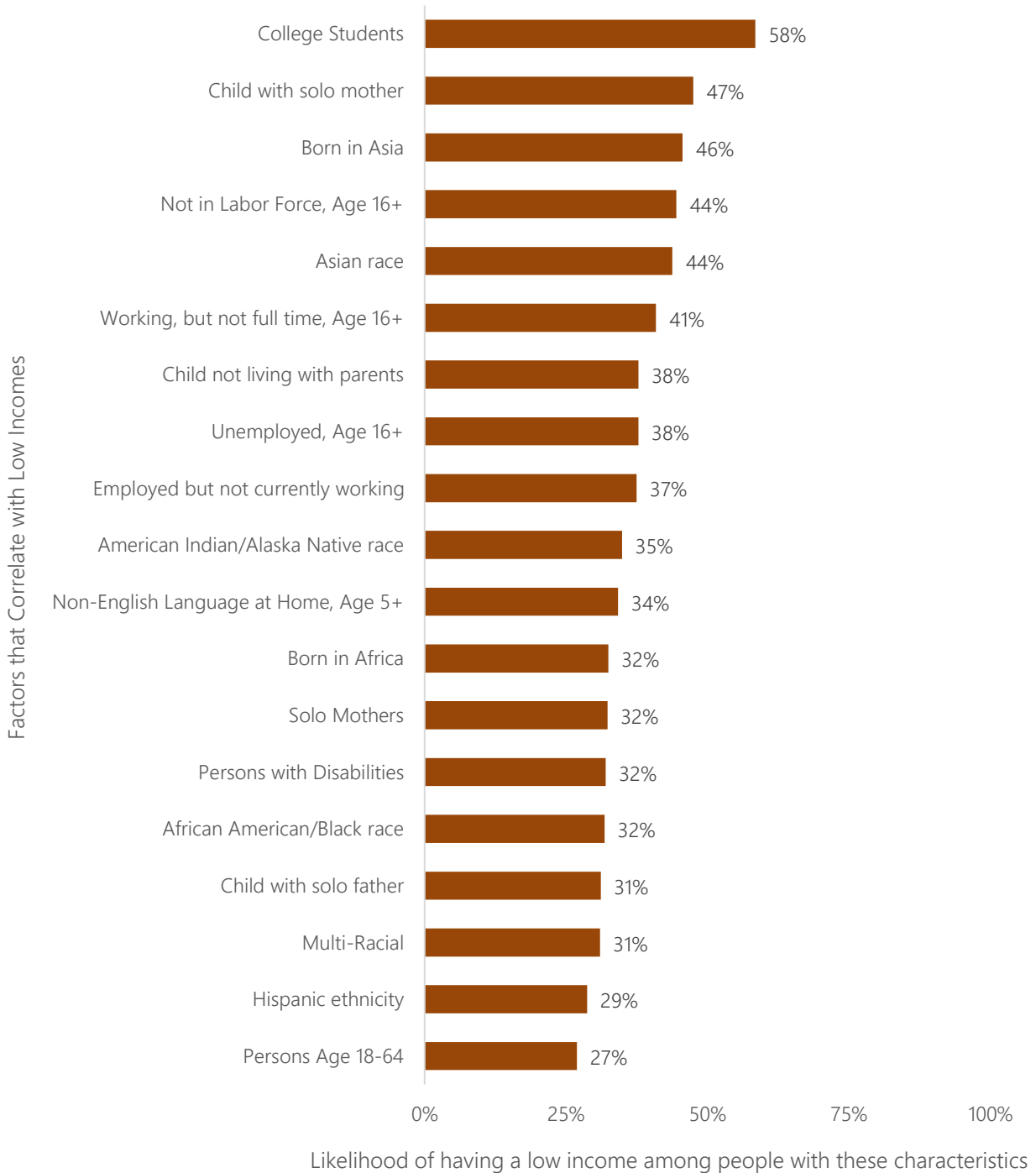


SUMMARY AND COMMUNITY SEGMENTATION

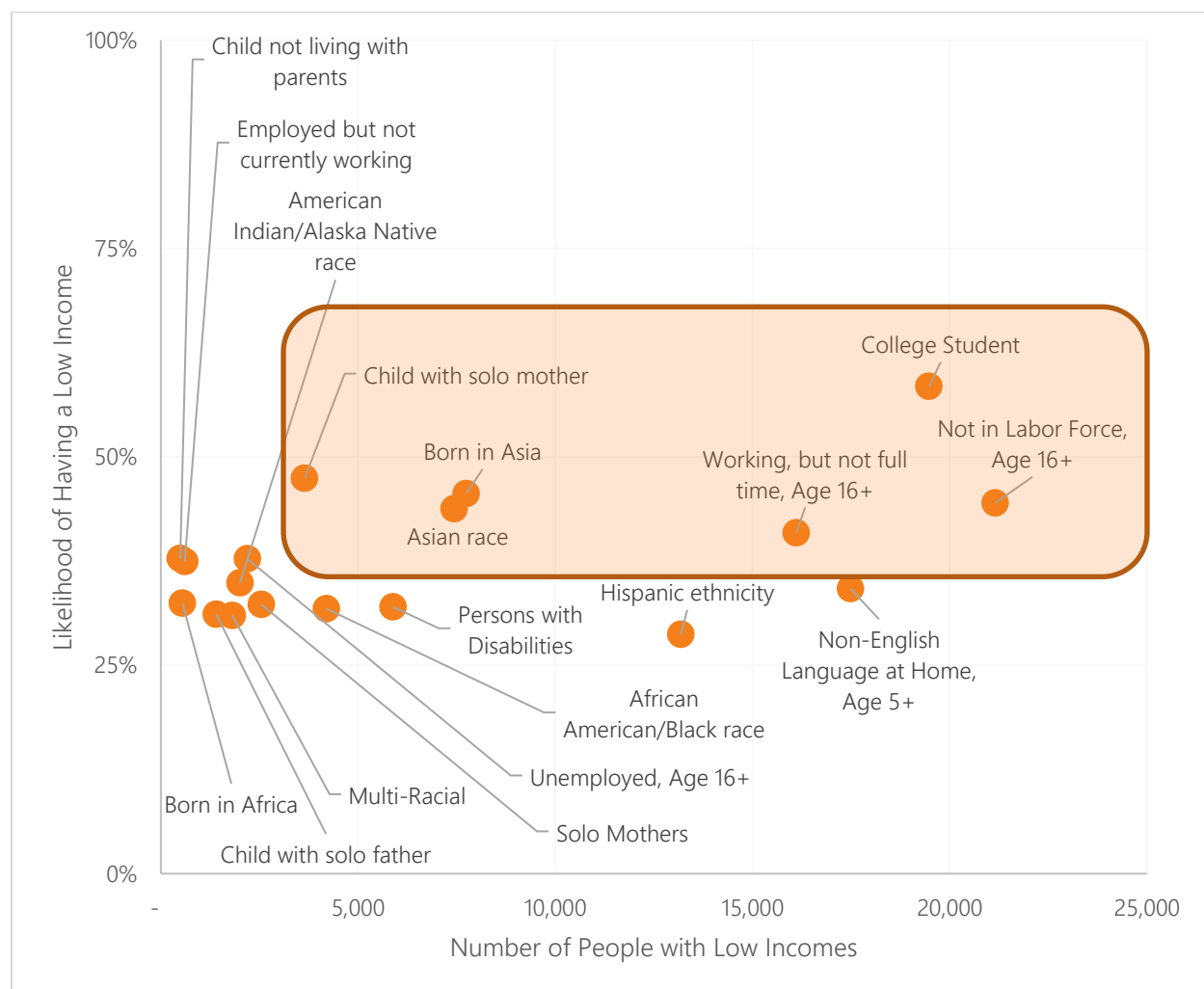
The following graph summarizes the number of people with low incomes in each identified demographic group that has an above-average likelihood of having low incomes. (Recall that this is 26% citywide, or approximately 50,500 people in total.) An individual person can be included in more than one category below, and often are. The average low-income person is associated with three of these characteristics.



As seen earlier in this section of the report, some traits are more likely to be associated with low incomes than others. The graph below summarizes this information. For example, 58% of college students have low incomes, compared with 47% of children with single mothers, 46% of people born in Asia, and so on.



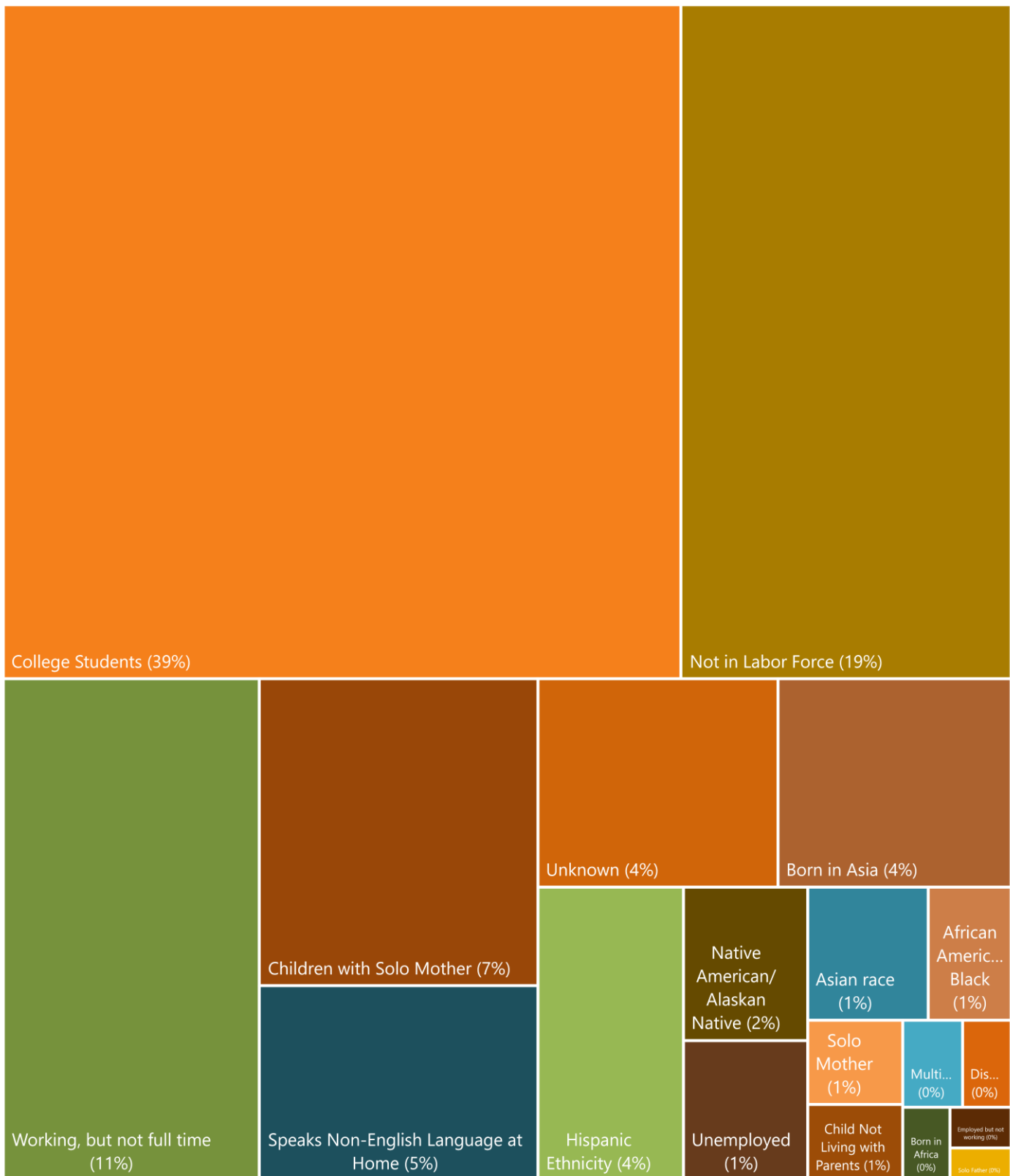
The chart below combines these two measures to identify specific traits that are strongly related to low incomes and associated with larger numbers of residents.



One additional group, the general population age 18-64 is not shown on the graph due to their large population of 38,462, with a low-income likelihood of 27 percent.

Because many people are associated with more than one of these characteristics, it is challenging to identify the extent, if any, that the characteristic causes low income. However, we developed a segmentation model by assigning each person in the dataset to the characteristic that statistically had the strongest correlation to low-income status. For example, we would classify a college student born in Asia working part-time as a "college student" since that characteristic had a stronger correlation to low income than working part time. Doing this with all individuals in the data yielded the following low-income population segmentation.

College students are the largest segment, accounting for 39% of people with low incomes. Job-related issues, including being out of the work force or working part-time, summed to 30% of people with low income. Children living in single mother households were a prominent segment, as were households that spoke a language other than English at home. A number of immigration and racial/ethnic segments add up collectively for another large segment, with the largest individual segments being people of Hispanic ethnicity, and people born in Asia.



SECTION 2:
PROVIDING HUMAN SERVICES
*SURVEY OF HUMAN SERVICE PROVIDERS &
PARTNERS*

KEY INSIGHTS | SERVICE PROVIDER SURVEY

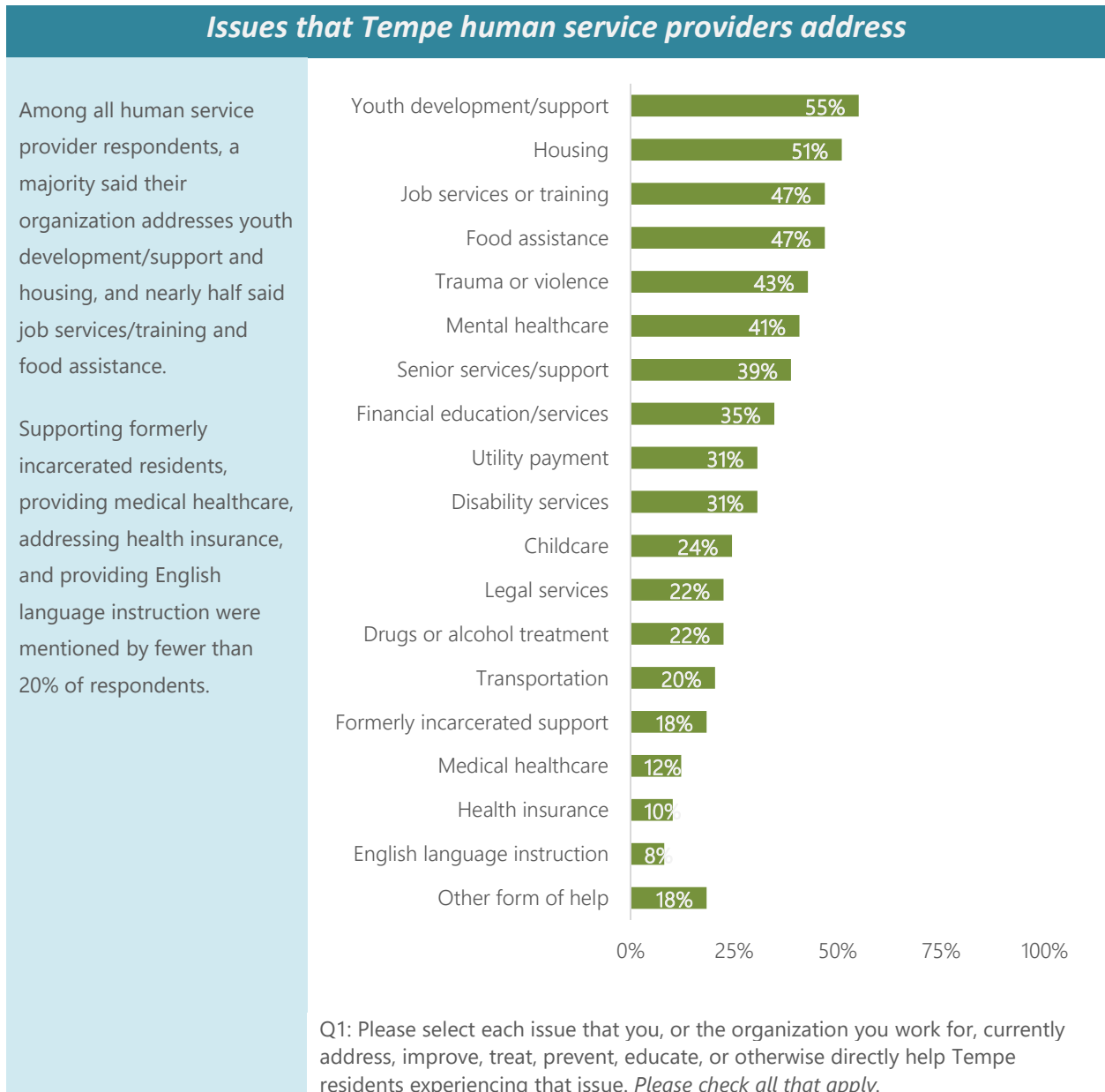
An online survey of human service providers, partners, and experts in Tempe was conducted to gauge the human services system's ability to address various community and population needs. A full description of the survey methodology is found in [Appendix B](#).

The following key findings summarize the results from the human service provider survey.

1. **Difficulty:** The most difficult community challenges (i.e., require the *most effort and resources* to help individuals thrive) included supporting people who are disabled so they can live independently, addressing alcohol and drug abuse, and helping domestic and child abuse survivors.
2. **Limited Capacity:** The community challenges with the *least capacity to serve more people* included paying for housing, teaching English, helping people access medical healthcare, and helping survivors of violence.
3. **Difficulty by Capacity:** Looking at challenges across those two dimensions (i.e., difficulty and capacity), addressing alcohol and drug abuse requires the most intervention and has the highest rates of providers who are over capacity (unable to serve more). Other challenges with high difficulty and limited capacity were accessing mental and medical health care, finding and paying for housing and utilities, and youth having issues at home and at school.
4. **Key Populations:** Among providers who serve and support these populations, many thought Tempe was not serving mentally ill residents or homeless residents well. Indeed, 15% of providers who support residents experiencing homelessness said they were currently not at all well served in Tempe.
5. **Housing Challenges:** Housing and homelessness was clearly the most commonly mentioned community-wide challenge when respondents took into account both the extent of the problem and its individual severity. Housing was also the area that the most providers thought should be a top-five priority to improve human services in five years, and 37% of service providers thought homeless individuals were not well-served in Tempe. Several housing related challenges were identified as difficult, and providers addressing those challenges were over-capacity.
6. **Other Community Challenges:** Besides housing, mental health was a notable challenge, with 59% of all human service providers saying it should be a top-five priority for action, and 38% saying mentally ill residents in Tempe were not well-served. Additionally, two mental health challenges (i.e., addressing alcohol or drug abuse and accessing mental healthcare) were identified as difficult to address, and providers addressing those challenges were likely over-capacity.
7. **Community Strengths:** Tempe's community strengths were the ability to recognize and respond to needs, the dedication of staff and organizations, inter-organizational collaboration, and the community's compassion for those in need. Leadership, staff, and volunteers, listening ability, funding, and specific programs such as food and housing assistance were also mentioned as strengths.
8. **Future Improvements:** Top ideas for improving human services included increasing or improving funding, strengthening collaborations, and engaging with the community, including those in need and the broader public. Some respondents noted the need for a human service delivery plan, and others suggested focusing on specific needs, such as housing and mental health.

SUMMARY OF FINDINGS

SERVICES PROVIDED

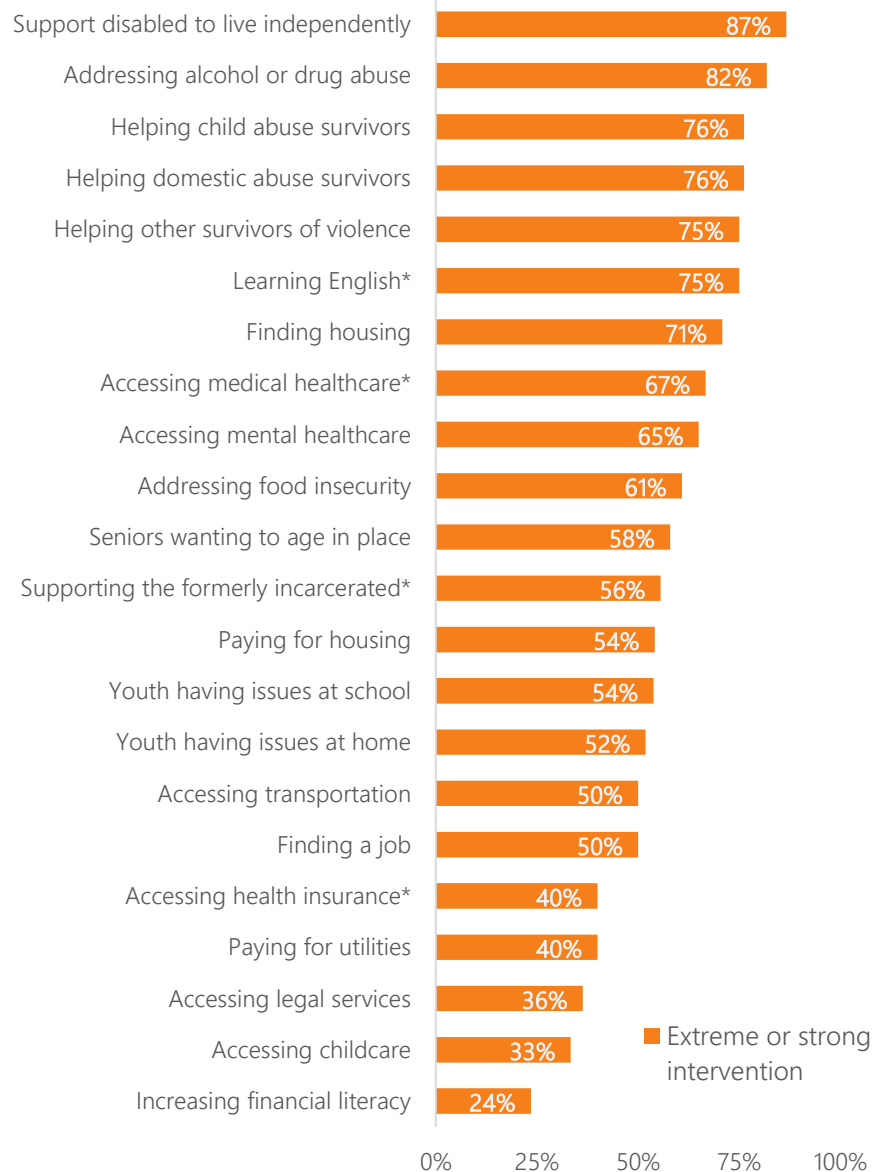


Issues that require an extreme or strong intervention

Respondents rated the level of intervention required to help residents overcome the challenges they face. Respondents only answered for the challenges that their organization addresses.

Helping people who are disabled live independently and addressing alcohol and drug abuse were the two challenges rated as most likely to require an extreme or strong intervention, followed by helping abuse and violence survivors, helping people learn English, and helping people find housing.

Note that 25% of respondents who were asked about learning English said they did not know the level of intervention needed.



Q2: [Only show the issues marked in Q1] For each issue below, please indicate the amount of intervention needed for a typical person facing that issue to make a significant improvement. A "slight intervention" means few resources (effort, money, space, expertise) will be needed to see improvement, while an "extreme intervention" means a lot of resources will be needed. Do not worry about how many people may be facing the issue. While no person may be "typical," try your best to answer each row. If needed, you can mark "don't know."

* Estimates based on fewer than ten respondents

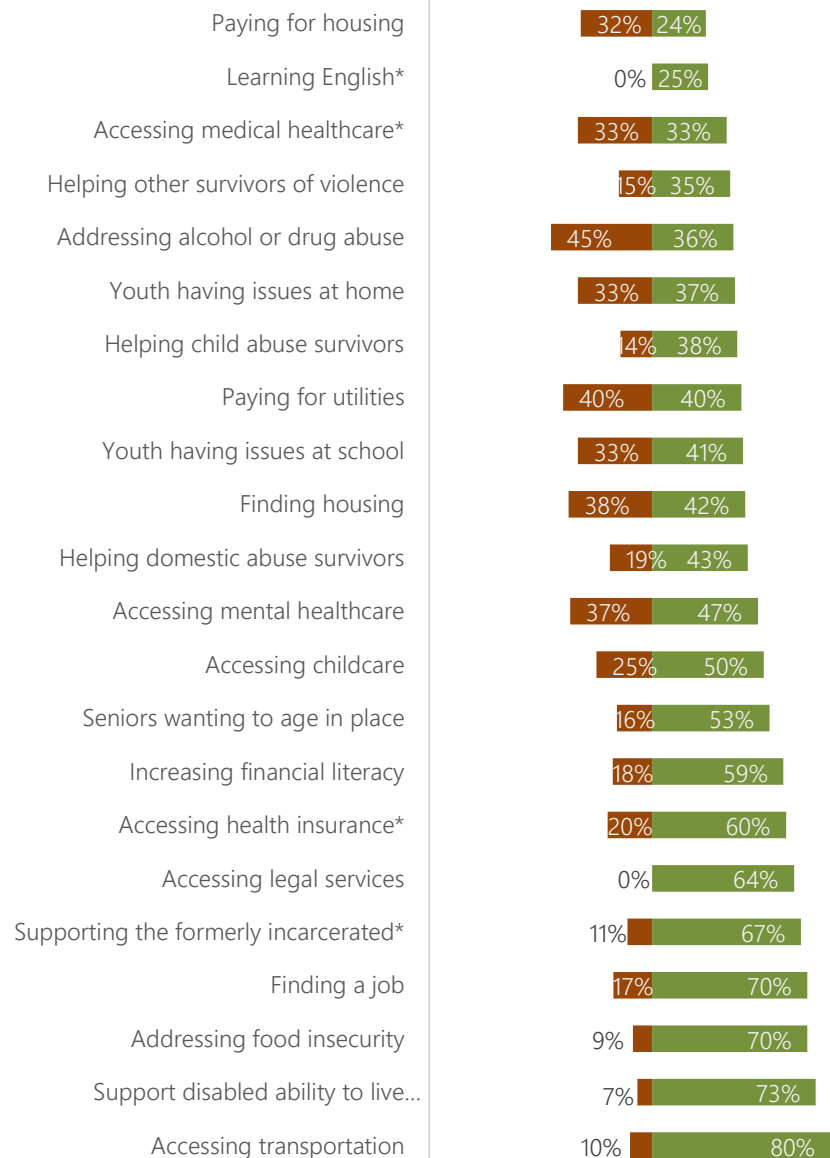
Over capacity and ability to serve more

Five challenges with the least capacity to serve more residents are paying for housing, teaching English, accessing medical healthcare, helping survivors of violence, and addressing alcohol and drug abuse.

Some human service organizations are at or over capacity (cannot serve more), while others may be able to serve more people. Collaboration and referral may help reduce capacity imbalances.

There does seem to be adequate capacity to serve more residents facing challenges such as finding a job, accessing food, living independently with a disability, and accessing transportation.

Several providers mentioned that a lack of funding limits their ability to serve more residents, a few mentioned limitations due to COVID (Q4).



■ Over capacity ■ Able to serve more

Q3: [Only show the issues marked in Q1] For each issue below, mark your organization's capacity to serve more residents facing that issue than you currently do. For this question, capacity is defined as the combination of time and resources (such as money, staff, and hours of operation) available. If needed, you can mark "Don't know."

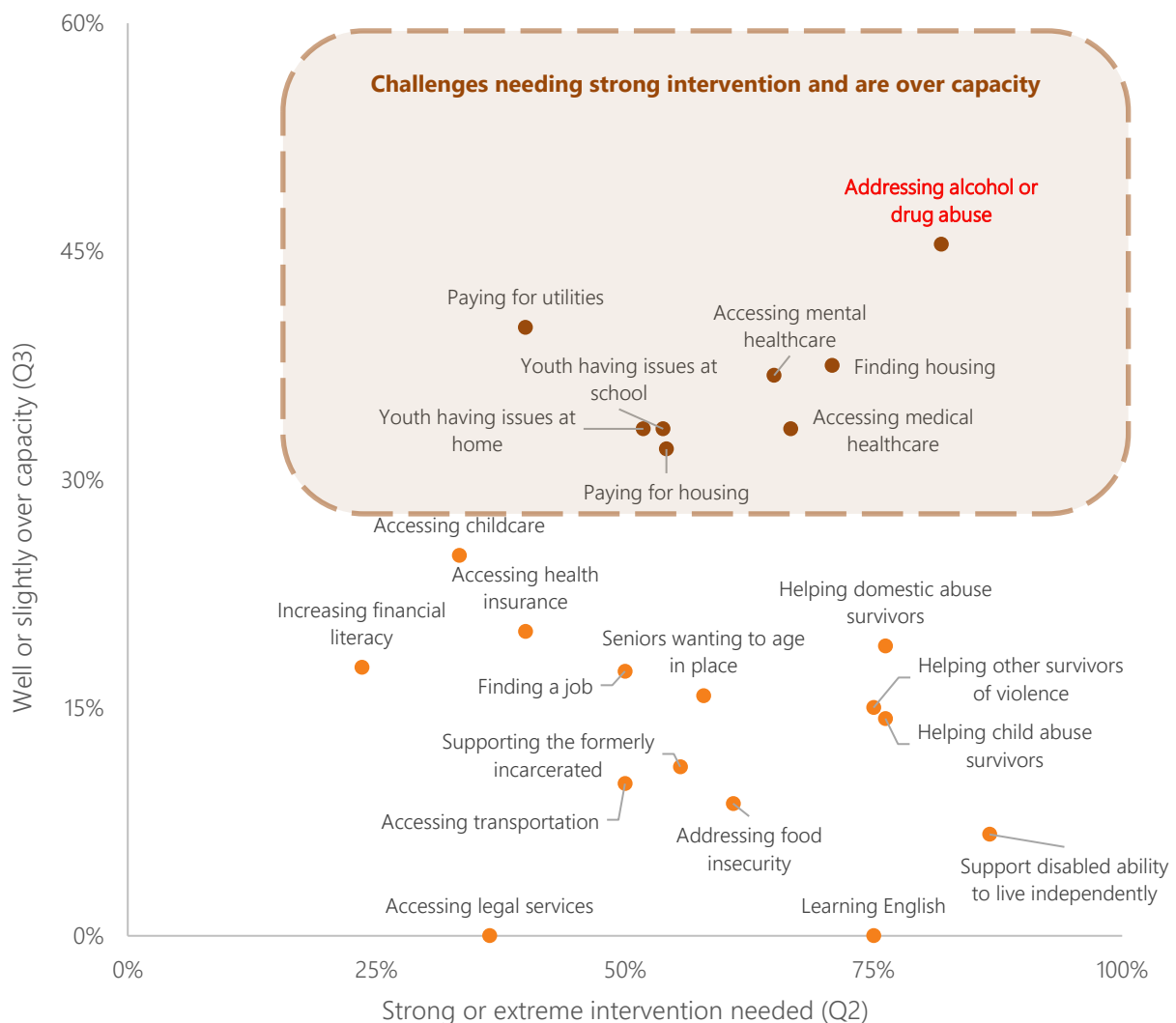
* Estimates based on fewer than ten respondents

Level of intervention needed by amount over capacity

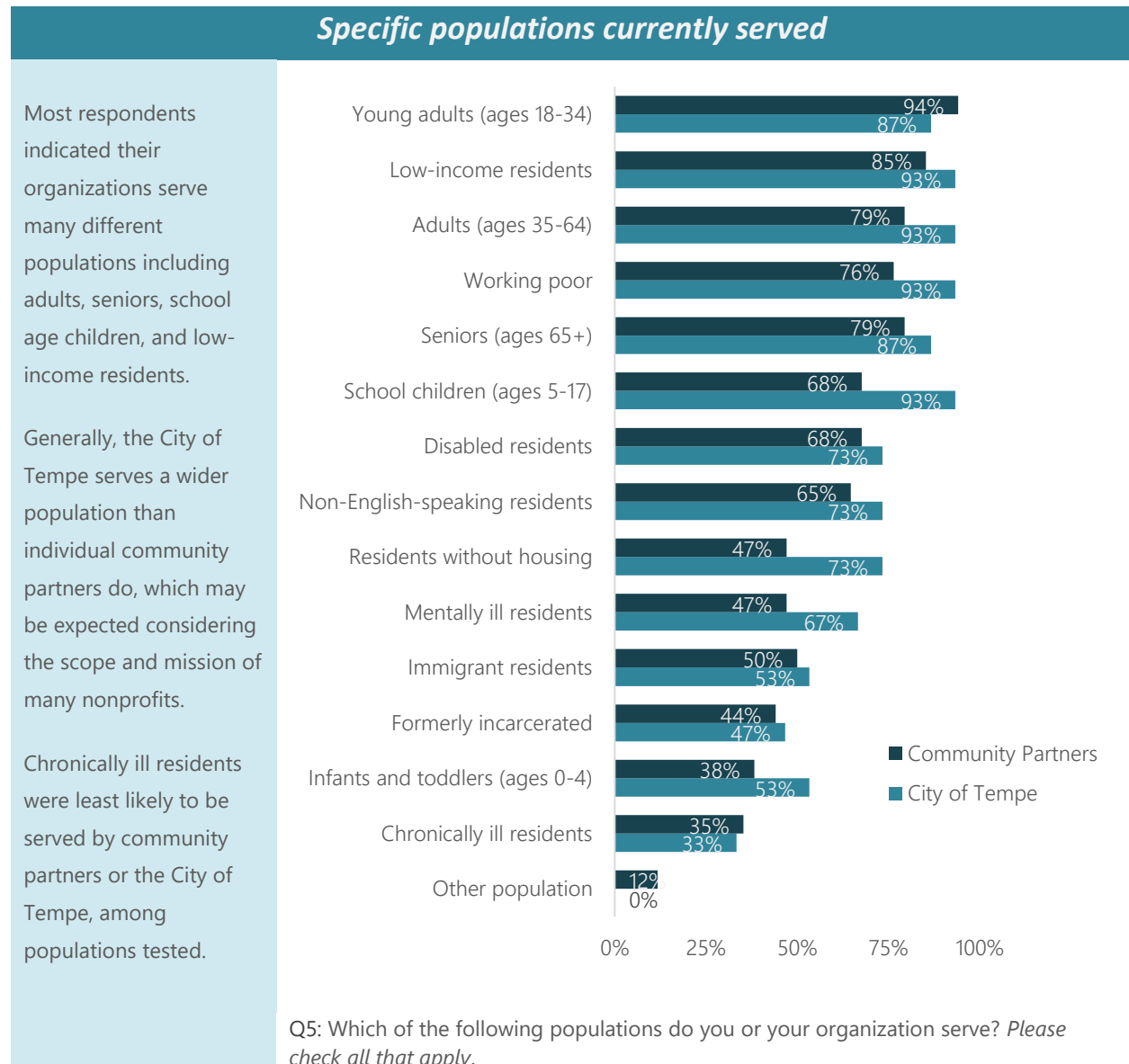
By plotting both the level of intervention needed to help residents overcome challenges (horizontal axis) by the amount of current capacity to help residents (vertical axis), we can see which challenges appear to have relatively high intervention demand and low capacity to meet that demand.

Addressing alcohol and drug abuse requires strong intervention, but many local service providers that address this challenge are over capacity to meet current demand. Other similar challenges are accessing mental and medical health care, finding and paying for housing and utilities, and youth having issues at home and at school.

Although some challenges, such as supporting disabled individuals' ability to live independently, take much strong interventions, there is currently capacity to serve more residents facing this challenge. Improving access to food, transportation, and legal services appears to take less intervention, and there is currently some capacity to serve more residents with this need.



UNDERSERVED POPULATIONS

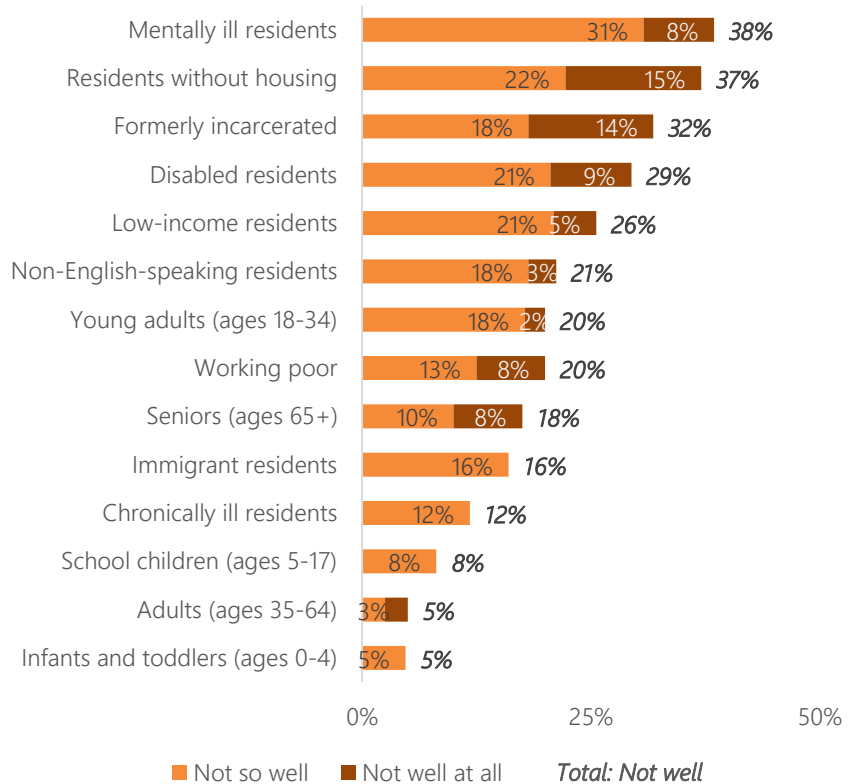


Specific populations, not well served

Respondents rated the extent that the Tempe community is meeting the needs of key populations. Respondents only answered for the populations that their organization serves.

Mentally ill residents and residents without housing were noted as being “not so well” served or “not well at all” served in Tempe by more than one-third of respondents.

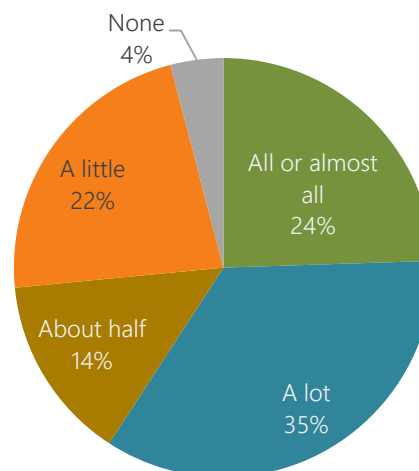
Although not shown here, an additional 41% of respondents were unsure how well formerly incarcerated residents were being served. Similarly, 48% did not know how well immigrants were being served.



Q6: [only show items checked in Q5] Please mark how well you think Tempe is currently meeting the needs of people in each group.

Focus on serving underrepresented racial or ethnic groups

Nearly two-thirds of respondents said that all, almost all, or a lot of their programming focused on increasing access to services or resources for members of underrepresented racial or ethnic groups. Very few said none of their programming had this focus.

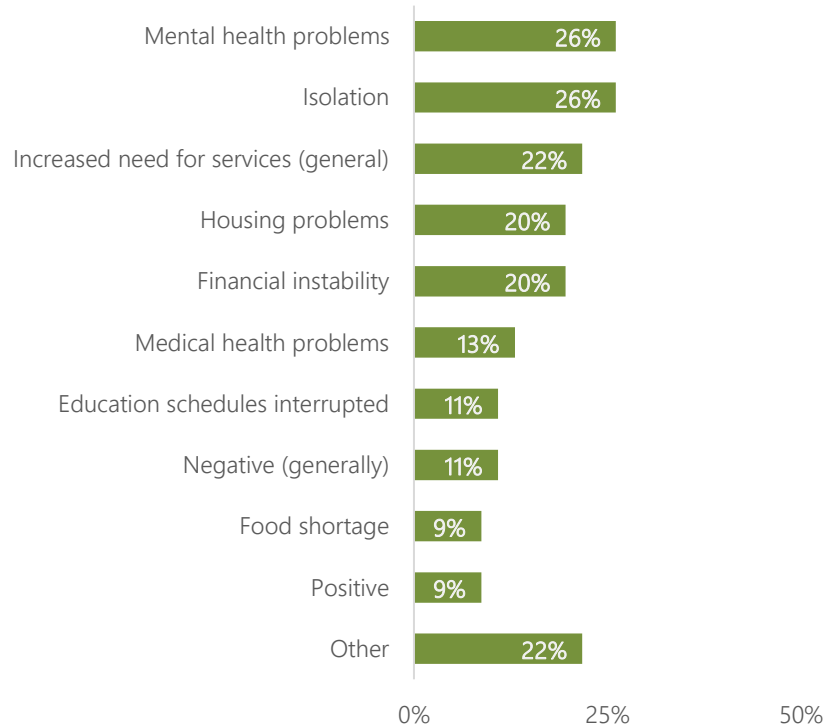


Q8: How much of your programming is focused on increasing access to services/resources for members of underrepresented racial or ethnic groups?

How COVID has impacted populations served

Mental health problems and isolation were common ways that respondents said COVID impacted the populations that partners and providers typically serve.

Other common ways COVID impacted their populations were increasing the need for services, increasing housing problems, and causing financial instability.



Q7: How would you describe the impact that COVID-19 has had on the populations you serve?

"The shut downs have had immense impact, increasing isolation to a population which is already highly isolated due to communication barriers. The health of individuals showed a marked decline due to the restrictions."

– Human Service Partner

"Significant challenges for families having lost employment or are now underemployed. Many families still apprehensive about vaccine and are reluctant to have children return to school. Seniors are increasingly isolated with limited knowledge of how to engage through social media or with technology in general."

– City of Tempe Employee

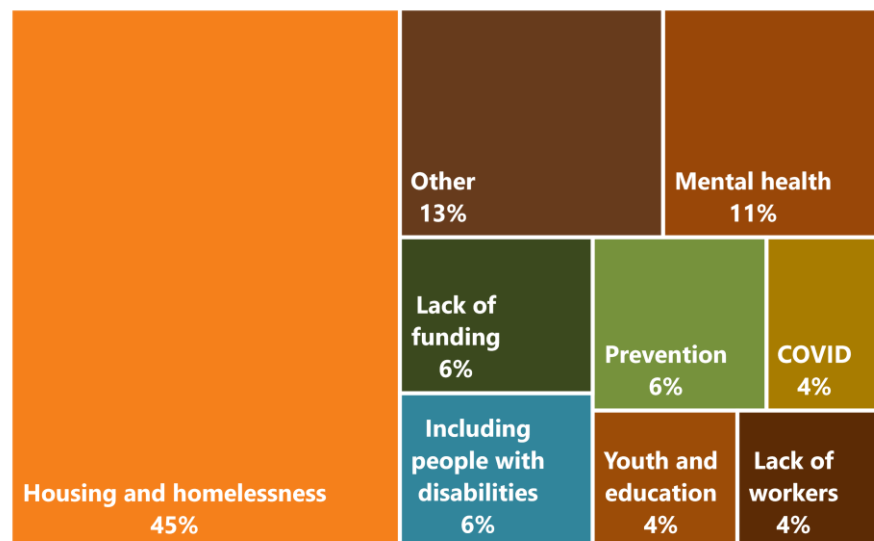
COMMUNITY

Greatest community-wide challenge

A

Housing and homelessness was clearly the most commonly mentioned community-wide challenge, when respondents took into account both the extent of the problem and its individual severity.

Other challenges included domestic violence, serving seniors, and accessing legal services.



Q9: Taking into account both the number of people experiencing a particular challenge, and the severity of the challenge (amount of suffering it causes), what is our ONE greatest community-wide challenge, with regard to human services?

Greatest community strength

Human service providers noted many community-wide strengths such as dedication, collaboration, and compassion.

Tempe's compassionate community listens to residents, recognizes their challenges, and discusses solutions. Dedicated staff and leaders collaborate to identify and meet the most pressing needs.



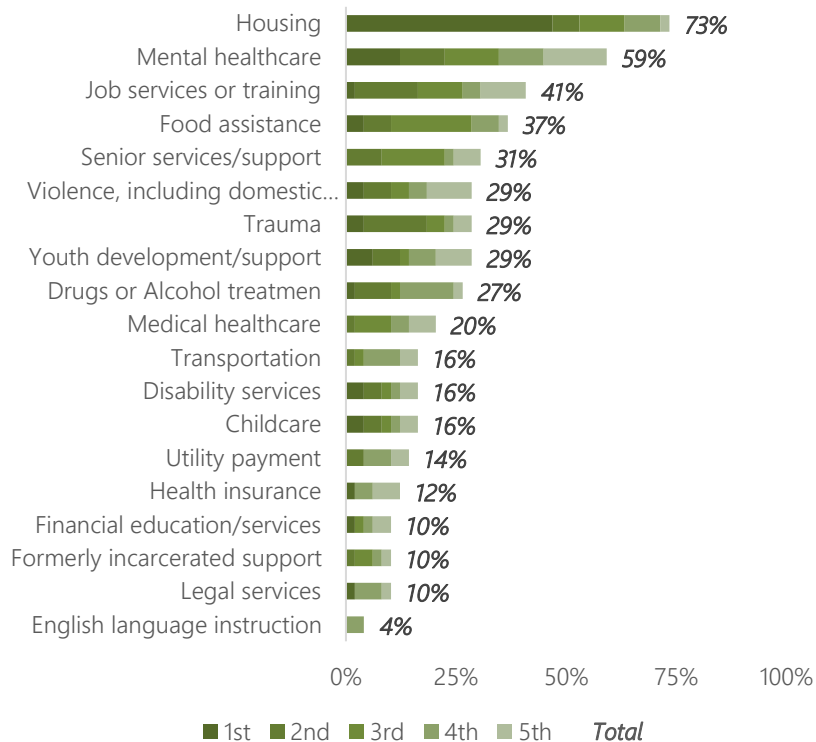
"A willingness to look at creative solutions at existing problems"

- Service Provider

Q10: What are our 1-2 top community-wide strengths with regard to human services?

Top five priority areas for action (next 5 years)

Housing and mental healthcare were the two human service areas that the most respondents said would be one of their top-five priorities, if they were in charge of improving human services in five years. Indeed, housing received half of all 1st priority rankings. Job services or training, food assistance, senior services, trauma, and youth development were also often selected as top-five priorities.



Q11: If you were in charge of improving human services for Tempe residents, what would be your top five priority areas for action in the next five years?

One best way to improve human services

Common ways to improve human services included increasing or improving funding, strengthening collaborations, and engaging with the community, including those in need and the broader public. Some respondents noted the need for a plan, and others suggested focusing on specific needs, such as housing and mental health.



Q12: What is the number one thing that you think would improve Tempe's ability to address human service needs in the community?

SECTION 3:
**PERSONAL RESOURCES, CHALLENGES, AND
HUMAN SERVICE NEEDS**
*STASTICALLY VALID SURVEY OF HOUSEHOLDS
IN HIGH-NEED NEIGHBORHOODS*

KEY INSIGHTS | COMMUNITY SURVEY

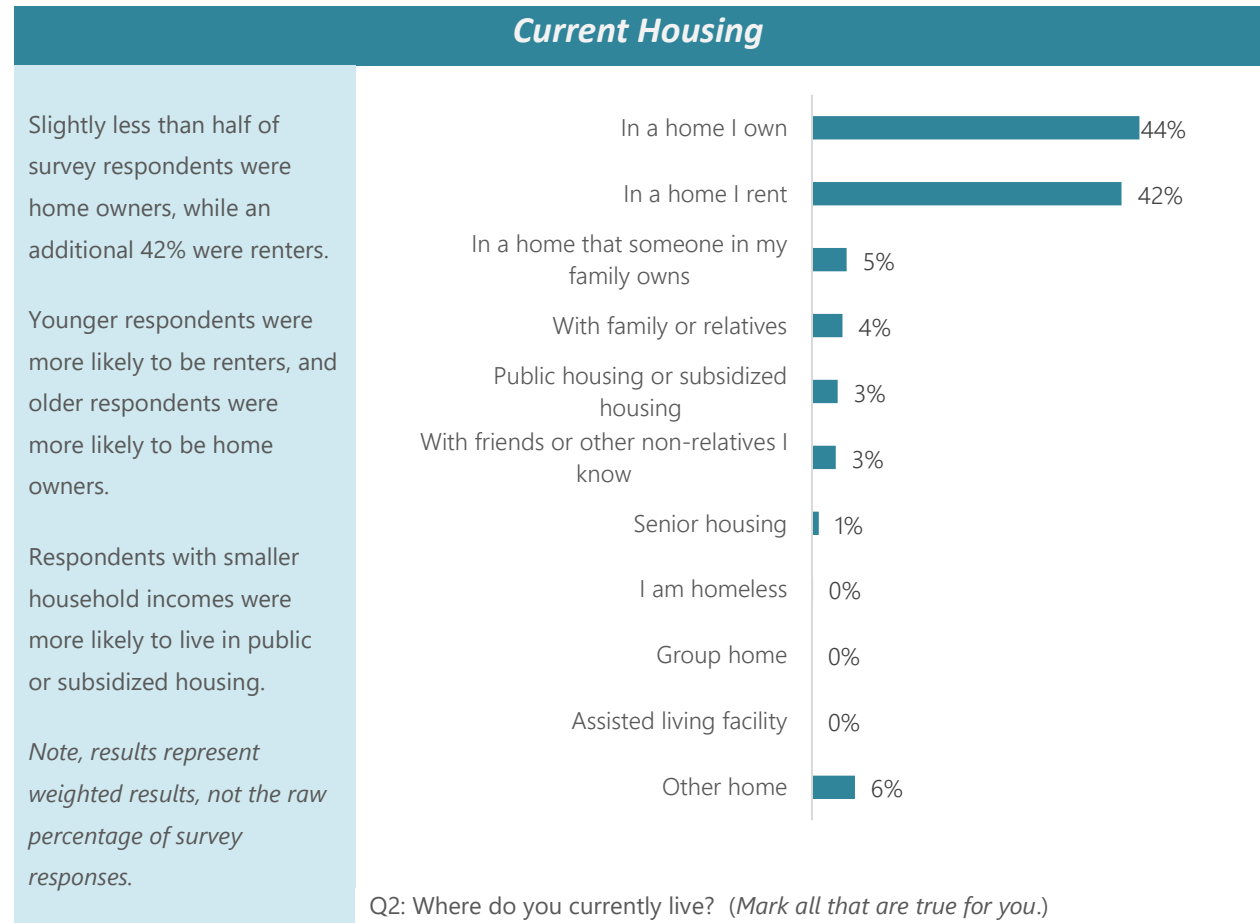
A mail survey targeting low- and moderate-income households was conducted to measure the amount and variations of human service needs across the community. A full description of the survey methodology and questionnaire is found in [Appendix C](#).

The following key findings summarize the results from the community survey.

1. **Almost 40% of the community is Struggling or Suffering.** According to the Cantril Self-Anchoring Striving Scale (Cantril, 1965), Struggling individuals are those with inconsistent or moderate levels of well-being, while Suffering individuals are those with well-being that is at risk. Over a third of respondents were Struggling, and an additional 3% were Suffering. Struggling and Suffering survey respondents reported poorer health, finances, and housing than their Striving counterparts. They worry more about their housing situation and have fewer resources in their safety net. They are more likely to have experienced stressful events in the past 12 months, to be lonelier, and to have experienced poor mental health in the past 30 days.
2. **Mental health care is a large need of the community.** Almost half of survey respondents reported poor mental health in the past 30 days. Interestingly, while this would suggest that a similar percentage might also be receiving or seeking out mental health care, this was not the case. About 40% of those who had experienced poor mental health in the past 30 days reported not needing help finding or getting mental health care. These individuals may feel like they can take care of their mental health needs on their own or they may have not yet decided whether they need help.
3. **Common resources in the community include smart phones and health insurance.** However, there are age differences. Seniors were less likely to have technology, like smart phone and high-speed internet, while younger respondents were less likely to have health insurance and less likely to have nearby friends and family who could help them if needed. Only about two thirds of all respondents had access to everything they need to “get by” without help from others, a retirement savings account, or nearby family or friends who could help if needed.
4. **At least one third of the community would face financial instability if a large expense came up.** About a third of respondents reported that a \$400 emergency expense would impact their ability to pay other bills this month. Additionally, more than one-third of respondents reported that they would not be able to pay off their credit cards if they wanted to.
5. **A significant proportion of the community are dealing with a disability, handicap, or chronic disease in their household.** About a fifth of survey respondents reported a disability, handicap, or chronic disease was preventing them or someone in their household from participating in typical activities. These respondents were also more likely to be classified as Struggling on the Cantril scale.
6. **Covid has had a sizeable impact on this community.** About one quarter of respondents said that Covid itself or something related to the pandemic was the most significant challenge they faced this past year.

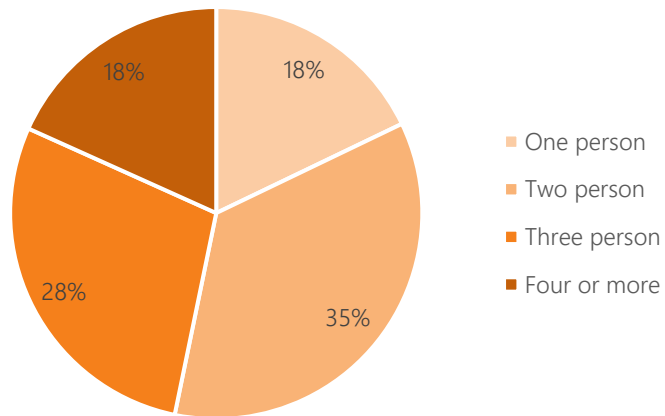
SUMMARY OF FINDINGS

LIFE IN TEMPE



Household Size

About half of respondents lived in a one- or two-person household. More than one-quarter of respondent 65 and older lived by themselves, which was the most of any age group.

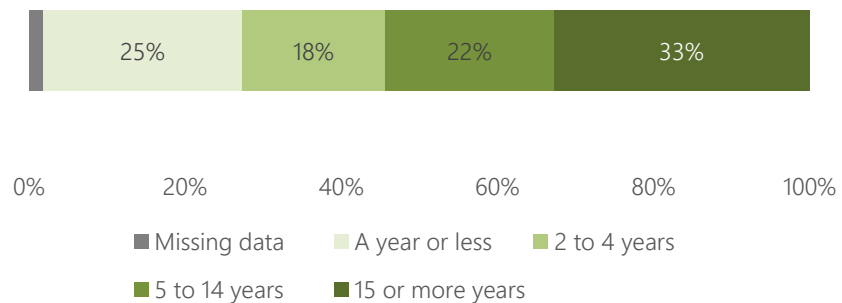


Q3: How many other people currently live in your home? _____ (if none, write "0")

Tenure in Tempe

One third of respondents had lived in Tempe for 15 years or more, while one quarter had been there for a year or less.

Homeowners and older respondents were more likely to have lived in Tempe longer.



Q4: How long have you lived in Tempe, in total? _____ (write number of years)


Cantril Self-Anchoring Striving Scale (Cantril, 1965)

[The Cantril Self-Anchoring Striving Scale](#) (Cantril, 1965) is used to measure subjective wellbeing. Gallup employs this scale in its daily poll of America's well-being and its World Poll of more than 150 different countries. The scale is developed by asking respondents to indicate where they personally stand today on a ladder where 0 represents the worst possible life and 10 represents the best possible life. Then, respondents are asked which step they think they will stand on five years in the future.

For the next two questions, the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

6. On which step would you say you personally feel you stand at this time?


10 ☐
 9 ☐
 8 ☐
 7 ☐
 6 ☐
 5 ☐
 4 ☐
 3 ☐
 2 ☐
 1 ☐
 0 ☐



Best possible life (10)


Worst possible life (0)

Continue



7. On which step do you think you will stand about five years from now?

10 ☐
 9 ☐
 8 ☐
 7 ☐
 6 ☐
 5 ☐
 4 ☐
 3 ☐
 2 ☐
 1 ☐
 0 ☐



Their answers can then be combined to categorize individuals as Thriving, Struggling, or Suffering. Those who are categorized as Suffering have been found to have more than double the disease burden of those who are Thriving, less access to health insurance and care, more stress, more pain, and less likely to have reliable food and shelter. Those who are Struggling have been found to report more stress and worries about money, more sick days, and more unhealthy behaviors.

| Thriving | Struggling | Suffering |
|---|--|--|
| Respondents rate their current life as a 7 or higher AND their future life as an 8 or higher. | Respondents either rate their current life moderately (5 or 6) OR rate their future life moderately (5, 6, or 7) or negatively (0 to 4). | Respondents rate their current life negatively (0 to 4) AND their future life negatively (0 to 4). |
| 57% | 37% | 3% |
| in study area | in study area | in study area |

An additional 3% of respondents did not answer both questions. Homeowners were more likely to be Thriving, while renters were more likely to be Struggling. Respondents with greater household incomes were also more likely to be Thriving. Additionally, respondents who reported that they or someone else in their household has a disability, handicap, or chronic disease that prevented them from engaging in typical activities were slightly more likely to be Struggling.

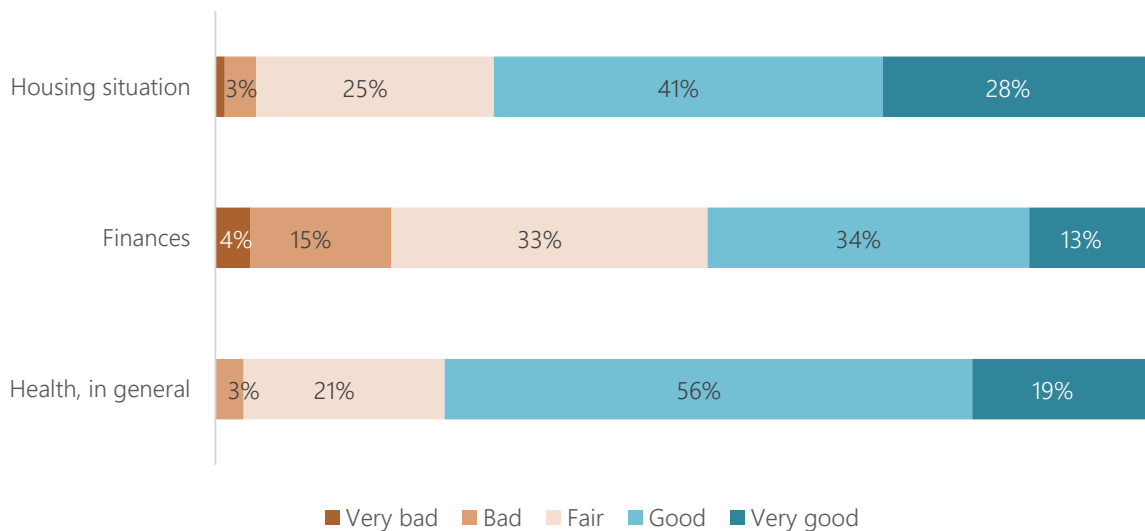
Ratings of Housing, Finances, and Health

Respondents rated their health most positively; about three quarters rated it as “Good” or “Very good”.

Respondents who reported that they or someone else in their household has a disability, handicap, or chronic disease that prevented them from engaging in typical activities rated their health as worse.

Ratings of finances were the lowest of the three items. More than half of respondents rated their finances as “Fair” or worse. Respondents 65 and older were more likely to rate their finances and housing situation more positively, and people who are homeless rated all of these items worse than respondents with homes.

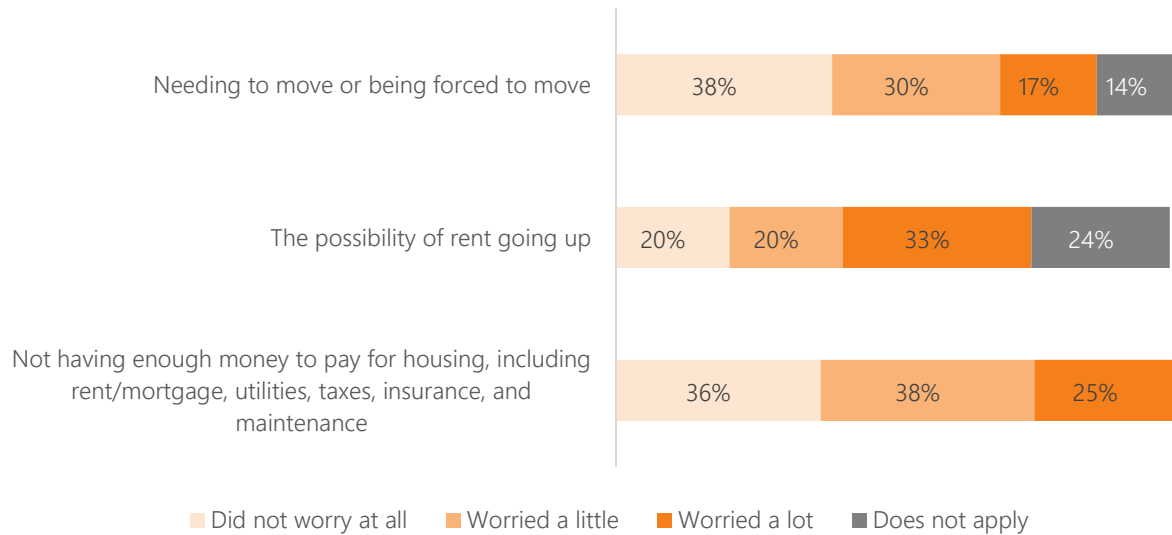
Tempe residents who are Thriving rated their housing, finances, and health higher than those who were Struggling or Suffering. Respondents who are renters, who are less educated, and who have smaller household incomes all rated their housing, finances, and health more negatively.



Q7. For you personally, how would you rate the following?

Concerns About Housing

Increasing rent was the biggest housing concern for respondents. Those who are Struggling or Suffering and renters were more concerned about all the tested items, compared to Thriving respondents and those who are homeowners. Respondents who are homeless were more concerned than others about needing to move or being forced to move. Not surprisingly, respondents with smaller household incomes were more concerned about not having enough money to pay for housing costs.



Q8. How much have you worried about the following, in the past 12 months?

GETTING BY

Resources

Only about two thirds of respondents had everything they need to “get by” without help from others.

The most common resources that respondents had access to were a smart phone, health insurance, and a checking or spending account.

Two thirds of residents reported having nearby family or friends who could help if needed or a retirement savings account.

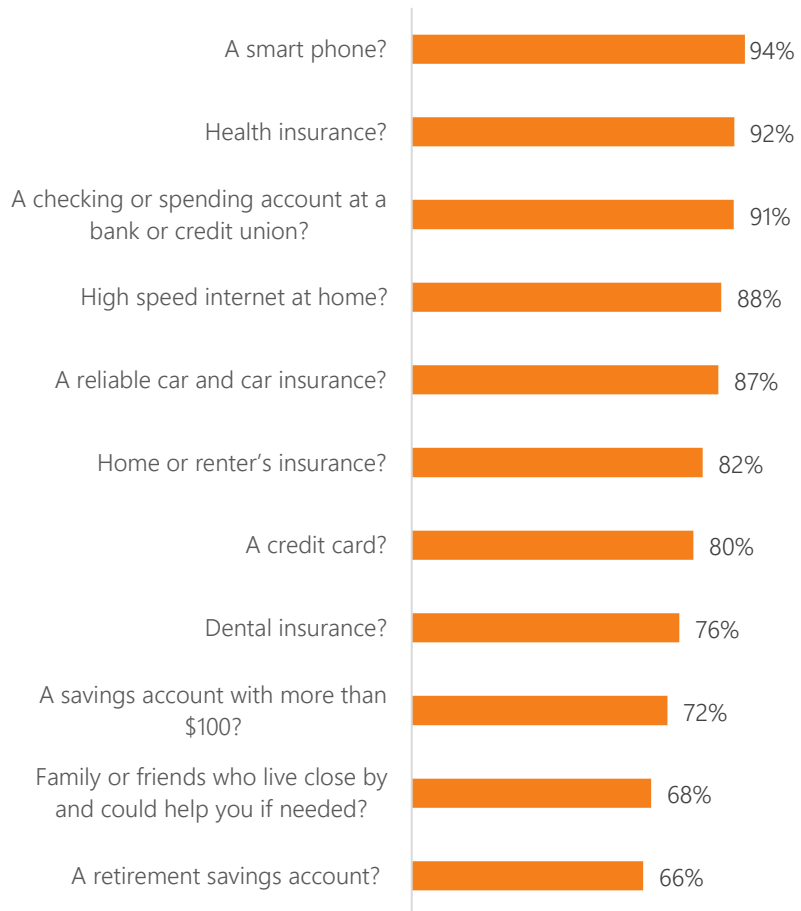
Respondents 65 and older were less likely to have smart phones or high-speed internet. Respondents 35 to 64 years old were less likely to have health insurance and less likely to have nearby friends and family, compared to other age groups.

Respondents who are homeless, who are Struggling or Suffering, who are renters, who have less education, or who have smaller household incomes have fewer resources.

Do you have “Everything you need to “get by” without help from others”?



Do you have...?

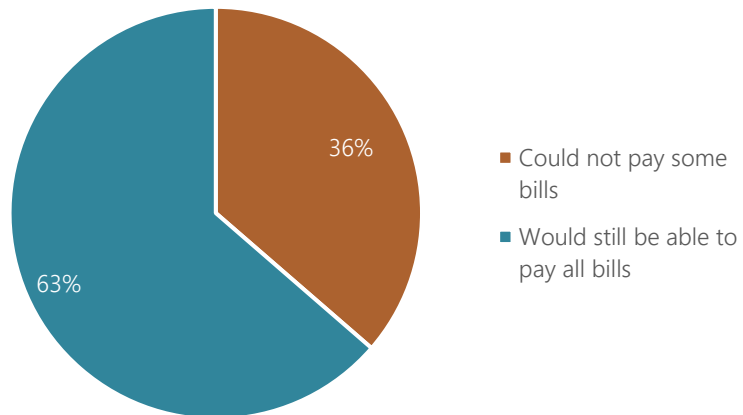


Q9. Do you have ...?

Affording an Emergency

About one third of respondents reported that a \$400 emergency expense would impact their ability to pay other bills this month.

Respondents who are Struggling or Suffering, who are renters, who have less education, and who have smaller household incomes were less likely to be able to afford a \$400 emergency.

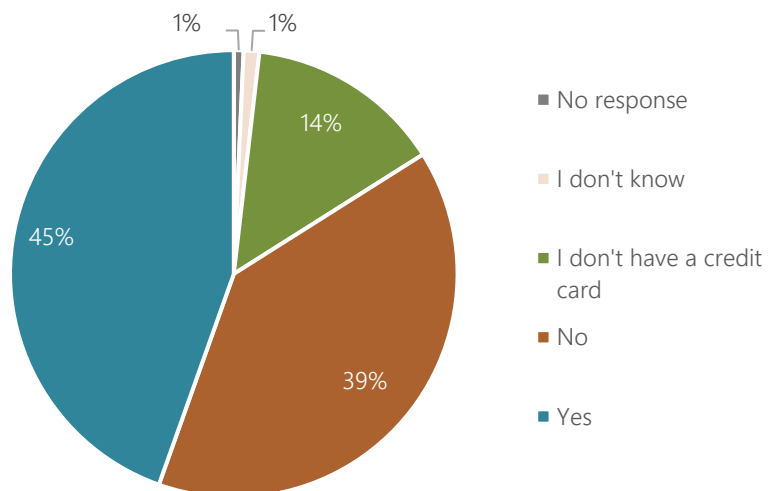


Q10. How would a \$400 emergency expense that you had to pay impact your ability to pay your other bills this month?

Paying Off a Credit Card

More than one third of respondents reported that they would not be able to pay off their credit cards if they wanted to.

Younger respondents, those who are Struggling or Suffering, those who are renters, those with less education, and those with smaller household incomes were less likely to be able to pay off their credit cards.

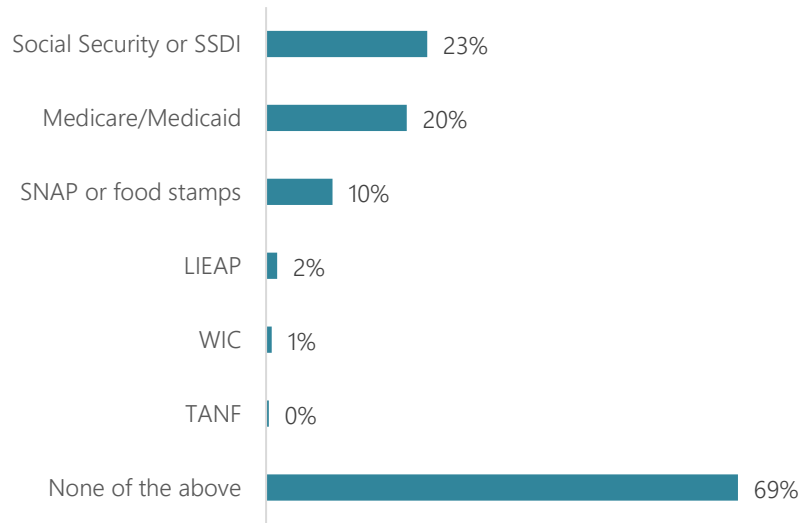


Q11. Today, could you pay off what you owe on your credit cards if you wanted to?

Benefits

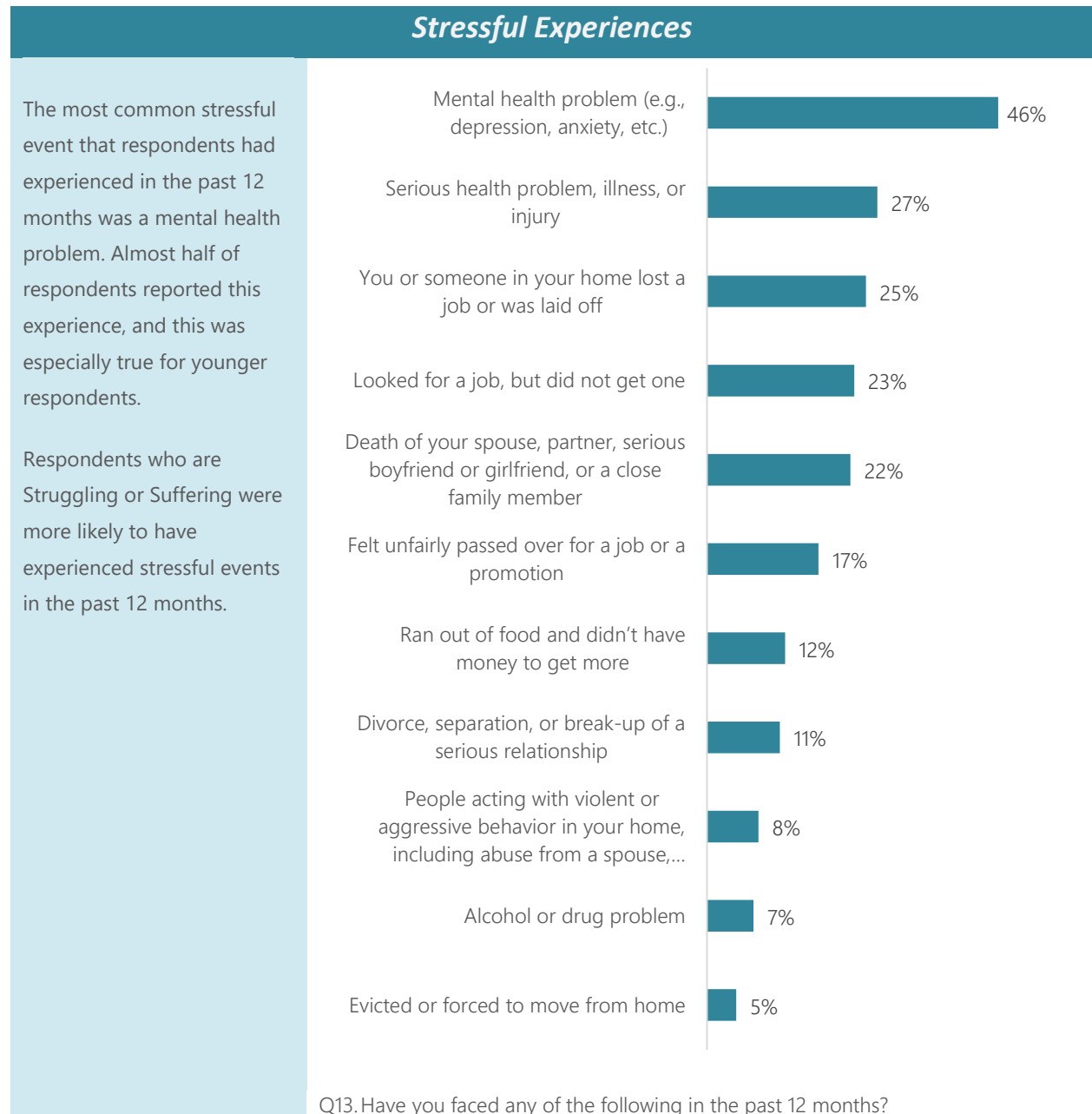
Almost a third of respondents reported that they or someone in their household received benefits. Respondents 65 and older were more likely to receive benefits, specifically Social Security and Medicare/Medicaid.

Respondents who are Struggling or Suffering, those with less education, and those with smaller household incomes were more likely to be receiving benefits.



Q12. Mark each benefit that you, or someone you live with, receive?

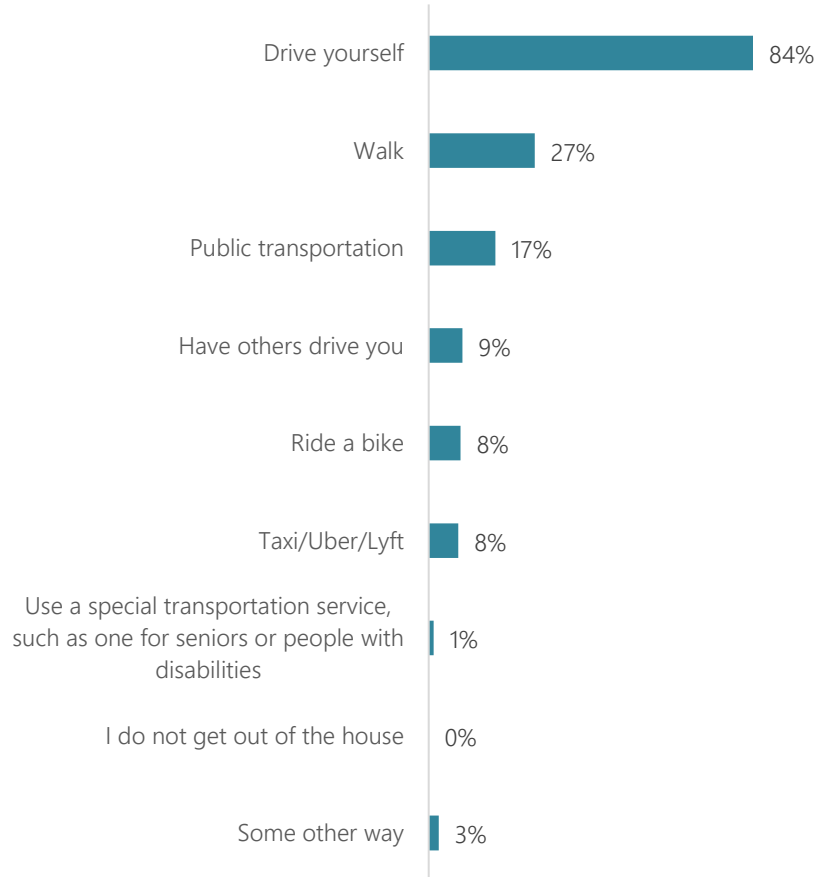
EXPERIENCES



Getting Around

Most respondents get around their community by driving themselves.

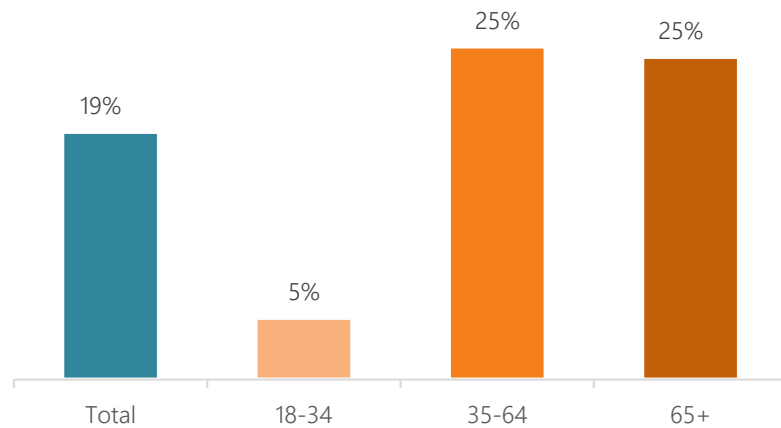
Younger respondents were slightly more likely than older ones to walk, take a taxi/Uber/Lyft, or use public transportation.



Q14. How do you usually get around your community for things like shopping, visiting the doctor, running errands, or other things?

Disability, Handicap, or Chronic Disease

Almost a fifth of respondents reported that a disability, handicap, or chronic disease kept them or someone in their household from fully participating in typical activities. This was especially true for respondents 35 and older.

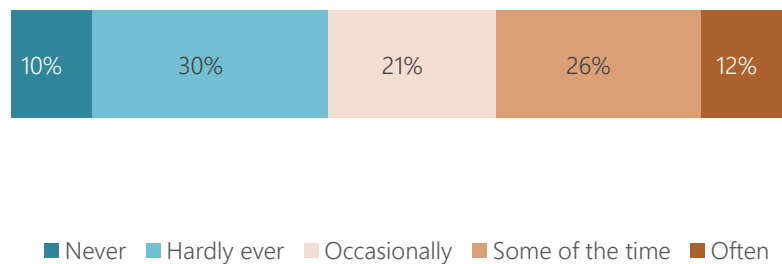


Q15. Does any disability, handicap, or chronic disease keep you or anyone you live with from participating fully in work, school, housework, or other activities?

Loneliness

Almost 40% of respondents reported feeling lonely "Some of the time" or "Often".

Respondents who are homeless, who are Struggling or Suffering, who are renters, or who have smaller household incomes reported higher levels of loneliness.

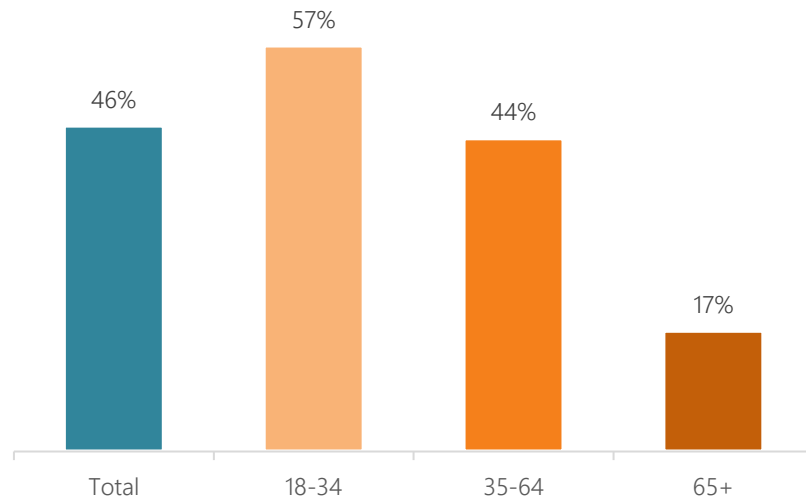


Q16. How often do you feel lonely?

Poor Mental Health

Almost half of respondents reported experience poor mental health in the past 30 days. This was especially true for younger people.

Respondents who are Struggling or Suffering and those who are renters were more likely to have experienced poor mental health in the past 30 days.



Q17. Have you had a day when your mental health was NOT good, in the past 30 days?

Current Needs

The most common needs among respondents were help finding an affordable home and help finding or getting mental health care.

Younger respondents were more likely to need help finding an affordable home. Additionally respondents who are Struggling or Suffering and those who are renters were also more likely to need help finding an affordable home.

Relative to other needs, a slightly larger percentage of respondents did not know if they needed help finding or getting mental health care. Respondents who are Struggling or Suffering were more likely to say that they need help with mental health care. Additionally, respondents with children under 18 in the household were more likely to report that they needed help with mental health care.

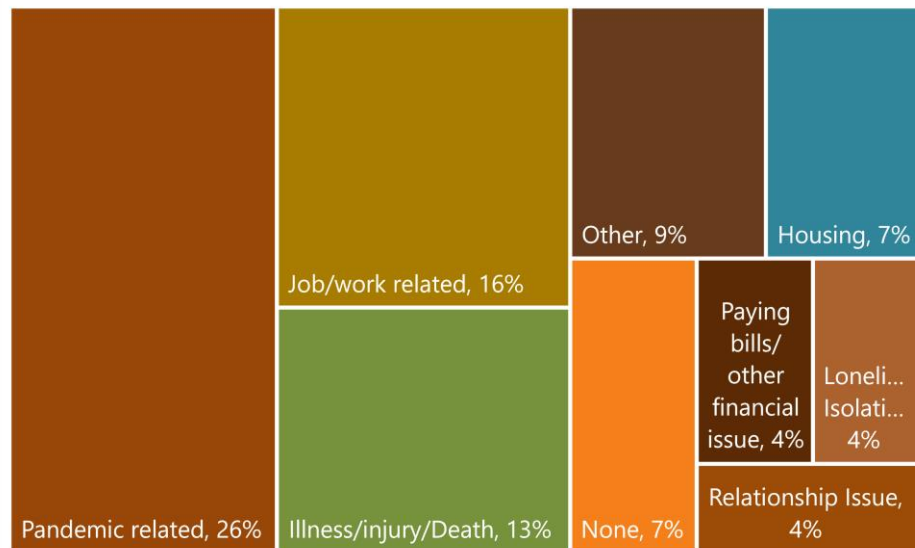


Q17. Have you had a day when your mental health was NOT good, in the past 30 days?

Most Significant Challenge of the Past Year

The top 3 challenges of the past year for respondents were pandemic related, work related, or health related.

While many respondents noted challenges, not many had suggestions for what could have made it easier for them.



Q19. What was the most significant challenge you faced in the past year, and what could have helped make things easier for you? (Coded open end)

"COVID-19; how to pay my urgent care bill when was told all COVID-19 expenses are paid for by government."

- Tempe Resident

"Working long hours due to COVID-19 without regard for my health or additional compensation."

- Tempe Resident

"Hard dealing with the death of both my in-laws, unable to be there while they were in the hospital. It would of helped having less restrictive visitor rules during 2020."

- Tempe Resident

DEMOGRAPHICS

| Community Survey | |
|---|-----|
| Total respondents | 350 |
| Kids <18 in Household | 18% |
| Single Parent | 16% |
| Age | |
| 18 to 34 | 31% |
| 35 to 64 | 60% |
| 65+ | 7% |
| College Student | 17% |
| Identify as LGBTQ+ | 13% |
| Gender | |
| Female | 52% |
| Male | 47% |
| Prefer to self-describe | 0% |
| U.S. Citizen | 93% |
| Education | |
| Less than a high school diploma | 4% |
| High school diploma/GED | 14% |
| Associate degree | 14% |
| Some college or technical school | 36% |
| Bachelor's degree | 20% |
| Graduate degree | 12% |
| Race/Ethnicity | |
| White / European American | 68% |
| Black / African American | 7% |
| Native American / American Indian | 5% |
| Hispanic / Latino | 17% |
| Asian / Pacific Islander | 5% |
| Other | 5% |
| Worked for Pay in Past 12 Months | 76% |
| Mean Number of Adults in Home Working for Pay | 1.4 |
| Household Income | |
| Less than \$25,000 | 24% |
| \$25,000 to \$49,999 | 30% |
| \$50,000+ | 33% |

SECTION 4:
**MENTAL HEALTH COMPLEXITIES AND
OPPORTUNITIES**
*GROUP DISCUSSION WITH MENTAL HEALTH
PROVIDERS, EXPERTS, AND COMMUNITY LEADERS*

KEY INSIGHTS | MENTAL HEALTH FOCUS GROUP

Thousands of Tempe residents have days when their mental health is not good. Personal mental health issues can make it difficult for residents to achieve their goals. Likewise, mental health problems can make it more difficult for human service providers to meet the complex needs of their clients.

An online focused group discussion was held with mental health providers, experts, and community leaders, to identify solutions and prioritize actions that the human service community can do to ensure they are better serving residents who live with personal mental health issues. A description of the focus group methodology is in [Appendix D](#).

The following key insights summarize the results from the focus group discussion.

1. **Mental health care is typically distinguished as proactive or reactive:** The proactive approach focuses on day-to-day holistic strategies for maintaining optimal mental health, while the reactive approach aims to treat mental health symptoms that negatively impact the individual's ability to function in life.
2. **Mental health care does not fall solely on the shoulders of licensed therapists and other professionals in the field.** One common misunderstanding about mental health is the expectation that mental health professionals are the only ones responsible or capable of improving mental health for individuals.
3. **Vulnerable populations can be anywhere.** While there are often robust systems in place for helping populations that have already been identified as high need, the most vulnerable populations are people who do not fit into those categories and are not able to get the help they need.
4. **Peers are a key strategy for maximizing available resources and helping community collaborations around mental health.** Peers can be utilized at all intersections of the crisis system to serve as a bridge to persuade individuals to engage in services and offer on-going support for those who need it.
5. **Trauma-Informed approaches to mental health get at the root cause of the crisis.** Behaviors that manifest through drug and alcohol use or arrests are associated with root trauma and cannot be adequately addressed by the crisis response team in the moment of crisis. Trauma-informed counseling and early assessment and detection through tools like the Adverse Childhood Experiences (ACEs) help with addressing the root cause of trauma.
6. **Lack of knowledge about available resources received the highest ranking in the challenge prioritization exercise.** Group participants ranked this challenge high in level of effort and somewhat low on momentum.

SUMMARY OF FINDINGS

DEFINING MENTAL HEALTH SERVICES

In discussing approaches to defining mental health for the general public, the participants drew a distinction between proactive and reactive approaches for understanding mental health. The proactive approach foregrounds mental wellness and paying attention to the individual's overall condition with regard to their emotional and psychological wellbeing and ability to cope with stressors in life. With this approach, caring for mental health is part of routine health maintenance, and individuals are taught coping mechanisms to help maintain good mental health. On the other hand, the reactive approach foregrounds treatment of mental health symptoms that are negatively impacting a person's life and their ability to function. With this approach, mental health care is given once one's mental health has deteriorated enough to require treatment.

Focus group participants mentioned that mental health terms like depression, anxiety, and PTSD are now more widely known, recognizable, and accepted by the general public. Some of the focus group participants attribute this, in part, to the pandemic's effects of social isolation, added stress and anxieties that made more people realize the need for mental healthcare resources and become more familiar and accepting of the accompanying terminology. This shift toward greater recognition and acceptance of seeking out mental health resources helps normalize public perceptions around mental health needs. It also seems to disproportionately rely on the reactive treatment model for understanding mental health, which dovetails into some of the common misunderstandings around mental health.

MISUNDERSTANDINGS ABOUT MENTAL HEALTH

One of the key public misunderstandings around mental health mentioned by the group is the overwhelming reliance on mental health professionals and licensed therapists. Improving the mental health in the community requires a holistic approach. This is particularly evident when approaching mental health and wellness from a proactive standpoint and actively pursuing coping and resilience strategies.

The group also brought up the often-unrealistic expectations around mental health therapy. Oftentimes, the public expect that seeing a therapist consistently is going to 'fix the problem,' when the reality is that engaging in therapy is just the beginning. Most recovery toward wellness and health happens outside of the therapist's office.

VULNERABLE POPULATIONS

While the group brought up key vulnerable populations with regard to mental health, they also highlighted that there are often robust systems in place for helping populations that have already been identified as 'high need.' From that standpoint, the most vulnerable populations are people who do not fit into those categories and are not able to get the help they need. These groups include:

First responders,
including police
officers

Teachers, especially
special education
teachers

Medical health
providers

Mental health
providers
themselves

Military service
personnel

At risk youth

Homeless

Families dealing
with domestic
violence

COMMUNITY COLLABORATIONS

Focus group participants brought up several examples of effective collaborations and community partnerships between mental healthcare-focused organizations and other community-serving organizations in Tempe.

Example 1: Tempe Police Department working in partnership with Care 7 when responding to calls for service.

This collaboration identified a lot of trauma and lack of coping skills among middle school and high school age youth. The partnership recognizes the importance of doing the warm hand-off to the mental health providers who can then help youth develop the skills they need.

For the police officers themselves, it feels more normal now to come forward about potential issues with PTSD and take time to process things after they have been through an incident, like a shooting. They are now taking the time before coming back to work.

"In the past, we've had officers be involved in a shooting, and then they would try to come back within the next week. And there is nothing normal about being involved in a shooting or taking somebody's life. But then we try to come back, saying 'well, this is part of the program. This is what I signed up for.' And then months later you see these individuals having problems at home and in their everyday life. But now we're seeing the officers are doing a much better job of doing that reporting."

Example 2: EMPACT collaboration with the Tempe Police Department:

This collaboration is addressing the Opioid crisis by training law enforcement officers and fire department personnel to administer Naloxone (Narcan) to people who are overdosing on Opioids. The collaboration is also structured to provide 24/7 wrap-around behavioral health support for individuals in need. A SAMHSA grant supports the ability to provide navigator services to engage the people recovering from the overdose and help them get connected to mental health services.

Utilizing peer navigators has been the key to success for this program. The peer navigators are individuals who have lived through similar experiences, so they are able to engage on a much deeper more meaningful level. They also help to supplement the shortage of therapists, not only in Arizona, but nationally.

"The first individual who was ever involved in the program was a young gentleman who was actually blind. He overdosed on Opioids, and law enforcement was able to administer Narcan. He was revived, and our peer went out to the hospital to meet with him and his family. It was actually identified that this individual overdosed on purpose. It was actually a suicide attempt. So this individual was able to be engaged. His family was so appreciative and gracious that we had the ability to bring him back and set him up with all the services."

Example 3: Collaboration between Open Hearts and the Community Health Centers

The collaboration brings in Adverse Childhood Experiences (ACE) assessment into primary healthcare delivery settings for youth. The program is structured to refer youth with a positive ACE score to behavioral health service providers.

STRATEGIES FOR COMMUNITY COLLABORATIONS AROUND MENTAL HEALTH

Participants generated some key strategies for maximizing community collaborations around mental health.

Peers are a tremendous resource that can be utilized at all intersections of the crisis system. They are also able to serve as a bridge to get individuals to engage in on-going services.

- > They can be utilized to do life skills training. A number of community collaboration initiatives focus on utilizing peers in various life skills training programs.
- > Peer navigators also help in situations where individuals are stuck in cyclical patterns of being in the crisis system. Peers help break that cycle by acting as a kind of a mirror. Showing that what the individual is currently doing is not working for them. Utilizing the peers to try to get that person to (re)engage in treatment and support them to stay engaged in on-going behavioral health services leads to amazing successes stories.

"Seeing peers work is absolutely amazing. If you can connect with an individual on a different level by saying, 'Hey, I've been in your shoes. I've had some of the same experiences as you have, and I've been able to get through it. This is how I was able to do it. I'm not saying that's the exact same way you should do it, but let's try to work this out together and see what can help.' That has really been a tremendous tool for the behavioral healthcare system in general. A peer can engage with somebody so much faster and for so much longer a period of time than I ever could."

- > The base strategy for utilizing peers relies on the Peer Navigation model from the substance use realm, where peers are utilized as substance use recovery coaches. Now other programs are building on that knowledge base, and using peers in other areas of crisis intervention.
- > Strategies for finding and keeping peers are necessary.
 - Offering paid peer positions is also an important element. It offers people a career path they can also build. "They can make a living and have a career path of 'giving back.'"
 - Offering a 40 hour long 'Peer Academy' training program (certified by the state) will be necessary for individuals looking for peer certification.

"Great peers are the people who have gone through their challenges and have come out on the other side. They are wanting to give back."

Case Managers are critical for what happens after the crisis response. A case manager can be a peer or a social worker, or just a person who is able to check in with a mental health patient and gauge how they are doing and what help is needed. They have the ability to connect with people who are dealing with some very complex issues. The biggest issue is helping people deal with the root cause of the crisis; activities like an arrest or drug or alcohol use are all symptoms of unaddressed trauma. They are behaviors associated with something that cannot really be addressed

by the crisis response team in the moment of crisis. A case manager can help individuals actually engage with the mental health services that are needed to work through the trauma by physically taking them to appointments and helping to set up the ongoing therapy logistics.

Trauma-Informed approaches, such as the Adverse Childhood Experiences (ACE) assessment for youth, were mentioned by focus group participants. Behaviors associated with having experienced trauma manifest differently for different people. When delivered in combination with primary healthcare to youth, assessing ACEs is a powerful way to get at the root cause of the troublesome behavior patterns.

Enabling youth to seek out non-clinical behavioral healthcare services without having to get parental consent before they can speak to a provider is also important. In Arizona, youth have to be 18 or older to seek out mental health services without parental consent. This presents barriers for youth who are not able to ask parental permission. For schools that partner with external agencies to provide non-clinical mental health services for students and offering social support services on campus, active parental consent is still required. Schools and agencies are working on:

- > Building a common level of understanding with parents about what the services are and building that level of comfort and trust.
- > Shifting from an active 'opt-in' via consent model to an active 'opt-out' of services that are offered on campus for youth. Making it a part of the culture of what is offered at the school for all students, and if parents do not want it, they can opt out.

Creating services that do not look like services was also suggested. Creating programs that provide mental health care services while not resembling 'traditional' mental health care services can help bring in clients who struggle with engaging in 'traditional' counseling. For example, offering supportive programs for wellbeing and teaching coping strategies provide people with ways to engage in activities and interactions while also learning resilience and coping strategies and self-soothing techniques. These programs are particularly important for youth and include programs that are socially based. They help to build self-confidence and social skills, and don't look like traditional behavioral health services. Some examples of these programs might include music and art therapy, cooking classes, or trauma-informed yoga.

PRIORITIZATION OF MOST PRESSING CHALLENGES

Prior to the focus group, participants identified seven mental health challenges facing Tempe communities:



During the focus group, the participants were asked to rank the top three challenges for each of the following dimensions: urgency; momentum; permanency; vulnerable populations (disproportionately impacts vulnerable populations); complementarity (with helping non-mental health problems); political will; level of effort; (individual) personal benefit; and community benefit.

Challenges were then scored by assigning three points each time the challenge received a number one rank on any dimension, two points for a number two rank, one point for a number one rank, and no points if it was not ranked in the top three. The sum of all points for all focus group participants for each dimension are shown below. The table below shows the two highest scored challenges were lack of knowledge about available resources and obtaining and keeping affordable housing.

| | Most urgent | Benefit the most people | Long-term benefit | Support the most vulnerable people | Keep momentum going | Balanced level of effort | Total |
|--|-------------|-------------------------|-------------------|------------------------------------|---------------------|--------------------------|-------|
| Lack of knowledge about available resources | 9 | 13 | 13 | 11 | 6 | 20 | 72 |
| Obtaining and keeping affordable housing | 12 | 6 | 12 | 12 | 9 | 2 | 53 |
| Stigma of seeking mental health care | 7 | 8 | 8 | 0 | 9 | 8 | 40 |
| Need for trauma-informed care | 5 | 4 | 4 | 7 | 11 | 8 | 39 |
| Lack of therapists and lack of consistency across behavior health care | 7 | 9 | 9 | 6 | 4 | 3 | 38 |
| Social isolation and residents feeling alone | 6 | 6 | 0 | 4 | 6 | 5 | 27 |
| Access to care for the homeless | 2 | 2 | 2 | 8 | 3 | 2 | 19 |

Implications

Lack of knowledge about available resources received by far the most points, and many participants ranked this challenge high on the balanced level of effort dimension. However, this challenge may be a bit low on momentum currently.

Obtaining and keeping affordable housing was the most urgent and one that appears to support the most vulnerable people. However, this challenge did not receive many points in terms of balanced level of effort, an acknowledgement that addressing this challenge would be resource intensive.

Additionally, no focus group participant ranked reducing stigma as a top three challenge on the supporting the most vulnerable populations dimension. Mental health care for people who are homeless was not often ranked as a top-three challenge, except for the dimension of supporting the most vulnerable people. The need for trauma-informed care appears to have some positive momentum and is a good balance of effort for benefit. Lastly, the lack of therapists is an urgent challenge that, if addressed, could benefit many people and provide long-term benefits; however, this challenge appears to lack momentum and will require a high level of effort for the benefit.

SECTION 5:
AGING AND INDEPENDENT LIVING
IN-DEPTH INTERVIEWS WITH RESIDENTS

KEY INSIGHTS | RESIDENT INTERVIEWS

To further explore the challenges of living independently, particularly among older adults, Corona Insights interviewed 11 Tempe residents who were either older than age 55 and struggle with living independently or were caring for an older or disabled family member who required their help.

The following key insights summarize the results from the interviews.

1. **The increasing cost of living in Tempe was a common challenge.** This finding is not surprising given that the majority of the interviewees live on a fixed income either because they are struggling to find full-time work or are on retirement or disability. Because their income cannot keep up with the increase in rent and other living expenses, individuals express considerable anxiety over their ability to pay their bills in the future.
2. **Transportation is another common challenge.** Interviewees expressed concerns over the rising amount of traffic and lack of reliable access to transportation and parking. Reliable and affordable access to transportation presents challenges for residents with limited physical and/or financial resources who wish to maintain their independence. This is a crucial resource for being able to keep medical appointments, get groceries, prescription medication, and other necessities.
3. **Most interviewees wish to maintain their independence and are reluctant to commit to a full-time assisted living situation.** However, they often feel frustrated by the lack of options when it comes to affordable housing that includes the accessibility features crucial to individuals with limited mobility.
4. **Aging residents anticipate needing more help with basic household chores.** Interviewees expect that keeping up with daily chores around the house, like cooking, cleaning, maintenance, and yard work, will become increasingly more challenging with age. Maintaining their level of independence will require getting help with accomplishing household chores as mobility becomes increasingly difficult.
5. **Majority of interviewees rely on family and friends for support.** Findings indicate that most residents are relying on word of mouth for guidance and suggestions about possible resources for help. Close friends and family are the most frequent and trusted source for help and information.
6. **Caregivers are overwhelmed by all the expectations and responsibilities.** Interviewees who are providing help to family members feel overwhelmed by the sheer multitude of responsibilities that are required. The most frequently mentioned issues include the logistics of managing healthcare needs, meal planning, multiple appointments, insurance logistics, and figuring out possible options for senior living facilities in the future.

SUMMARY OF FINDINGS

A majority of the interviewees lived on a fixed income either because they were struggling to find full-time work or are on retirement or disability. Three of the 11 interviewees worked full time but were still experiencing financial difficulties with managing the expenses of financially supporting elderly parents and/or children in their household.

Overall, the increasing cost of living, especially the cost of housing, was a major issue for residents.

A large portion of the interviewees (4) are caring for elderly and/or disabled family members; three interviewees were elderly, living alone and working on maintaining their independence as they age, two interviewees were caring for children, and another two were caring for both children and elderly parents at the same time. Not surprisingly, managing the care-taking responsibilities and multiple needs of family members was overwhelming for many caregivers. While most interviewees did not feel they were able or willing to fully commit to a full-time assisted living situation, they wished for better access to affordable part-time services to help manage caregiver duties.

LIVING IN TEMPE

Most the interviewees had lived in Tempe for well over a decade. Most of them felt fondly about the sense of community they experienced in their proximal neighborhoods but were unhappy about the drastic increase in the city's population they had witnessed over the recent years. Concerns over traffic, transportation, and parking, and the rise in homeless populations were the issues that present challenges for Tempe communities. On the other hand, people who otherwise had limited resources, often pointed to their immediate networks of neighbors, friends, and family who live relatively close, as their primary assets to call upon for help.

PRIMARY CHALLENGES

The most pressing challenges identified by interviewees revolved around limited finances. Not surprisingly, the rising cost of living in Tempe was a major concern for many residents. This was particularly a problem for those living on a fixed income that could not rise along with the cost-of-living demands. Retirees, individuals living off of disability payments, and people who were only able to find limited part-time work were especially vulnerable to falling behind on their rent and feeling like they had no alternative options to find affordable housing.

Moreover, interviewees expressed frustration around trying to find affordable housing that was specifically designed with accessibility features that are crucial to individuals with limited mobility (due to age or disability) who want to live independently. For most interviewees, full-time assisted living facilities were not a good option. Some interviewees were worried they could not afford it, while others were just more comfortable maintaining their independence and wished to stay in their own home. In either case, keeping up with daily chores around the house, like cooking, cleaning, maintenance, and yard work, were increasingly more challenging with age. The logistics of getting and re-filling prescription medication was another important challenge for individuals who could not easily and frequently travel to the pharmacy.

Lack of access to reliable and affordable transportation options, the increasing traffic, and lack of parking were other additional challenges that restricted residents with limited physical and/or financial resources from maintaining their independence. Residents also mentioned that several of their neighborhood grocery stores had closed, thus eliminating their access to groceries within walking distance.

For caregivers who are providing help to family members, the burden of managing all the caregiving responsibilities often feels overwhelming. The most frequently mentioned issues include the logistics of managing healthcare needs, meal planning, multiple appointments, insurance logistics, and figuring out possible options for senior living facilities in the future.

Both caregivers and those in need of care, have expressed frustrations around the process of applying for government-funded services. The process of applying is often complex and difficult to understand. People often receive conflicting information from different sources and feel like there is no one reliable source of information to guide them through finding, applying, and receiving all the services for which they may be eligible.

"Taking care of my elderly mother gets overwhelming, and it takes up about 50% of my life. I just want to make sure I get all the services that are out there for her, but when you're dealing with the government, everything has to be precise. You have to make sure you know what you're doing. Otherwise, she gets a prescription and it's no longer covered because I didn't do something right. That has been the most challenging for me is the documentation. Making sure that everything is up to par for the programs she is on."

PAST 18 MONTHS

Not surprisingly, the interviewees face a wide range of additional challenges brought about by the Pandemic. While a substantial portion (4) did not express having specific issues come up within the past 18 months, others are particularly concerned with increased difficulties around transportation options. Public transit and grocery shopping feel especially unsafe. This presents the greatest problems for those with very limited financial resources who could not afford the extra payments for grocery delivery services.

Seniors living on their own also have a difficult time with feeling isolated during the Pandemic lockdowns. On the flip side, caregivers with multiple family members cooped up in the same household were struggling with having limited space and no outlet for family conflict. Having senior community centers and local libraries closed during the pandemic meant that seniors living with family members had nowhere else to go to socialize. Combined with some additional burdens of home-schooling for younger children and managing working from home demands, the Pandemic brought about more intense moments of stress.

ANTICIPATED CHALLENGES

Not surprisingly, many interviewees anticipate age-related future challenges around navigating senior housing options. Weighing out the pros and cons and the affordability of staying in their current house vs. going into an assisted living facility, feels complicated. Most people would like to try to maintain their independence by seeking out additional resources and services that can help them stay in their current house. Particularly, residents anticipate needing someone to come to the house and help with the household chores as mobility becomes increasingly difficult. In addition, residents anticipate needing food delivery options and on-call transportation services.

GETTING HELP

Most of the interviewees reported relying on word of mouth for guidance and suggestions about possible resources for help. Some interviewees have also contacted organizations and referral resources to find the help they need, but the majority of interviewees rely primarily on family and friends for support. Interviewees mentioned several organizations and public resources that they consult for resources:

Paratransit services

- 3 people

Tempe Community Action for seeking assistance with rent and utilities payments

- 2 people

Local food bank and food boxes

- 2 people

Hospital or doctor's office recommendations for health-related services

- 2 people

Shaded tree seminars around sustainable living strategies

- 1 person

Neighbors Helping Neighbors volunteer organization

- 1 person

Local library branch for available classes

- 1 person

211 number to get referred to specific agencies to access service providers

- 1 person

"It takes a lot of energy. It's very stressful because one person tells you one thing, another person tells you another thing. But you have to do it."

Several interviewees felt frustrated about long processing and waiting times, especially when it comes to getting financial assistance. Others felt that they often receive conflicting information from different staff members and get passed around from one person to another without getting answers. One interviewee also mentioned that she often encounters outdated information and broken links on service provider websites.

"You just go around in circles. People are not as knowledgeable, so they send you off to someone else instead of taking ownership or following up to see if you found help."

Interviewees also mentioned several services that they need but were not sure how to get:

- > Mental health counseling services, particularly for people who either do not have health insurance coverage, or whose insurance does not provide sufficient coverage for behavioral health;
- > Services that may be available for people living with limited physical mobility; and
- > Help with figuring out the logistics of senior housing and any other services that are specifically available to seniors living in the community.

PROPOSED SOLUTIONS FOR LIVING INDEPENDENTLY

Residents can sometimes be the best source of realistic solutions that will fit into one's lifestyle and be adopted. This list of solutions was generated from interviewed residents.

- > Affordable housing options that are specifically designed with accessibility features that enable independent living.
- > Accommodations and cost of living adjustments for seniors who technically don't qualify for food stamps, but have to make large rent payments, and can't afford groceries.
- > 411 number to call for up-to-date services and information about resources available to seniors and/or people living with a disability.
- > 'Walk-in' options for mental health services that don't require scheduling or keeping appointments – a first-come-first-served model.
- > More flexible and reliable transportation services options. Possibly on-call transportation services for seniors that don't require 24-hour reservation notice or a 2-hour wait time for getting picked up.
- > Ongoing prescription medication refill delivery subscription connected to the primary pharmacy.
- > Food box delivery options.
- > Including people with lived experience in decision-making processes around community resource allocation.

SECTION 6:
PRIORITIZATION OF NEEDS & RESOURCES
PRIORITIZATION SUMMIT

KEY INSIGHTS | PRIORITIZATION SUMMIT

An in-person prioritization summit was held on October 20, 2021. The summit was hosted by the Tempe Community Council and facilitated by Corona Insights. The goals of the summit were to share an understanding of current human service needs, collect input regarding priorities, and discuss implications and strategies.

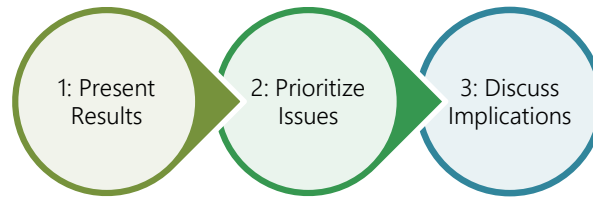
20 people attended the summit, including 7 staff from the City of Tempe, 6 from partner agencies, and 2 TCC staff, 2 TCC board members and 3 Tempe residents who had previously participated in the community survey and resident interviews.

The following key insights summarize the insights gained at the prioritization summit. Because the goal was to prioritize among a number of issues, any descriptions of ranking “high” or “low” are relative to other issues explored during the summit.

- 1. Improving access to mental healthcare is a high priority.** Summit participant input broadly suggested that improving access to mental health care is clearly 1) in the interest of a broad array of social organizations, 2) will have a great benefit on people who are currently facing this issue, and 3) Addressing this issue will prevent, mitigate, or solve other issues. It will also support the most vulnerable populations, benefit the community broadly, and it offers long-term benefits. However, participants tended to rank this opportunity lower than other issues in terms of momentum, leadership (it lacks strong community champions), and resource efficiency (it requires a large investment per beneficiary).
- 2. Supporting children and youth and helping residents pay for housing were also top priorities.** Participant input also suggests that supporting children and youth is a strategy that should have a long-lasting impact, gets good “bang for the buck,” and is an issue where progress is realistically achievable. The urgency of supporting children and youth ranked low compared to other issues. Paying for housing, including rent, mortgage, and utilities, was ranked as a top-three priority broadly across many criteria, but not particularly high in any one criterion.
- 3. Two other actions, providing emergency shelter and helping residents find homes they can afford, were also noted to be high priorities.** As might be expected, providing emergency shelter was noted as very urgent and an action that would produce great personal benefit to those who need shelter. This issue has strong leadership and champions in the community, and there is much public will to address it. Helping residents find affordable housing also has strong leadership, according to summit participants.
- 4. Other actions will help produce some specific desired outcomes.** Participant input indicates that supporting individuals with disabilities so they can live a full and independent life will support vulnerable populations and improve social equity. Reducing alcohol and drug abuse is an urgent issue to address, although this issue may lack a strong community champion. Supporting immigrants and foreign-born residents will help to improve social equity.
- 5. Lower priority issues were increasing financial education and supporting immigrants and foreign-born residents.** Although increasing financial literacy may have some long-lasting impact, it was otherwise rarely ranked as a top priority. Likewise, supporting foreign-born populations was believed to increase social equity, it was rarely ranked as a top priority based on other criteria. While this should not be interpreted that these issues are not important to address in their own right, they did not rank high when compared to other issues of interest.

SUMMARY OF FINDINGS

The prioritization summit was arranged into three steps:



First, a summary of the needs assessment research results was presented so that all summit members would be better informed about the current state of needs and need gaps within 16 critical human services that had been previously identified by agency and partner stakeholders. This presentation allowed time for summit participants to ask questions and it elicited their comments and observations.

A prioritization exercise was then conducted to produce a crowd-sourced perspective on the community issues that were presented earlier. The prioritization activity asked participants to rank the top three human service issues based on each of a set of 14 criteria. After receiving instructions, each participant logged into an online survey and ranked the top three issues they personally thought could be addressed based on each of the individual criterion alone. For example, participants ranked the top three issues if the only criterion was “urgency” (see definition below). Then they identified their top three issues if the only criterion was “permanency,” and so on. Each issue was then scored on a three-point scale; issues that received a #1 rank for a criterion received three points, issues ranked #2 received two points, and issues ranked #3 received 1 point. All other issues received zero points. Scores were calculated by summing each issue by each criterion, and for each issue across all criteria. Because the highest ranked issues were assigned a larger number (3) than the second—highest ranked issue (2), and so on, the highest sums represented the issues that ranked high across many dimensions for many participants.

CRITERIA

The criteria used for prioritization, and their definitions, are listed below.

Personal Benefit - Addressing this will have a great benefit on people who are currently facing this issue.

Progress - This is an issue that we can make reasonable progress on.

Breadth of Benefit - Improving this issue directly or indirectly will benefit a lot of people

Urgency - This is an urgent issue to address.

Most Vulnerable - Addressing this issue will help people who are the particularly vulnerable

Momentum - We already have momentum in this area.

Permanency - Progress on this issue will have a long-lasting impact.

Leadership - There is a strong champion(s) in the community to lead/organize this as a priority.

Cooperation - Addressing this issue is of interest to a broad array of social organizations

Stakeholder Will - Leaders and practitioners are strongly on board with this being a priority.

Equity - Addressing this issue will help to improve social equity in the community.

Public Will - The public is on board with this being a priority.

Resource Efficiency - We get a good "bang for the buck" on investing in this issue.

Complementary Solution - Addressing this issue will prevent, mitigate, or solve other issues.

The table below shows the score for each issue by each dimension and as the total. The issues with the highest combined scores were improving access to mental health care; helping residents pay rent, mortgage, or utilities; and supporting children and youth, which are highlighted in blue. The green cells represent issues that had a sum in the top three for that column (i.e., criterion). For example, providing emergency shelter; helping residents pay rent, mortgage, or utilities; and helping reduce alcohol and drug abuse produced the top three highest sums for the "urgency" criterion.

After the prioritization activity, the results were quickly tabulated and presented to the participants to observe and discuss.

PRIORITIZATION EXERCISE RESULTS

| Criteria | | | | | | | | | | | | | | | |
|---|------------------|----------------|------------------------|------------|-------------|--------|---------------------|----------|---------|----------|------------|------------------|-------------|------------------------|----------------|
| | Personal Benefit | Public Benefit | Vulnerable Populations | Permanency | Cooperation | Equity | Resource Efficiency | Progress | Urgency | Momentum | Leadership | Stakeholder Will | Public Will | Complementary Solution | Combined Score |
| Supporting individuals with disabilities | 9 | 6 | 17 | 9 | 7 | 18 | 8 | 13 | 3 | 3 | 8 | 3 | 5 | 8 | 117 |
| Supporting older adults living independently in their homes | 3 | 11 | 7 | 5 | 3 | 2 | 8 | 3 | 4 | 3 | 4 | 10 | 9 | 7 | 79 |
| Providing emergency shelter | 19 | 9 | 9 | 1 | 4 | 3 | 5 | 5 | 27 | 15 | 17 | 14 | 16 | 2 | 146 |
| Increasing financial education | 0 | 0 | 0 | 10 | 0 | 2 | 2 | 2 | 0 | 0 | 2 | 0 | 0 | 4 | 22 |
| Helping residents find homes they can afford | 14 | 11 | 1 | 14 | 13 | 8 | 11 | 5 | 9 | 6 | 16 | 13 | 14 | 10 | 145 |
| Improving access to mental health care | 23 | 15 | 18 | 16 | 25 | 7 | 7 | 9 | 14 | 5 | 6 | 12 | 10 | 22 | 189 |
| Helping residents pay rent, mortgage, or utilities | 10 | 11 | 5 | 5 | 14 | 13 | 14 | 14 | 15 | 12 | 12 | 7 | 9 | 13 | 154 |
| Reducing alcohol and drug abuse | 5 | 11 | 12 | 8 | 3 | 3 | 6 | 3 | 16 | 5 | 0 | 7 | 7 | 12 | 98 |
| Helping Survivors of sexual and domestic violence | 1 | 0 | 7 | 3 | 0 | 1 | 2 | 4 | 2 | 12 | 9 | 2 | 6 | 3 | 52 |
| Supporting children and youth | 4 | 11 | 9 | 22 | 12 | 11 | 17 | 16 | 4 | 11 | 10 | 9 | 14 | 5 | 155 |
| Improving access to childcare | 2 | 3 | 5 | 1 | 5 | 3 | 5 | 2 | 0 | 4 | 1 | 3 | 3 | 6 | 43 |
| Providing food or money to pay for food | 7 | 6 | 4 | 1 | 4 | 2 | 1 | 9 | 3 | 8 | 0 | 2 | 3 | 4 | 54 |
| Supporting the formerly incarcerated | 3 | 3 | 4 | 2 | 2 | 8 | 3 | 3 | 0 | 0 | 1 | 5 | 0 | 1 | 35 |
| Supporting immigrants and foreign-born people | 0 | 0 | 0 | 0 | 1 | 18 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | 23 |
| Improving access to medical health care | 2 | 2 | 1 | 1 | 4 | 3 | 6 | 4 | 5 | 1 | 0 | 4 | 2 | 3 | 38 |
| Improving non-car transportation options | 0 | 3 | 0 | 4 | 5 | 0 | 1 | 4 | 0 | 9 | 4 | 2 | 3 | 0 | 35 |

Cells highlighted in colors represent the three top-ranked issues within each criterion (green) and the three top issues with the highest overall score, assuming that each criterion is of equal importance (blue).

SECTION 7:
PROMISING PROGRAMS
MODEL PROGRAM SEARCH

KEY INSIGHTS | MODEL PROGRAM SEARCH

The prioritization summit revealed stable housing and mental health as two key human service areas to address in Tempe. To leverage lessons learned in other communities, a search for permanent supportive housing model programs was conducted. Seven programs were chosen and summarized. Each program sought to achieve multiple outcomes, such as stabilize housing, improve mental health, reduce substance use, reduce demand for emergency services, or support formerly incarcerated residents. The following key insights summarize the results from the model program search.

1. **Programs that provide permanent supportive housing (PSH) clearly stabilize housing.** People experiencing homelessness who enroll in a housing program tend to acquire housing and stay housed for multiple years. Receiving housing, however, often takes several months or longer, a crucial transition time. Further, once housing is secured initially, participants may decide to move several times to find a home that meets their evolving needs. Several programs reviewed empower their participants to decide what type of housing will work best for them, and those programs try to prevent any gaps in housing status.
2. **Housing First programs work.** Research completed by The Urban Institute indicated positive long-term outcomes for individuals who are provided housing with no additional requirements, such as participation in a program, receiving other services, or commitment to quit using substances. People are more likely to participate in and complete rehabilitation programs once they are provided with stable housing. Most of the programs included in this search follow a Housing First philosophy.
3. **Stabilizing housing does not necessarily lead to better health.** Although most programs reviewed succeeded in stabilizing housing, and several succeeded in reducing some acute healthcare demand while increasing primary and preventive care, very few programs documented physical or mental health improvements or decreases in substance use. A lack of improvement in health and wellness outcomes was even evident in programs that employed an Assertive Community Treatment (ACT) model. There are several potential reasons for lack of health improvements. First, participants may not have known about personal chronic health conditions when they were experiencing homelessness, but these conditions were revealed once they began receiving adequate healthcare. In other words, the program may help reveal poor health conditions as participants spend more time in the program. Second, most programs are evaluated for one or two years into participation, which may not be long enough to measure improvements in health. Additionally, stabilizing health and wellness conditions may be a positive alternative to worsening conditions that they may have experienced if they remained unhoused.
4. **Some programs have reduced the cycle between homelessness and the criminal justice system.** Human service providers and law enforcement both recognize that people experiencing homelessness are more likely than the housed population to be arrested, and therefore homelessness increases demand on the criminal justice system. Some programs specifically aim to reduce this cycle, while others tracked incarceration rates as a secondary outcome. Several PSH programs did reduce the number of police contacts, number of arrests, and/or days spent in jail. However, other programs saw no decrease. Relatedly, some programs did see reductions in detox services needed; however, other programs did not find evidence that program participation was related to reduced substance use.
5. **Building trust with clients takes time but is key to success.** Program directors and case managers acknowledge their clients have consistently dealt with hardship that does not dissolve once they are housed. Managers must first gain the trust by developing rapport and maintaining consistency. Doing so builds confidence of participants. However, increasing trust and confidence may affect outcome evaluation measurements in unintended ways. For example, pre-program participation evaluation measures may have more social-desirability bias, which may result in artificially low propensity of negative behavior such as drug or alcohol use. If trust and confidence is established with providers, participants may more accurately self-report their negative behavior, making pre-post comparisons difficult to interpret.
6. **Preventative and support services are critical.** Most PSH programs provide wrap-around resources and support besides housing, such as case management, direct services such as job training, or connection to

other human services such as healthcare or transportation. Services can be wide ranging and include support such as veterinary care and home furnishings. These services are often provided before an individual or family is facing an emergency. Early intervention with financial counseling, rent support, substance use treatment, or other services lead the way for a positive outcome.

7. **Program evaluations differ substantially, making it difficult to assign labels such as “evidence-based.”**
Most programs included in this search received an implementation and/or outcome evaluation. As described below, the rigor of evaluation differed substantially. Less rigorous evaluation tended to find more and bigger positive results than more rigorous evaluations, and all evaluations have some level of limitation. This pattern has been noted by other housing program researchers. In addition to the level of evaluation, programs that succeed in one context (e.g., location, population) may not perform as well in a different context. All programs reviewed here provided important lessons and insights that can guide the implementation of housing programming in Tempe.

SUMMARY OF FINDINGS

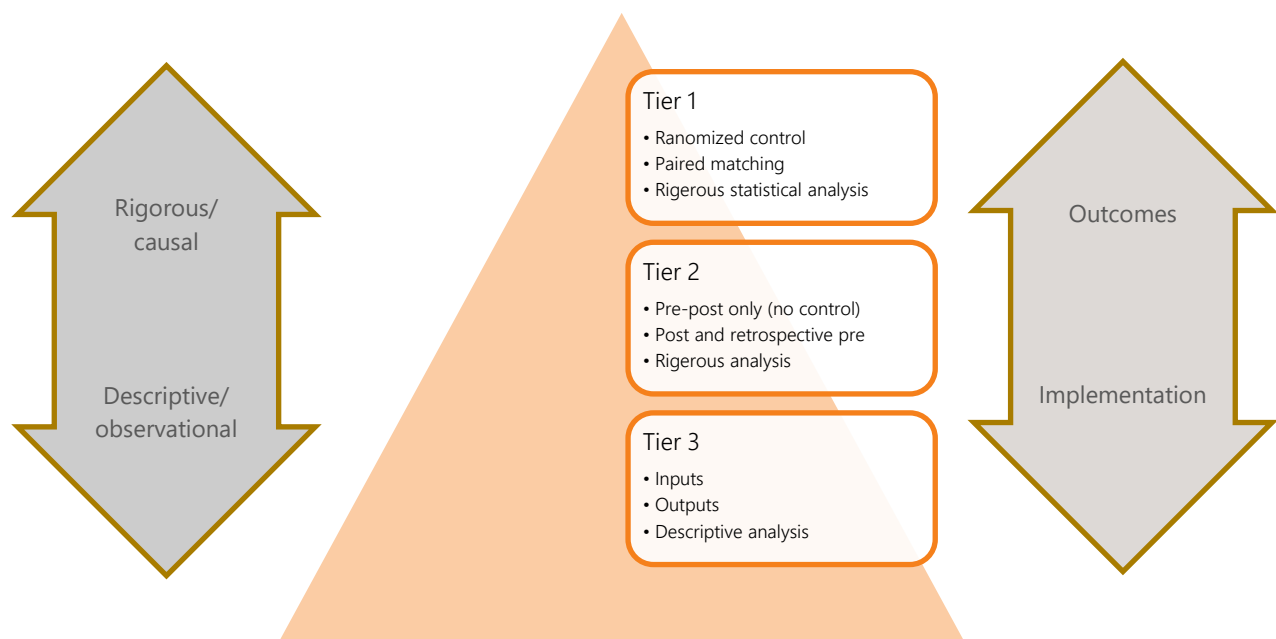
BACKGROUND

After the prioritization summit, a nationwide search for evidence-based or novel permanent supportive housing programs that address mental health, substance use, and reentry from incarceration was conducted. The purpose of this research was to provide TCC and its partners with additional resources it can use to plan for and take action to meet residents' needs. Programs were found online using search terms such as permanent supportive housing; PSH; homelessness; mental health; substance use; criminal justice; incarceration; Housing First; collaboration; and case management.

LEVELS AND TYPES OF PROGRAM EVALUATION

The term "evidence-based program," unfortunately, does not consist of a universal standard. Evidence that a program effectively achieves its target outcome(s) can be derived from a program evaluation, but program evaluations range from describing basic observations of inputs and outputs to rigorously measuring outcomes and determining causal effects. Some evaluations explore a program implementation process, while others measure, track, and analyze desired outcomes, such as improved health or reduced costs.

Evaluations can roughly be categorized into three tiers based on their purpose and the methods used. Top-tier evaluations employ rigorous methods such as randomized control trials or paired matching, which allow for causal inferences to be made of the program within the context of the location and study population. Middle-tier evaluations can provide evidence that a program could be effective, but it may not be able to isolate the program as a cause (positive or negative) of any outcome. Lower-tier evaluations are helpful at describing the population and/or how a program was implemented, such as inputs and outputs, but they lack the power of determining program efficacy.



The permanent supportive housing programs described below received some level of evaluation that provided evidence of effectiveness or desired outcome achievement, although the evidence from lower-tier evaluations provide less assurance. Additionally, some evaluations may not have found evidence of desired outcomes, not because the program was ineffective, but because observing and measuring outcomes is difficult or because administrative data was incomplete or insufficient. Finally, even program evaluations that have shown positive effectiveness in one setting (e.g., location, population) will not necessarily produce the same positive results in another context. Therefore, the level of evaluation and the evaluation results should be used to aid, not determine, a decision of what type of program could help achieve desired outcomes in Tempe.

SUMMARY OF MODEL PROGRAMS

| Program Name | Location | Summary | Evaluation Level | Targeted Outcomes | Results |
|--------------------------------------|------------------------|--|------------------|---|---|
| Social Impact Bond Initiative | Denver, CO | Philanthropic loans pay for new housing and support services primarily to reduce criminal justice cycles | Tier 1 | <ul style="list-style-type: none"> ○ Stabilize housing ○ Reduce criminal justice cycles ○ Reduce substance use | <ul style="list-style-type: none"> ✓ Stabilized housing ✓ Reduced police contact and arrests ✓ Required less detox services |
| Project Welcome Home | Santa Clara County, CA | A permanent supportive housing program for frequent service users who were homeless | Tier 1 | <ul style="list-style-type: none"> ○ Stabilize housing ○ Reduce acute healthcare use ○ Reduce criminal justice cycles | <ul style="list-style-type: none"> ✓ Stabilized housing ✓ Reduced psychiatric ER visits ✗ No reduction in total ER visits or hospitalizations ✗ No reduction in days jailed |
| Housing for Health | Los Angeles County, CA | Permanent supportive housing for high-need homeless residents, focused on improving health outcomes | Tier 2 | <ul style="list-style-type: none"> ○ Stabilize housing ○ Improve health ○ Reduce costs | <ul style="list-style-type: none"> ✓ Stabilized housing ✗ No health improvements detected ✓ Reduced safety net costs |
| Moore Place | Charlotte, NC | Permanent supportive housing program serving chronically homeless people with at least one disabling condition | Tier 2 | <ul style="list-style-type: none"> ○ Stabilize housing ○ Increase income ○ Improve health and mental health ○ Reduce emergency medical need ○ Reduce criminal justice cycles | <ul style="list-style-type: none"> ✓ Stabilized housing ✓ Increased SSI ✗ No health or mental health improvement detected ✗ No decrease in alcohol or drug use ✓ Reduced ER visits and inpatient days ✓ Reduced days incarcerated |

| Program Name | Location | Summary | Evaluation Level | Targeted Outcomes | Results |
|--|-----------------|---|----------------------|--|--|
| Supportive Residential Community | Las Animas, CO | Veteran-focused housing stability program in a rural setting | Tier 3 | <ul style="list-style-type: none"> ○ Stabilize housing ○ Substance use recovery ○ Improve quality of life | <ul style="list-style-type: none"> ✓ Stabilized housing ✓ Reduction of substance use ✓ Health score improvements across various categories |
| Housing First | Pima County, AZ | Fully integrated housing and support services program for whole families | Tier 2 (in-progress) | <ul style="list-style-type: none"> ○ Stabilize housing ○ Law enforcement deflection ○ Provide services that will improve health | <ul style="list-style-type: none"> ? Stabilize housing to be determined ✓ Reduced engagement with law enforcement ? Health improvement to be determined |
| Minnesota Supportive Housing and Managed Care Pilot | Minnesota | A piloted permeant supportive housing program serving adults and families in urban and rural settings | Tier 3 | <ul style="list-style-type: none"> ○ Stabilize housing ○ Improve health outcomes ○ Improve quality of life | <ul style="list-style-type: none"> ✓ Stabilized housing ✗ No health improvement detected ✓ Improved sense of safety and quality of life |

DENVER SOCIAL IMPACT BOND INITIATIVE (SIB)

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| Location | Denver, Colorado |
| Agency or sponsor(s) | City and County of Denver, Colorado Coalition for the Homeless, Cooperation for Supportive Housing |
| What it does | Philanthropic entities loan money to build new Housing First units. Bonds are loaned with the understanding that they will only be repaid by the city based on the success of the program. In addition to paying for new housing construction, the bonds also fund other supportive services, such as mental health counseling, substance use treatment, and HIV education. Since the program launched in February 2016, the program has been able to fund housing for more than 250 individuals. |
| Population(s) served | People experiencing homelessness, especially those with frequent interactions with criminal justice and emergency health services. |
| Housing First | This program has no preconditions or requirements for admission. |
| Evidence | The Urban Institute conducted a randomized controlled trial for the SIB program. They randomly assigned 724 individuals eligible for the supportive housing program; |

363 people received supportive housing services and 361 people received traditional housing services. The results indicate the program has achieved many of the targeted outcomes:

- > Shelter stays for Denver SIB supportive housing program participants decreased on average by 40%.
- > Police contacts declined 34% and arrests declined 40%.
- > A year after entering stable housing through SIB, 86% of participants stayed in stable house, at year two 81%, and at year three 77%.
- > SIB participants received 560 more days of housing assistance over three years, compared to those who received more traditional services.
- > SIB participants had a 65% decrease in detoxification services.

Why it matters

By shifting the focus of services targeted at the housing insecure from curative programs to preventative care, the city can work towards stopping homelessness before it occurs. Providing Housing First services allows for anyone to move into permanent housing without having to make a commitment to programs that they may or may not be able to complete. Traditional services often fail the highest risk populations by creating barriers to entry that they cannot overcome. Once individuals are housing secure, their assigned case manager is able to connect them to a number of other resources such as mental health counseling, sober living support, and a variety of legal services; all with the aim of keeping individuals housed and out of the criminal justice cycle.

Website

<https://www.coloradocoalition.org/social-impact-bond-initiative>

Evidence citation

Cunningham, M., Hanson, D., & Gillespie, S. (2021, July 15). Breaking the Homelessness-Jail Cycle with Housing First: Results from the Denver Supportive Housing Social Impact Bond Initiative | Full Report | Urban Institute.

https://www.urban.org/research/publication/breaking-homelessness-jail-cycle-housing-first-results-denver-supportive-housing-social-impact-bond-initiative/view/full_report

PROJECT WELCOME HOME

Location

Santa Clara County, California

Agency or sponsor(s)

Santa Clara County, Adobe Services

What it does

Santa Clara County, in partnership with a nonprofit agency that provides programs to end homelessness, launched a permanent supportive housing (PSH) program to reduce chronic homelessness, increase health and wellbeing of residents, reduce use of emergency support services, and shift financial resources from short-term to long-term solutions. The program uses a Housing First model and a modified Assertive Community Treatment team model to provide on-site services and intensive case

management. The program received \$6.8 million in startup funding, which was to be repaid to donors by Santa Clara County if the program successfully achieved the desired outcomes, including reducing service costs to Santa Clara County.

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| Population(s) served | The program purposefully recruited the community's most vulnerable residents based on their predicted likelihood of being a high-service user. All participants had some combination of previously receiving emergency room healthcare or psychiatric services, hospital or jail stays, were chronically homeless, and were not receiving intensive case management or other permanent supportive housing. |
| Housing First | The program provides housing with no initial service use requirement. |
| Evidence | <p>A rigorous randomized control trial was conducted to compare the outcomes of program participants to an otherwise comparable control population that received "usual care" of county services. This approach is a gold-standard of evaluation because it controls for program participation likelihood.</p> <ul style="list-style-type: none"> > 86% of program participants received housing, compared to 36% in the control group. > Participants stayed in emergency shelters nearly two-thirds fewer days than the control group. > Participants tended to use emergency services less often, including fewer psychiatric emergency room visits. > Compared to the control group, program participants received almost twice as much mental health outpatient care. > Participants were less likely to be admitted to the hospital for psychiatric inpatient services and less likely to use the emergency room for health care, although neither of these differences were statistically significant, meaning there is uncertainty if program participation was related to these outcomes. |
| Why it matters | <p>This program did increase housing stability for many of the community's most vulnerable residents. Even in a PSH model, program participants tended to move multiple times, with 70% moving at least once. PSH programs in other communities may need to anticipate helping participants find new housing, possibly several times, as they are receiving services and their needs and preferences change.</p> <p>The program evaluation employed a randomized trial methodology, which provides more validity to the results than the more common single group pre-post evaluations that have suggested broader and larger positive effects. This level of rigor is needed to understand what is actually effective and for what populations and context. This study supported other pre-post research with reliable evidence that PSH can reduce homelessness and reduce the need for some acute healthcare services. However, it did not provide clear evidence of improvement in reducing emergency room visits, inpatient care, or jail stays.</p> |
| Websites | <p>https://osh.sccgov.org/solutions-homelessness/special-initiatives/project-welcome-home</p> <p>https://www.thirdsectorcap.org/santa-clara-homelessness/</p> |

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| Evidence citation | Raven MC, Niedzwiecki MJ, Kushel M. A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services. Health Serv Res. 2020;55(Suppl. 2):797–806. https://doi.org/10.1111/1475-6773.13553 |
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HOUSING FOR HEALTH – PERMANENT SUPPORTIVE HOUSING

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| Location | Los Angeles County, California |
| Agency or sponsor(s) | Los Angeles County, Department of Health Services |
| What it does | <p>Housing for Health is a permanent supportive housing (PSH) program that provides long-term affordable rental housing paired with intensive case management and wrap-around services focused on maintaining and improving participants' long-term health. Funding is provided, in part, through a Flexible Housing Subsidy Pool, which is a flexible financial tool that allows the program to adjust its services as clients' needs and preferences change.</p> <p>The program helps participants navigate the affordable housing system, including move-in assistance. Intensive case management connects participants with mental health, addiction, and health care services. Other services include skill building, crisis intervention, and housing retention.</p> |
| Population(s) served | Homeless individuals with complex health needs such as serious mental health conditions and substance use that require frequent use of the public health care system. Within a two-year study period, almost one-third of participants met the criteria for physically disabled, and nearly nine-of-ten had both physical and mental health conditions. |
| Housing First | The program provides housing with no initial service use requirement. |
| Evidence | <p>A formative baseline evaluation and an outcome evaluation were conducted by the Community Health and Environmental Policy Program of the Rand Corporation, a neutral and non-partisan third-party. The evaluation found many positive outcomes:</p> <ul style="list-style-type: none"> > Among nearly 900 enrolled participants, 93% remained in the program for at least one year. > Participants made fewer emergency room visits and spent less time in the hospital. > They required fewer crisis interventions and less financial support from the county. > County costs spent on healthcare for this population decreased during the study period by \$20 million, savings that more than offset the additional \$13.5 million cost of implementing the program. This equates to a 20% net cost savings. |

- > Self-reported outcomes from program participants included improved mental health compared to before entering the program; however, no improvement was found in physical health. Evaluators suggested that the study period may not have been long enough to detect improvements in the participants' chronic health conditions.

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| Why it matters | <p>It is well documented that homeless individuals are more likely than others to chronically express poor mental and physical health. While housing is expensive, more public spending is invested in healthcare for homeless individuals than invested in housing them. The Housing for Health program attempts to leverage this relationship to improve both housing and health outcomes.</p> <p>Local government human service agencies are always going to be resource limited, and therefore often make choices on how to serve various needs. The Housing for Health program suggests that investing in housing a relatively small but high-need population can reduce resources spent on healthcare. This is a net gain, even if health outcomes do not necessarily improve.</p> |
| Lessons learned | <p>The evaluation explored both program implementation and outcomes. However, because the program was relatively new, the evaluation did not include a control group or similar rigorous methods, which are needed to definitively determine the program costs and benefits, including health and housing outcomes. Los Angeles County plans to continue evaluating permanent supportive housing programs in partnership with RAND.</p> |
| Contact(s) | <p>Sarah Hunter, Director, RAND Center on Housing and Homelessness</p> <ul style="list-style-type: none"> > Sarah_Hunter@rand.org > (310) 393-0411, x7244 |
| Website | <p>https://dhs.lacounty.gov/housing-for-health/our-services/housing-for-health/programs/</p> <p>https://www.rand.org/pubs/research_briefs/RB10000.html</p> |
| Evidence citation | <p>Hunter, Sarah B., Melody Harvey, Brian Briscoe, and Matthew Cefalu, Evaluation of Housing for Health Permanent Supportive Housing Program, Santa Monica, Calif.: RAND Corporation, RR-1694-BRC, 2017. As of May 14, 2020: https://www.rand.org/pubs/research_reports/RR1694.html</p> <p>Alina I. Palimaru, Kathryn G. Kietzman, Nadereh Pourat & Ricardo Basurto-Davila (2021) A qualitative evaluation of Housing for Health in Los Angeles County, Journal of Social Distress and Homelessness, https://doi.org/10.1080/10530789.2021.1908486</p> |

MOORE PLACE – PERMANENT SUPPORTIVE HOUSING

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| Location | Charlotte, North Carolina |
| Agency or sponsor(s) | A HousingWorks program of the Urban Ministry Center |
| What it does | <p>This single-site residential facility provides non-time limited permanent supportive housing, including comprehensive wrap-around services delivered on-site by case managers, social workers, counselors, and mental health clinicians using an Assertive Community Treatment (ACT) model. There is no time limit for how long residents can receive housing and services.</p> <p>The program employs a Housing First approach based on five pillars: minimize eligibility criteria, use a harm reduction approach to substance use, prevent evictions. Program compliance or success is not required to maintain housing, and participation is not time limited.</p> |
| Population(s) served | Chronically homelessness adults with at least one disabling condition: mental health and substance use disorders, chronic health disorders, physical disabilities, and developmental disabilities. Tenants tend to be older and have greater health vulnerability than participants in similar programs. |
| Evidence | <p>A two-year pre-post outcome evaluation was conducted to examine the extent that program participation increased quality of life, stabilized housing, improved physical and mental health, and reduced substance use. The evaluation relied upon self-reported outcomes periodically measured between one and 24 months of residence.</p> <ul style="list-style-type: none"> > About 80% of participants were in stable housing (although not necessarily in Moore Place) after two years. This is notable considering the population was homeless, on average, for seven prior years. > Emergency room visits decreased by 81%, and inpatient hospitalization days decreased by 62%. > Countering the reduction in ER visits, outpatient visits for primary care increased the first year and decreased slightly the second year. > However, measures of quality of life, mental health improvement, or perceived physical or mental health improvement did not change. Further, self-reported measures of alcohol and drug use did not change over the study period. > Perceived social support of family or friends did not improve. > The number of arrests decreased by 82% and days incarcerated decreased by 89%. |
| Why it matters | Supporting extremely vulnerable populations requires substantial resources and time. Participating in this program stabilized housing for many residents who had previously been chronically homeless. In addition to stable housing, participation was related to many desired outcomes that reduced demand on service providers, a result that may make this model program attractive to policy makers. However, program participation may have not provided substantial personal health and wellness |

benefits to participants. Although income rose slightly, there was no evidence of physical and mental health improvement, on average. There may be logistical or methodological reasons for lack of success, such as the timing of when evaluation measurements were made. However, programs that show positive community outcomes (less use of resources) may not be fixing underlying conditions of the homeless population.

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| Website | https://www.mecknc.gov/CommunitySupportServices/HomelessServices/Pages/MoorePlace.aspx |
| Evidence cited | <p>Thomas, M.L. & Priester, Mary & Shears, Jeffrey & Pate, M.C.. (2015). Moore Place Permanent Supportive Housing Evaluation Study Final Report. 10.13140/RG.2.1.1121.3289.</p> <p>https://www.researchgate.net/publication/282026013_Moore_Place_Permanent_Supportive_Housing_Evaluation_Study_Final_Report</p> |

FORT LYON SUPPORTIVE RESIDENTIAL COMMUNITY

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| Location | Las Animas, Colorado |
| Agency or sponsor(s) | Colorado Coalition for the Homeless, Bent County, and the Colorado Department of Local Affairs |
| What it does | <p>Fort Lyon, once a VA hospital, has been repurposed into a supportive residential community in a rural setting that serves homeless residents throughout Colorado, with a focus on supporting veterans. Rather than providing services in the community where people who are homeless continue to struggle, this novel approach helps residents start fresh in a new, rural location. Residents are encouraged to stay up to two years with the goal of attaining health stability and help with finding long term housing. Residents are fully involved in the operations at Fort Lyon, they can participate in peer-led recovery groups and are given the opportunity to take classes in local colleges. Participants are also provided reintegration support, including help finding employment and finding and paying for housing when they leave the program and move to their community of choice.</p> <p>In 2018, Fort Lyons served 510 people with an average of 232 residents per month.</p> |
| Population(s) served | People experiencing or at risk of homelessness across Colorado. There is a focus on serving homeless veterans. Most residents have adverse health conditions such as mental illness and alcohol usage upon entry. |
| Evidence | According to the Fort Lyons 2017-2018 annual report: |

Among the 25 former residents that participated in a six-month post program review for 2018, 80% had stable housing and no episodes of homelessness six months after the program.

Of the 139 residents who completed both an entry and exit assessment:

- > 65% had an increase in their physical health score.
- > 76% had an increase in their psychological health score.
- > 72% had an increase in their social relationships health score.
- > 85% had an increase in their environmental health score.

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| Why it matters | By providing the residents the stability of housing and a supportive community, residents can focus on recovery and completely turn their life around. Having vocational training programs and other opportunities for education empowers residents to be confident that they can achieve long term stability. |
| Website | https://www.coloradocoalition.org/fortlyon |
| Evidence cited | Colorado Coalition for the Homeless. <i>Fort Lyon Supportive Residential Community Annual Report</i> . July 2017- June 2018. https://www.coloradocoalition.org/sites/default/files/2018-12/Fort%20Lyon%20Annual%20Report%202018%20%288%29.pdf |

PIMA COUNTY'S HOUSING FIRST PROGRAM

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| Location | Pima County, Arizona |
| Agency or sponsor(s) | Pima County's Criminal Justice Reform Unit, Old Pueblo Community Services (OPCS), and Intermountain Centers |
| What it does | <p>The program offers supplemental support services. Whole families including children and pets are allowed. Permanent housing includes move in ready supplies and resources. While waiting for a permanent housing assignment, participants are placed in transitional housing. Both housing situations are fully integrated with the treatment.</p> <p>The overall goal of the program is to lower the use services related to healthcare and legal systems. Examples include use of emergency rooms, calls for service to first responders, jail bookings, and involvement with the criminal justice system.</p> |
| Program requirements | Participants must be homeless, have either a substance-use or a mental health issue, and have been booked into the Pima County Adult Detention Center at least twice in the previous 12 months. |

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| Evidence | <p>In progress program evaluation research conducted by the RAND Corporation compare data from all the health care and criminal justice parties involved in the program. Interim report findings indicate that participants of the program decreased engagement with the Tucson Police Department and the Pima County Sheriff's Department by more than 55%.</p> <p>Program effectiveness regarding overall benefits provided to participants is currently being evaluated and will be published in a future report in late 2021 or early 2022.</p> |
| Why it matters | <p>According to the report, as of May 4th, 2021, there were eight children born to current participants of the program. Pima County anticipates the program will break cycles of incarceration and homelessness for future generations because the children currently in the program and those born into it are able to grow without housing insecurity.</p> |
| Lessons learned | <p>Several observations were made during the program's two-year pilot phase and considered as future implementations. Some lessons learned that will be incorporated in the future are, providing participants with family reunification support, implementing "phases" with the goal of participants graduating from the program, and further utilizing trauma informed care.</p> |
| Contact(s) | <p>Terrance Cheung – Former Director of Justice Reform Initiatives</p> <ul style="list-style-type: none"> > Email: Terrance.Cheung@pima.gov > Phone: (520) 724-3062) <p>Tom Litwicki – C.E.O at Old Pueblo Community Services</p> <ul style="list-style-type: none"> > Email: tlitwicki@helptucson.org |
| Website | <p>https://www.tucsonaz.gov/hcd/housing-first</p> <p>https://helptucson.org/services/housing-first/</p> |
| Evidence citation | <p>Pima County, Arizona: Housing First Proposal Narrative – BJA FY21 Second Chance Act Pay for Success Initiative Memorandum. 2021.</p> <p>May 4, 2021 - Pima County's Housing First Program.pdf</p> |

MINNESOTA SUPPORTIVE HOUSING AND MANAGED CARE PILOT

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| Location | Primarily Blue Earth and Ramsey Counties, Minnesota |
| Agency or sponsor(s) | Hearth Connection and The National Center on Family Homelessness |
| What it does | <p>The Minnesota Supportive Housing and Managed Care Pilot provided single adults and families with housing and supportive services in both urban and rural settings. This program created an intensive service model that had low caseloads numbers of less than 10 households per staff member. It also included many types of in-house</p> |

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| | <p>specialty service providers. On average, the cost of services per year was \$4,239 per participant. A total of 518 individuals participated in the program.</p> <p>Service providers prioritized engaging with participants who entered the program weary. Eventually, trust and relationships were built, and a community of participants and service providers was created, which helped make the services effective.</p> |
| Population served | <p>People with complex needs (such as medical problems, mental illness, chemical dependency, traumatic experiences, and for some, children with special needs) who had been homeless for long periods of time.</p> |
| Evidence | <p>Program participants experienced significant increases in housing stability and smaller improvements in other outcomes over the course of the 18 months covered in the pilot study. A program evaluation was conducted by an independent third-party, which resulted in four different studies: a quantitative outcome study of adults, a qualitative study conducted annually, a cost study, and a child study.</p> <p>Information on mental health, substance use, and residential stability was tracked through annual qualitative studies with participants. After the initial 18 months, participants had significantly improved residential stability compared to their experience before the program, they experienced less mental health symptoms, and their use of alcohol and/or drugs was lower as well.</p> <p>Among participants there was also a greater sense of safety and improved quality of life reported. Participants did not show evidence of overall improvement to physical health functioning after the initial 18 months. This could be due to the type of health conditions that participants had, many of them (40%) had chronic conditions where measurable change could not happen in the study time frame.</p> |
| Why it matters | <p>Having stable housing is only the first step in addressing the needs of participants. Once participants had a living situation they were comfortable in, they could then focus on proactively attending to their health needs which could include general health, chronic health issues, mental health, and/or substance use. Some of the participants involved were families; having this type of assistance could be a way to break cycles of poverty, domestic violence, substance use or other behavior/ circumstances that have been proven to become patterns among families.</p> |
| Lessons learned | <p>One of the biggest challenges can be to gain the trust of participants and build confidence among populations who have consistently dealt with hardship. Building rapport and maintaining consistency through service providers and services offered is essential.</p> <p>It was noted that many single adults grew lonelier because of their new housing situation, a lesson learned here, is that it is important to connect individuals and build a community.</p> |

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| How the program has expanded | Near the pilot project's competition, several other metropolitan and suburban counties in Minnesota collaborated to create the Metro Regional Project to End Long-Term Homelessness. In 2017, this project supported over 781 participants, both children and adults. |
| Website | https://www.hearthconnection.org/metroregionalproject |
| Evidence citation | <p>The National Center on Family Homelessness. (2009). <i>The Minnesota Supportive Housing and Managed Care Pilot Evaluation Summary</i>. Hearth Connection.</p> <p>https://www.air.org/sites/default/files/downloads/report/Evaluation-Minnesota-Supportive-Housing-and-Managed-Care-Pilot-2009.pdf</p> |

APPENDIX A: METHODOLOGY - EXISTING DATA SOURCES AND ANALYSIS

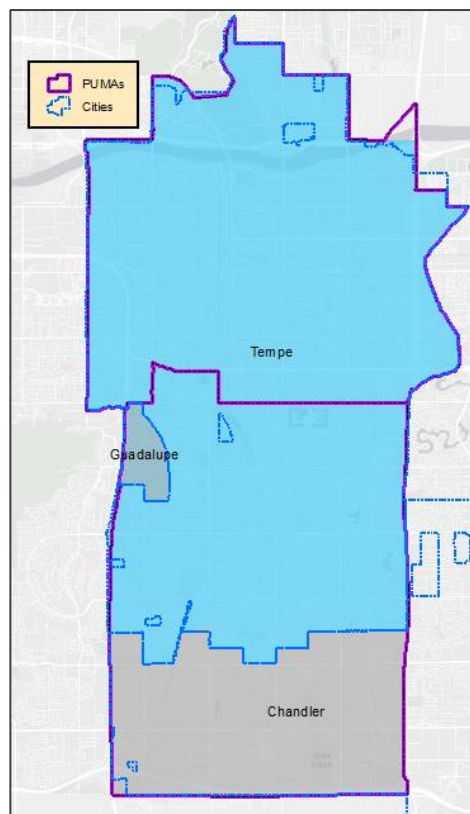
SECONDARY DATA SOURCES

- > U.S. Census Bureau
 - American Community Survey (ACS), 1-year (2019) and 5-year (2015-2019) datasets
 - Public Use Microdata Sample (PUMS), 5-year (2015-2019) dataset
 - Longitudinal Employer-Household Dynamics (LEHD)
 - Origin-Destination Employment Statistics, 2018
- > U.S. Centers for Disease Control and Prevention
 - Agency for Toxic Substances and Disease Registry
 - Social Vulnerability Index, 2018

COMMUNITY SEGMENTATION OF LOW-INCOMES ANALYSIS

The community segmentation model of Tempe's low-income residents was developed by analyzing a public use microdata sample (PUMS) of the American Community Survey (ACS) 2019 dataset, which is provided by the U.S. Census Bureau (2019 was the most recent data available). The U.S. Census Bureau makes these records available to researchers after taking numerous steps to remove identifying data from the records. The U.S. Bureau of the Census also provides statistical weighting measures to ensure that the samples represent the entire population of the pre-defined area, not just the sample they provide.

PUMS data is available by special geographies called public use microdata areas (PUMAs). There are two PUMAs in the City of Tempe; one is completely in the city and the other is mostly in the city, but also includes Guadalupe and part of northern Chandler. To increase the extent that results of this analysis represent residents of Tempe, the PUMS data were weighted to the sum of census tracts primarily in Tempe and Guadalupe. Weighting factors included total population, household income, and homeownership. Applying these weights creates a more representative sample of Tempe and Guadalupe residents and households overall.



Community Segmentation Study Area. The entire study area included both the northern and southern PUMAs, but data from the southern PUMA were weighed so the results more closely represented Tempe and Guadalupe residents only.

APPENDIX B: METHODOLOGY -

SURVEY OF HUMAN SERVICE PROVIDERS AND PARTNERS

BACKGROUND

An online survey of local human service providers, partners, experts, and affiliates was conducted in July and August 2021. The purpose of the survey was to gauge the difficulty (i.e., amount of effort) and ability (i.e., capacity) to provide services that address key population challenges such as finding housing, addressing food insecurity, and accessing health insurance, among many others. The survey also explored perceived ability to serve specific populations (e.g., residents without housing, disabled residents), the community's greatest challenges and strengths, and ways to improve human service delivery.

SAMPLING

The sample of human service providers was a list of City of Tempe staff and leaders at local partner agencies. This list was compiled by Tempe Community Council staff. The list contained one contact and email address for each partner organization along with contacts and email addresses of City of Tempe staff who work in the human service system. Among the 173 contacts, 55% were of City of Tempe staff and 45% were partner organizations.

DATA COLLECTION AND ANALYSIS

One survey invitation was emailed to every contact in the sample, and each contact was able to answer the questionnaire one time. Invitations were emailed on August 2, 2021, and providers were given until August 20 to respond to the survey. Several reminders were sent to providers who did not respond, encouraging their participation.

In total, 51 useable responses were collected and analyzed, representing a 30% response rate. Analysis included calculating percentages of responses to closed ended questions. Responses to open-ended questions were coded into themes and summarized as proportions.

APPENDIX C: METHODOLOGY - STATISTICALLY VALID SURVEY OF RESIDENTS LIVING IN HIGH NEED NEIGHBORHOODS

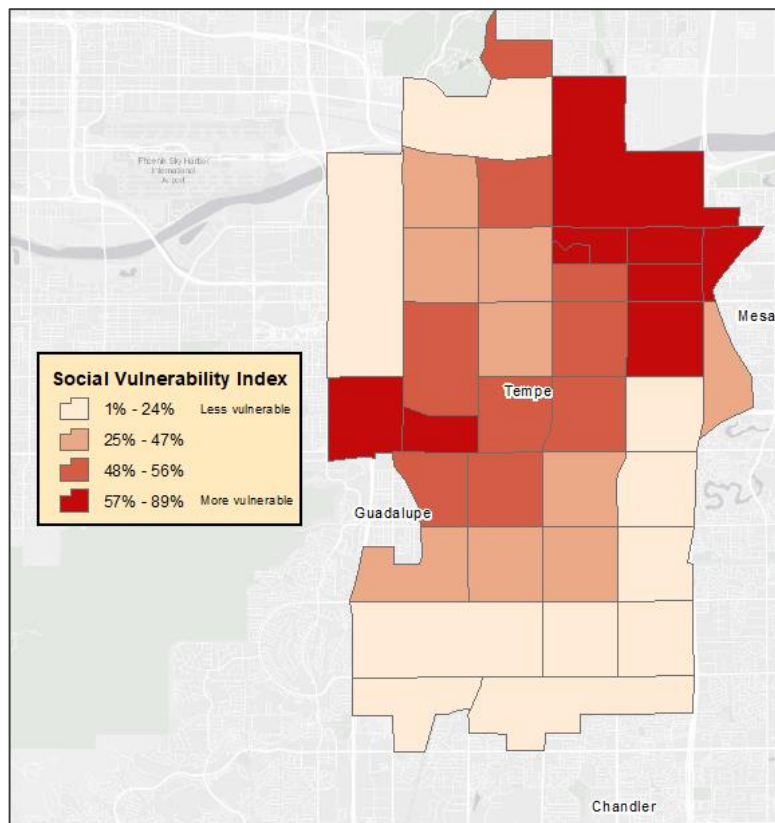
BACKGROUND

A statistically valid and rigorous community survey targeting low- and moderate-income households was conducted to measure the amount and variations of human service needs across the community. This survey captured the needs of residents who are currently receiving services as well as other residents who are not currently receiving any help or services. The latter population is extremely important to include in a needs assessment in order to accurately measure unmet need. A four-page survey questionnaire was developed by Corona Insights, with input and feedback from TCC staff to ensure the survey asked relevant, easy to interpret, and high-value questions. Questions explored several human service topics: need for and utilization of services such as food and housing assistance, healthcare, transportation, childcare, employment, and others. The survey was translated into Spanish by Corona Insights staff.

DEFINING THE STUDY AREA AND SAMPLING

Analysis of the Social Vulnerability Index, a measure calculated from U.S. Census data by the Center for Disease Control, demonstrates that some neighborhoods in Tempe have greater vulnerability and therefore more opportunity to benefit from human services than other neighborhoods. Specifically, people living in neighborhoods in Northeast Tempe and West-central Tempe have greater vulnerability than people living in neighborhoods in the south end of Tempe.

Additional analysis of existing social-demographic data, including poverty status, household income, lack of health insurance, inability to speak English well, further showed that census tracts in North and Northwest Tempe had high human service needs. Because the goal of this survey was to understand and measure the most predominant human service needs, we decided to focus the survey within Tempe's neighborhoods that demonstrated the highest needs, based on existing census data. By narrowing the study area, we were able to invest more resources into collecting completed questionnaires from residents with the most need.

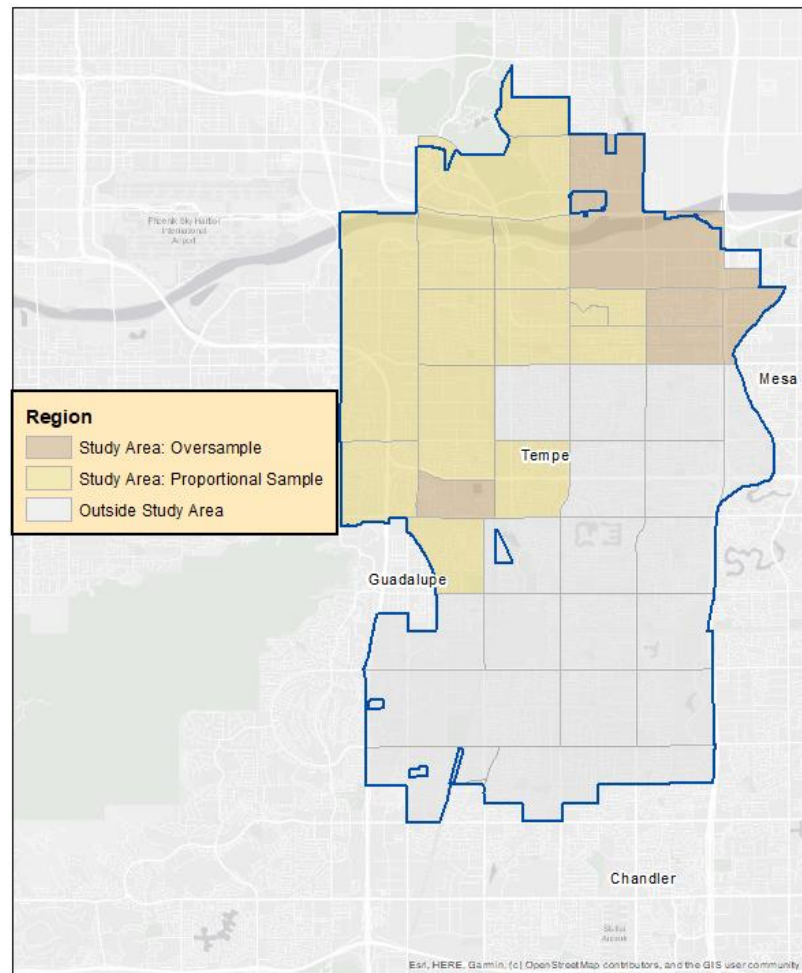


Social Vulnerability Index, 2018. Provided by Center for Disease Control, Agency for Toxic Substances and Disease Registry. Overall tract summary ranking.

DATA COLLECTION

The U.S. Census Bureau has found that residents with a lower social-economic status are less likely to participate in mail-back surveys. Therefore, we took several steps to try to maximize the response rate from people living in these high-need but hard-to-reach populations. First, we used expected response rates provided by the U.S. Census Bureau to predict how many questionnaires would need to be mailed to different neighborhoods. From this, we created two regions within the study area, and we mailed disproportionately more (i.e., oversampled) questionnaires to the neighborhoods with the lowest anticipated response rates. We mailed 5,000 survey packets to a sample of households in the study area. Second, we wrote a compelling cover letter, provided the survey in English and Spanish, and arranged for the survey to be completed in other languages. Third, we mailed reminder postcards to all residents in the sample about one week after the initial mailing. Fourth, we mailed a

second questionnaire to half of the households that did not reply to the first questionnaire or the reminder postcard. Lastly, we offered residents a chance to win one of five \$100 prizes drawn at random from all people who completed a questionnaire. All of these steps were taken in attempts to increase the participation among residents and ensure that hard-to-reach residents are still included and represented in the community survey results.



Community Survey Study Area, 2021. Survey questionnaires were mailed to a stratified-random sample of households in the study area.

Disproportionally more questionnaires were mailed to households in the “oversample” area.

DATA WEIGHTING AND ANALYSIS

To clean the data, we removed two duplicate surveys (i.e., two responses from the same household), which resulted in a mail survey sample of 315 responses. Not accounting for survey packets that were mailed to households but were undeliverable, the minimum response rate was 6.3%. Additionally, we had a sample of 35 surveys gathered through

homeless service providers. Adjusted for weighting (see below), the total sample has a margin of error of $\pm 7.3\%$ at the 95% confidence level.

Not everyone in a community is equally likely to participate in a mail survey. Thus, we applied weights to correct for slight differences in the sample that responded to the survey, relative to their proportions within the overall population. Additionally, a sample of surveys conducted with individuals experiencing homelessness was also collected. We also applied weights to fold those responses in with the mail survey sample, giving us a more complete picture of the population overall.

First, we compared the census tracts that were oversampled with those that were not to determine whether the overall sample was representative of all the census tracts. Once we determined that the oversampled tracts were not overrepresented in the sample, we treated the set of census tracts as our population universe. Next, a selection probability was calculated based on the number of adults in a household. This acknowledges that a person in a single person household has a greater chance of taking the survey than an adult in a multi-adult household. These selection probability values are the input for the next stage of weighting to demographic variables.

Then, we created raked weights for the sample based on age (<65 vs 65+), education (Less than a bachelor's vs. a bachelor's or greater), and housing (housed vs. unhoused). Population estimates for age and education attainment were obtained from the 2019 American Community Survey 5 Year Estimates. Estimates of the population experiencing homelessness were obtained from the 2020 Point-in-Time (PIT) Count Report for Maricopa County. Cell weighting is not possible because estimates of homelessness by the demographic variables are not available. Therefore, a process of iterative marginal weighting (i.e., raking or RIM weighting) was used to develop weights for each respondent in the cell and landline sample. Ten iterations were performed to allow convergence.

APPENDIX D: METHODOLOGY - FOCUS GROUP DISCUSSION WITH MENTAL HEALTH EXPERTS

BACKGROUND

The online focus group explored how resident's mental health intersects and impacts other community services. The goals of this research were three-fold. The first goal was to reveal the complexity of the issue by gaining the perspective of partners and experts who directly provide mental health care and resources or work in the intersection of mental health care and other community services. The second goal was to brainstorm and discuss solutions, both strategic and tactical, that community service providers could do to improve how they serve residents who are mentally unwell. The final goal was, in a collaborative way, to discuss, rate, and prioritize potential solutions so that service providers can take positive actions.

DISCUSSION PARTICIPANTS

Corona insights conducted one 120-minute-long online focus group with community partners and mental healthcare providers and experts. A total of 9 participants attended the focus group, representing various organizations: CARE 7; La Frontera EMPACT; City of Tempe Police Department; City of Tempe Courts/Mental Health Court; Mountain Park Health Center; Community Bridges; Tempe Union High School District; and Circle the City. These participants were purposefully chosen to represent a wide variety of perspectives and community resources including housing, education, law, community protection, and healthcare. Two focus group facilitators lead the discussion and exercise. The discussion was recorded and transcribed with the participants permission.

In preparation for the focus group, participants were asked to complete a brief set of questions on the current successes and challenges regarding mental health care in Tempe, to collect lists of barriers and assets that were used in the focus group prioritization exercise.

APPENDIX E: METHODOLOGY - IN-DEPTH INTERVIEWS WITH RESIDENTS

BACKGROUND

Results from the Tempe human services needs assessment community survey found there was a notable population of people living in Tempe who needed help or needed more help to live independently as they grew older. Therefore, the project team decided to further explore what life was like for this population and how community partners could support them

The resident interview research had three goals:

- > Illuminate the experience of Tempe residents who need help as they get older, either to live independently or help caring for aging family members.
- > Reveal challenges and barriers that some older residents have faced living independently.
- > Identify solutions that Tempe residents think could help them live independently, either with help or in a self-sustaining way.

INTERVIEW PARTICIPANTS

Corona Insights interviewed 11 Tempe community residents. Participants were recruited by contacting residents that had participated in the human services needs assessment community survey and met the following criteria:

Interviewees are age 55 or older, and have indicated that they struggle with living independently themselves or that they are caring for a family member who requires help due to age and/or disability:

Survey selection criteria:

- Q18e: needs help living independently in the home as they age
- Q18d: needs help caring for an older family member
- Age 55 or older
- Q15: has a disability, handicap, or chronic disease that keeps them from participating fully in work, school, housework, or other activities
- Q18f: needs help overcoming a physical disability, handicap, or chronic disease
- Q18j: needs help going places, such as to the store
- Q9l: not having everything needed to 'get by' without help from others

Interviews lasted 30-minutes and were conducted over the phone. Each discussion was recorded and transcribed with the interviewee's knowledge and consent. Participants received a \$50 compensation as a token of our appreciation for their participation in this research.

APPENDIX F: POTENTIAL OUTCOMES TRACKING TOOLS - STANDARDIZED ASSESSMENT TOOLS FOR MEASURING AND TRACKING INDIVIDUAL NEEDS, MENTAL HEALTH, AND SUBSTANCE USE

BACKGROUND

For supplementary materials to support future PSH initiatives, Corona Insights compiled a list of potential assessment and measurement tools that may be utilized for evaluation and outcomes monitoring purposes. While this list is not exhaustive, it is meant to provide some initial resources for any future evaluation of housing initiatives by offering standardized assessment tools in the areas of individual needs, risky behaviors, mental and emotional health, and substance use.

ASSESSMENT TOOLS

| Topic | Tool | Description | Domain(s) | Website |
|------------------|---------|---|--|---|
| Individual Needs | GAIN-1 | The GAIN-I is a comprehensive bio-psychosocial assessment designed to support clinical diagnosis, placement, treatment planning, performance monitoring, program planning and economic analysis. It is designed to be used primarily in clinical settings. | <ul style="list-style-type: none"> > Background > Substance use > Physical health > Risk behaviors and disease prevention > Mental and emotional health > Environment and living situation > Legal > Vocational > Addresses recency, breadth, and prevalence | https://gaincc.org |
| | GAIN-Q3 | The GAIN-Q3 is a brief screener used to identify and address a wide range of problems in clinical and general populations. It is designed for use by personnel in diverse settings such as student assistance programs, health clinics, and juvenile justice. | <ul style="list-style-type: none"> > Problems and service utilization > Substance use > Mental health (internalizing and externalizing problems) > Crime and violence > Stress > Physical health > School and work > Quality of life | https://gaincc.org |

| | | | | |
|---------------|-------------|---|---|---|
| | GAIN-SS | The GAIN-SS is a screener to be used in general populations to quickly and accurately identify clients who would be flagged as having one or more behavioral health disorders on the GAIN-I. | <ul style="list-style-type: none"> > Internalizing disorders > Externalizing disorders > Substance disorders > Crime and violence | https://gaincc.org |
| Mental Health | PHQ2 / PHQ9 | The PHQ-9 and PHQ-2, offer concise, self-administered tools for assessing depression. They incorporate DSM-IV depression criteria into a brief self-report instruments that commonly used for screening, diagnosis, monitoring. | <ul style="list-style-type: none"> > Depression | https://www.phqscreeners.com/select-screener |
| | GAD7 | The Generalized Anxiety Disorder Assessment (GAD-7) is a seven-item self-report instrument used to measure the severity of generalized anxiety disorder (GAD). | <ul style="list-style-type: none"> > Anxiety | https://www.phqscreeners.com/select-screener |
| | SF-12(MCS) | QualityMetric's SF-12v2 Health Survey produces separate Physical Component Summary (PCS) and Mental Component Summary (MCS). The MCS evaluates feelings of anxiety and depression, activity, and lack of activity due to emotional limitations. | <ul style="list-style-type: none"> > Anxiety > Depression > Activity | https://www.qualitymetric.com/health-surveys-old/the-sf-12v2-health-survey/ |
| Substance Use | CRAFFT | The CRAFFT is a well-validated substance use screening tool for adolescents aged 12-21. It is recommended by the American Academy of Pediatrics' Bright Futures Guidelines for preventive care screenings and well-visits. | <ul style="list-style-type: none"> > Adolescent Substance use | https://crafft.org |
| | S2BI | This screening tool consists of frequency of use questions to categorize substance use by | <ul style="list-style-type: none"> > Adolescent Substance use | https://massclearinghouse.ehs.state.ma.us |

| | | | | |
|--|---------|--|-----------------|---|
| | | adolescent patients into different risk categories. The accompanying resources assist clinicians in providing patient feedback and resources for follow-up. | | s/PROG-BSAS-SBIRT/SA3542.html |
| | AUDIT-C | The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument that reliably identifies persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument. | > Alcohol use | https://cde.drugabuse.gov/instrument/f229c68a-67ce-9a58-e040-bb89ad432be4 |
| | DAST-10 | The Drug Abuse Screen Test (DAST-10) was designed to provide a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research. It can be used with adults and older youth. | > Substance use | https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69 |