Enhanced and Adjustable Community Living Program Homes White Paper

Dick Dunseath

Holly Gieszl, JD

Charles Goldstein, MD

Laurie Goldstein

Barb Honiberg

Ken Levin

James McDougall, JD

Joshua Mozell, JD

Rachel Streiff

Len Tamsky, MD

January 5, 2024

Table of Contents

1. Introduction
2. Staffing & Support Services
3. Eligibility, Admission & Regulations
4. Leases & Eviction Policies
5. Family Involvement & Grievances
6. Evaluation Metrics
7. Benefits to Individuals, Families & Society
8. Conclusion
9. References
10. Appendix

Introduction

The Arizona Health Care Cost Containment System ("AHCCCS") indicates a Community Living Program ("CLP") in its Continuum of Care, which includes group homes with varying degrees of care based on the clinical needs of their Seriously Mentally Ill ("SMI") residents. Homes with the highest degree of care for residents are Enhanced Community Living Program Homes ("Enhanced CLP Homes") and Adjustable Community Living Program Homes ("Adjustable CLP Homes"), which have trained support staff inside the homes to help SMI residents with self-care.

Enhanced and Adjustable CLP Homes are designed for SMI individuals who repeatedly have been unable to manage their own care in less supportive living arrangements, some with a history of recycling through emergency rooms, hospitals, behavioral health residential facilities, the streets, jails, and back to emergency rooms or hospitals. These individuals who repeatedly recycle, we define as Chronically Mentally Ill (CMI).

CMI individuals may experience symptoms such as:

(a) *anosognosia* (inability to comprehend one's clinically evident mental illness, i.e., "lack of insight"), and/or

(b) *dual-diagnosis* (co-occurring addiction to illicit substances) and/or

(c) *complex conditions* (multiple disorders, such as schizophrenia, bipolar, depression, addiction, post-traumatic stress disorder, and others, i.e., "complex cases").

Some CMI individuals are so severely afflicted that they need long-term involuntary treatment. But many can do well in less restrictive and less costly Enhanced and Adjustable CLP Homes, either as a "step-up" from constant *recycling* or as a "step-down" from long-term involuntary treatment.

Enhanced and Adjustable CLP homes generally are four-to-five-bedroom single-family homes in safe neighborhoods. Generally, residents in each home are all male or all female, and they have their own bedrooms. They can leave the premises at will for any reason. Residents (or their guardians) sign leases and do not lose their beds if they are hospitalized or even incarcerated for as long as 30 days or longer, depending on circumstances. Operators of these homes must demonstrate a caring, person-centered culture, including pro-active eviction prevention policies, family involvement, and grievance procedures.

This paper is intended for informational purposes and should be considered in conjunction with the relevant authorities and agencies' detailed regulations, standards, and guidelines. The content herein may be subject to change based on evolving research and experience, and interested people should consult the appropriate professionals for specific advice on individual cases or situations.

Staffing & Support Services

Enhanced CLP Homes have trained Behavioral Health Technicians inside the home 24 hours per day and seven days per week to help residents with medication, nutrition, hydration, hygiene, shopping, doctors' appointments, transportation, household chores, community activities, etc., and to prevent unauthorized persons from entering the homes. Adjustable CLP Homes are the same, except they can adjust staffing inside the homes between 16 hours and 24 hours per day and seven days per week, depending on the needs of their clinically most challenged residents.

Behavioral Health Technicians, i.e., in-house staff ("staff"), are trained in motivational interviewing, crisis intervention, and other methods relevant to caring for these residents. Behavioral Health Professionals supervise staff, review specified daily data input from staff, and

then communicate challenges and progress to residents' clinical teams. The staff participates with residents, their guardians, helpful family members, their clinical teams, outside agencies, courts, and other entities in caring for residents as appropriate to individual needs and circumstances.

Residents have their own clinics through providers of their choice (as available) and other wrap-around services, including ACT services and supportive and recreational activities as determined by residents and their clinical teams, which might be different for each resident. Staff facilitates these services and activities either in the home or off-premises as appropriate. Staff encourages the residents to participate in supportive activities designed to improve their well-being sufficiently to step down to a living environment with less intensive supervision and care when clinically appropriate.

The staff adheres to specific professional standards, such as "Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services" and the standards and requirements of AHCCCS, the Regional Behavioral Health Authority, and other relevant regulators.

Eligibility, Admission & Regulations

Residents must be SMI as determined by AHCCCS, and placement is based on recommendations from clinical teams, which consider a lack of progress in less supervised living arrangements and approval of the state housing administrator. These homes are "housing, " not treatment facilities, and do not require licensure. However, staff providing services in the homes must be associated with a licensed behavioral health agency. Zoning and other municipal requirements must be respected.

Leases & Eviction Policies

Residents (or their guardians) sign leases (generally one-year, renewable), pay 30% of their income as monthly rent, and can live in the homes as long as warranted by their clinical

condition, subject to the terms of the lease. They can enter and leave the premises at will and have visits in the homes by family and friends at the staff's discretion, respecting the staff's responsibility to maintain a safe and pleasant home.

Operators of these homes will have a written eviction policy to be provided to residents and their guardians and family members who participate constructively in the residents' care. Residents will not be evicted for refusing to participate in treatment protocols or supportive activities, violating household rules (unless such rules are primary lease provisions), using illicit substances off the premises, or for other law violations. Operators of these homes will have a written eviction policy, which will include (a) policies and specific procedures to prevent evictions, (b) pre-notification of families and/or guardians of residents who face possible eviction, and (c) approval of all evictions by a senior executive of the operator. Residents will not be evicted without an appropriate alternate placement approved by their clinical teams and the RBHA or another relevant regulatory agency – a homeless shelter or "halfway house" will not be an appropriate alternate placement. Residents can be evicted for persistent, significant property damage or persistent violence towards others in the household or neighborhood or for other actions that jeopardize the safety of other residents, staff, neighbors, or other persistent violations of primary lease provisions. Staff will do everything possible to help residents avoid any such evictions.

Residents who exhibit symptoms of their illness, including psychosis and/or bizarre behavior, or who are caught in the act of damaging property or engaging in violence or other unsafe behavior towards others, or who return to the home under the influence of illicit substances will be redirected and de-escalated by staff in the least forceful manner possible under

the circumstances, with help from police if warranted, and be taken to a screening agency or to a hospital or arrested, *if necessary,* to protect the resident, other people or property.

Residents who leave the premises for extended periods or who are hospitalized or incarcerated can return to their home when clinically ready. A resident's continued absence from the home will be evaluated within 30 days to determine the reasons for such absence, the expected return date, and the next steps in the care of such resident.

Family Involvement & Grievances

Family members who support their loved one's well-being and are not dysfunctional or abusive, as determined in good faith by staff and residents' clinical teams, are encouraged to participate with staff, clinical teams, and outside agencies in the care of residents. Operators will have a written Grievance and Appeals process, which will be presented to residents, guardians, and family members during admission.

Evaluation Metrics

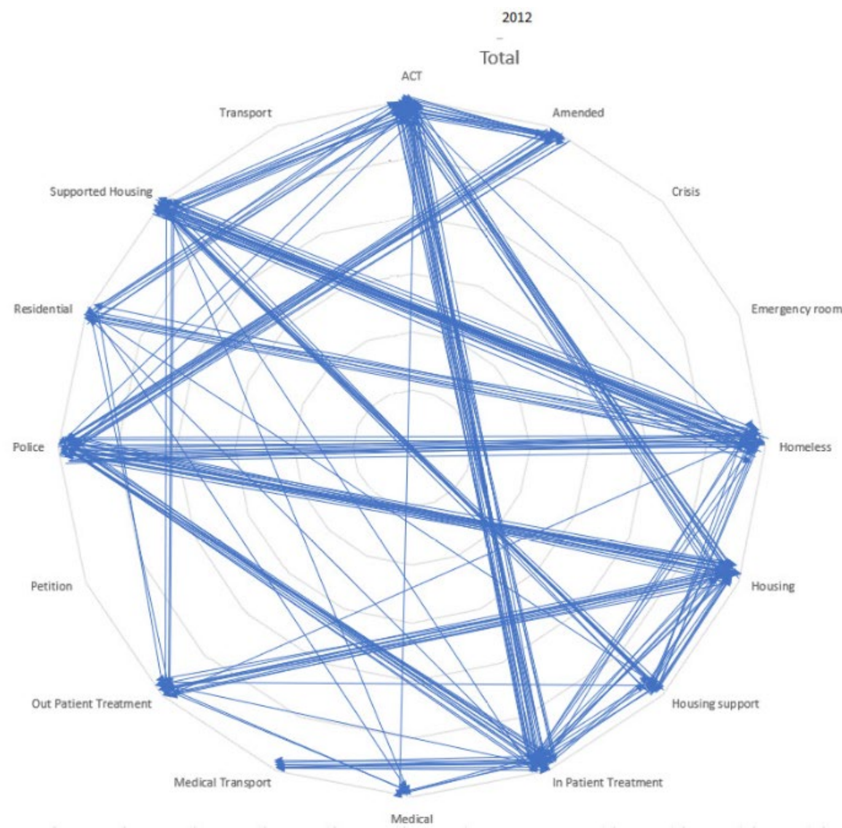
Operators of homes and their staff will be evaluated based on quantitative and qualitative metrics, including input from residents and their guardians and families, progress towards independent self-care, and potential step-down to less supervised living arrangements. However, operators and funding sources must realize some residents will "plateau" and might need continuing support in these homes indefinitely – residents will not become victims of "upward progress or out."

Benefits to Individuals, Families & Society:

These homes provide better clinical outcomes at a lower cost to society than allowing CMI individuals to recycle through emergency rooms, hospitals, behavioral health residential facilities, the streets, jails, and back to emergency rooms or hospitals. Per the diagram below,

"Allen" recycled endlessly in 2012 through many entities in our system, at a significant cost, as his mental and physical health deteriorated. This recycling caused enormous anxiety for Allen's parents and family members.

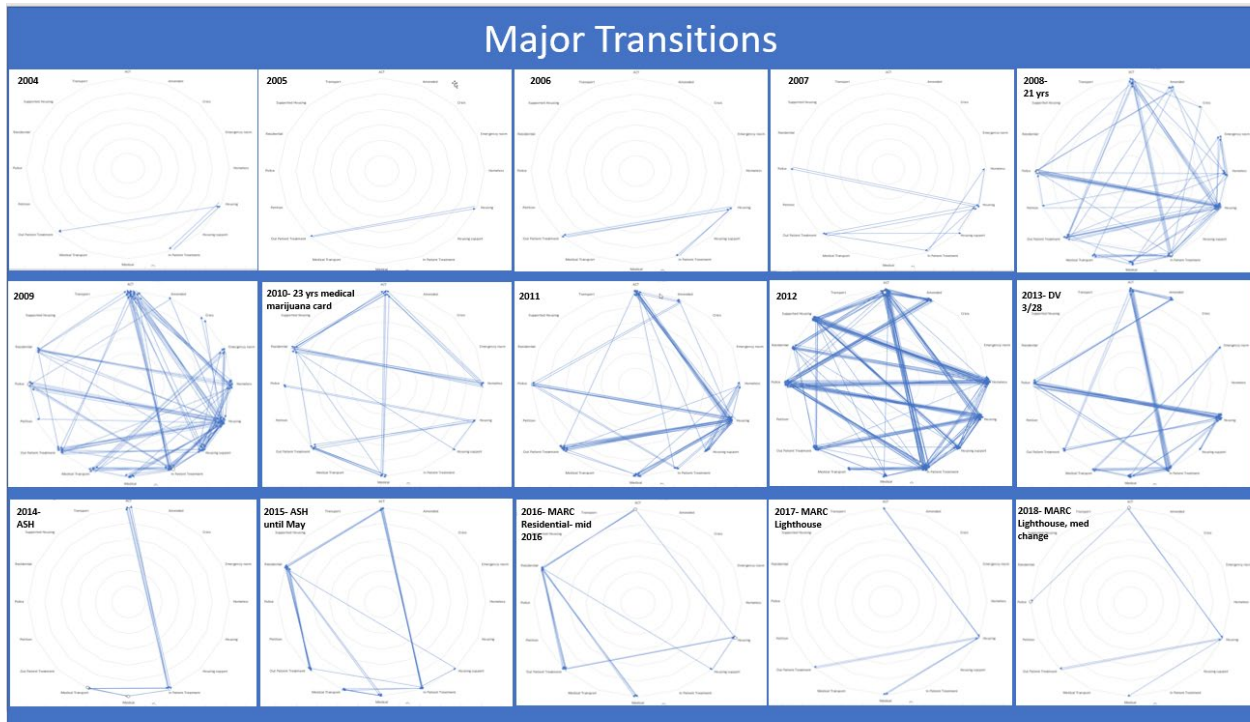
Transitions Diagram (2012)



Note: This graph shows each point of interaction between a public service and one clinically ill patient.

After two-plus years of involuntary hospitalization, in 2013 through 2015, Allen became a resident of an Enhanced CLP Home (entitled "Lighthouse") with ACT services beginning in 2016, and that stabilization helped reduce the chaotic transitions from one entity to another, per the diagram below. In subsequent years, Allen has been able to hold part-time jobs (albeit intermittently), play his guitar, and significantly improve his well-being and family relationships.

Yearly Transition Diagrams (2004 – 2018)



Note: This shows each point of interaction between public/private services and one clinically ill patient over a 15-year time period.

The May 2021 study by the Morrison Institute of Arizona State University, entitled "Housing *is* Health Care," indicates a 12.1% decrease in taxpayer costs associated with Enhanced and Adjustable CLP Homes compared with the recycling described above and a 28.7% decrease compared with CMI individuals experiencing homelessness — net result: better clinical outcomes and well-being at a lower cost to society.

Conclusion

Enhanced and Adjustable CLP Homes operated within a caring and person-centered culture are vital links in our Continuum of Care. This housing model creates more humane and clinically beneficial outcomes for CMI individuals at lower costs than recycling them through emergency rooms, hospitals, behavioral health residential facilities, scattered site placements, the

streets, courtrooms, and jails. Many CMI individuals have significantly improved their well-being over several years as residents in Enhanced CLP Homes and Adjustable CLP Homes.

As demonstrated by the 2021 report entitled "Housing *is* Healthcare," authored by Bausch, et. al., when the behavioral health system offers housing with supervision and treatment, it reduces overall costs by roughly 30 percent. Additionally, it enhances the quality of life for individuals, allowing them to lead lives of dignity.

References

AHCCCS. (2023). *AHCCCS Medical Policy Manual (AMPM)*. https://www.azahcccs.gov/shared/MedicalPolicyManual/

Mercy Care. (2023). *Regional Behavioral Health Authority Provider manual*. Aetna. https://www.mercycareaz.org/providers/provider-manual.html

Arizona Statutes, codes, and regulations. Legal research tools from Casetext. (n.d.). https://casetext.com/regulation/arizona-administrative-code/title-9-health-services/chapter-10-department-of-health-services-health-care-institutions-licensing/article-18-adult-behavioral-health-therapeutic-homes/section-r9-10-1806-assistance-in-the-self-administration-of-medication

Bausch, J., Cook-Davis, A., & Springer, B. (2021, May). *Housing is Health Care*. Housing is Health Care | Morrison Institute for Public Policy. https://morrisoninstitute.asu.edu/publication/housing-health-care

Appendix

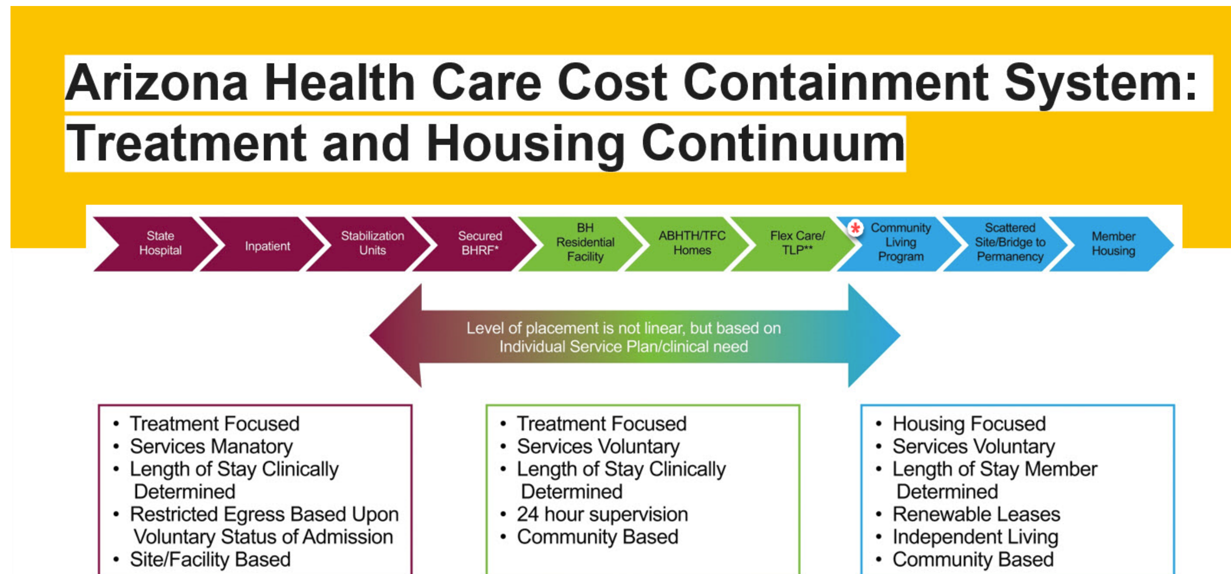
A. Continuum of Care

B. Operational Definition

C. Housing *is* Health Care, by ASU Morrison Institute, Executive Summary

D. Nine Guiding Principles for Recovery

Appendix A – Continuum of Care



Enhanced and Adjustable CLP Homes are elements of "Community Living Program" in the chart above (*AHCCCS Medical Policy Manual (AMPM)* 2023)

Appendix B – Operational Definition

Enhanced & Adjustable Community Living Program Homes – Operational Definition per the Association for the Chronically Mentally Ill ("ACMI"), revised 09-15-23

An Enhanced Community Living Program Home ("Enhanced CLP Home") and an Adjustable Community Living Program Home ("Adjustable CLP Home") must include ALL of the following characteristics. Operators of these Homes must nourish a person-centered culture of care for residents as demonstrated by compliance with these characteristics, responsiveness to members' needs and input from residents, guardians, and families of residents.

1. An **Enhanced CLP Home** is required to have support staff inside the home or on the premises 24 hours per day and 7 days per week as described in more detail below.

2. An **Adjustable CLP Home** is required to have such 24 hour per day and 7 day per week staff supervision, except it can adjust this supervision to 16-hours per day (daytime hours) and still 7 days per week if:

   a. All residents have slept through the night consistently for the preceding 30-to-60 days with no adverse incidents.
   b. No resident has medical conditions which might result in serious consequences if such resident is left unsupervised during the night.
   c. All residents have access to a list of emergency names and phone numbers posted prominently near the common telephone in the home.
   d. No other circumstances are evident for which 24-hour supervision might be required.
   e. The home immediately can revert to 24 hour per day supervision if any of these criteria no longer apply or if any circumstances arise indicating the need for 24 hour per day staff supervision.

3. Residents are placed in Enhanced CLP Homes or Adjustable CLP Homes based on the recommendations of their clinical teams and referrals from the state housing administrator contracted with the Arizona Health Care Cost Containment System (AHCCCS) to make such referrals and further based on their lack of progress towards recovery, repeatedly, in less supervised living arrangements.

4. An Enhanced CLP Home and an Adjustable CLP Home is NOT a treatment facility, and the facility does not require a license. However, staff providing services in the home must be associated with a licensed behavioral health agency. Zoning and other municipal requirements must be respected.

5. Residents must have been determined by the Arizona Health Care Cost Containment System ("AHCCCS") to have a Serious Mental Illness ("SMI"), be entitled to AHCCCS benefits and be members of the relevant Regional Behavioral Health Authority ("RBHA").

6. An Enhanced CLP Home and an Adjustable CLP Home is a four to five-bedroom single family residence in a safe neighborhood. The residence must have a yard and space for outdoor activities and recreation.

7. Residents sign individual leases and pay 30% of their income as rent. There is not a time limit on the length of lease and occupancy. Residents are entitled to live in these Homes per the terms of their leases as long as warranted by their clinical condition. Residents can enter and leave the premises at will and can have visits in the home by family or friends at the discretion of staff with respect of staff's responsibility to maintain a safe and pleasant household. Residents can choose to move from the home at any time.

8. Residents will not be evicted for refusing to participate in treatment protocols or in supportive activities or for violating household rules (unless such rules are primary lease provisions) or for using illicit substances off the premises or for other violations of law. Operators of these Homes will have a written eviction policy which will include (a) policies and specific procedures to prevent evictions, (b) pre-notification of families and/or guardians of residents who face possible eviction and (c) approval of all evictions by a senior executive of the operator. Residents will not be evicted without an appropriate, alternate placement approved by their clinical teams and the RBHA or another relevant regulatory agency – a homeless shelter or "halfway house" will not be an appropriate, alternate placement. Residents can be evicted for persistent, significant property damage or persistent violence towards others in the household or neighborhood or for other actions which jeopardize the safety of other residents or staff or neighbors or other persistent violations of primary lease provisions. Staff will do everything possible to help residents avoid any such evictions.

9. Operators shall present the written eviction prevention policy to the resident, guardians and family members during admission.

10. Residents who exhibit symptoms of their illness, including psychosis and/or bizarre behavior, or who are caught in the act of damaging property or engaging in violence or other unsafe behavior towards others or who return to the home under the influence of illicit substances will be redirected and de-escalated by staff in the least forceful manner possible under the circumstances, with help from police if warranted, and be taken to a screening agency or to a hospital or arrested, *if necessary,* to protect the resident, other people or property.

11. Residents who leave the premises for extended periods or who are hospitalized or incarcerated can return to their home when clinically ready. A resident's continued absence from the home will be evaluated within 30 days to determine the reasons for such absence, expected return date and next steps in the care of such resident.

12. Generally, each Enhanced CLP Home and each Adjustable CLP Home will be exclusively male or female, and each resident will have his or her own bedroom.

13. Support staff, i.e., Behavior Health Technicians, will be inside the home or on the premises 24 hours per day and 7 days per week except when taking all residents off-premises for shopping, community activities or other such purposes or temporarily responding to urgent situations related to the well-being of one or more residents.

14. Support staff will be trained specifically in principles of Motivational Interviewing (to meet residents *where they are* in their stages of recovery), crisis resolution techniques, ongoing assessment of mental, physical and functional status, how to respond to behaviors associated with symptoms and collaboration with residents' SMI clinical teams. Support staff will be supervised by Behavioral Health Professionals who review the daily information collected by support staff on mental, physical and functional status on an ongoing basis. The Behavioral Health Professionals will be responsible for communicating progress on issues to the SMI clinical team on a continuing basis.

15. Support staff will assist residents as follows:

a. Control access to the premises by non-residents.
b. Allow direct access to their own medications for residents whose treatment plans include independent medical administration IF their access is securely denied to other residents and provide "Assistance with Self Administration of Medication" (ASAM) for residents whose treatment plans do not include independent medical administration, i.e., remind them to take their medications which are securely stored (locked) in their personal lock boxes with keys and access to their lock boxes controlled by staff.
c. Prompt residents for proper nutrition, hydration, hygiene, exercise, washing clothes, and general up-keep of their bedrooms and common areas.
d. Help residents arrange interaction with doctors, clinics, pharmacies, grocery stores, employers, offsite recreational and community activities and various supportive activities and arrange transportation as needed.

16. The Operator of Enhanced CLP Homes and Adjustable CLP Homes shall integrate the following components into the Homes:

a. Residents will be encouraged to participate in supportive activities designed to improve their well-being sufficiently to step down to a living environment with less intensive supervision and care when clinically appropriate.
b. Residents will have their own clinics through providers of their choice (as available) and other wrap-around services, including ACT services, and supportive and recreational activities as determined by residents and their clinical teams, which might be different for each resident. Staff will facilitate these services and activities either in the home or off-premises as appropriate.
c. General Supportive and Rehabilitation Services provided by Home staff include the following and are based on the specific needs and preferences of each resident: Tenant's Rights Education, Case Management, Coordination of Services, Goal Development in collaboration with the Direct Clinic Teams, Crisis Intervention, Coping Skills,

Medications, Peer Mentoring, Support Groups, Recreational & Socialization Opportunities, Transportation (as applicable), Health Literacy, Healthy Living, Chronic Disease Management, Independent Living Skills, Communication Skills, Financial Management & Budgeting, Meal Prep Skills (with a focus on nutrition), Personal Hygiene/Self-Care, Housekeeping Skills, Using Public Transportation, Stress Management, Safety and Hazard Awareness/Recognition and Accessing Community Resources.

17. The Operator of Enhanced CLP Homes and Adjustable CLP Homes shall integrate the following professional standards into the Homes:

a. Services are provided in accordance with the Nine (9) Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems, RBHA Provider Manual, AHCCCS Medical Policy Manual (AMPM), RBHA Policies and Procedures, and RBHA Collaborative Protocols with Systems Stakeholders.
b. The Enhanced CLP Home program and the Adjustable CLP Home program will adhere to all requirements for provider eligibility including licensing by the Division of Licensing Services, registered with AHCCCS and credentialed by the RBHA.
c. Team collaboration with the Direct Care Clinic Team will facilitate transition planning and engagement before and after residency to coordinate necessary move-in arrangements and support services. Staffing will be conducted (at a minimum) every 90 days in accordance with the needs of each resident.
d. Services adhere to all cultural competency requirements as outlined in the RBHA Provider Manual and Cultural Competency Plan.
e. Helpful family members, who support their loved one's well-being and are not abusive or dysfunctional, will be encouraged to participate throughout the service planning and implementation process.
f. Services include relationships with key community constituents, providers, hospitals, stakeholder agencies and community stakeholders (i) to coordinate services and assist in accessing services and (ii) to assess and continually improve the service delivery system.
g. The operator will have an appropriate number of qualified and trained staff to deliver, manage and coordinate service delivery. All staff must demonstrate the expertise and competence to serve all members enrolled in the programs.

18. Enhanced CLP Homes and Adjustable CLP Homes will recognize the importance of family involvement and will encourage and welcome visits and involvement of helpful family members. With the resident's or guardian's approval, helpful family members will be involved on an ongoing basis and are encouraged to report their observations and concerns to staff as they appear.

19. Each step-down or discharge plan will include input from the affected resident and his or her clinical team, guardian and helpful family members who are involved.

20. Evaluations of these Homes will include qualitative and quantitative metrics, including:

a. Regular interviews of residents, their families and their guardians regarding their care.
b. Regular comparisons, before and after placements, of hospitalizations, incarcerations and crisis interventions.
c. Progress of residents towards volunteer work or employment or other recurring, scheduled and constructive outside activities.
d. Residents' participation in recreational activities in the community.
e. Residents' progress regarding medication compliance, nutrition, hydration, hygiene, doing household chores, maintaining their bedrooms, doing their laundry, preparing food, handling money and other personal living skills.
f. Success (or lack thereof) of clinically appropriate step-downs of residents to more independent living arrangements as evaluated approximately one year after each step-down.
g. Other applicable metrics, with due consideration for the reality that some residents will "plateau" and continuing support will remain necessary to maintain their levels of well-being - residents will not become victims of "upward progress or out".

21. Operators will have a written Grievance and Appeals process which will be presented to residents, guardians and family members during admission (*Regional Behavioral Health Authority Provider manual* 2023).

Appendix C – Housing *is* Health Care, Executive Summary

Executive Summary

Some individuals with serious mental illness experience severe, long-term symptoms of their disease. They may lack insight into their condition, not adhere to treatment, and have high support needs, among other challenges. These individuals can be considered to have a chronic form of serious mental illness. Without appropriate treatment, support, and housing, they can experience recurrent crisis episodes, homelessness, and frequent interactions with emergency, criminal justice, and health systems, incurring great public expense.

This study examines how housing and in-home supports affect public spending on individuals with chronic mental illness in Maricopa County, Arizona. It does so through a comparative analysis of average costs per person per year across three housing settings: permanent supportive housing, housing with unknown in-home support, and chronic homelessness. Specifically, it analyzes costs for housing, health care, and criminal justice during the period of 2014-2019. It also features a small-sample (small-N) case study of a housing setting that provides individualized, 24/7 in-home support to individuals with chronic mental illness (CMI) who have high support needs, examining average costs per person before and after moving into that setting (2016-2019). Finally, the study outlines recommendations from interviews with dozens of experts who work with and care for individuals with CMI in Maricopa County about reducing costs and improving care.

The results quantitatively delineated that the financial costs of individuals with CMI in permanent supportive housing were 28.7% lower than individuals with CMI experiencing chronic homelessness. Health care represented the largest category of expenses across housing settings, within which behavioral health comprised the largest percentage of costs.

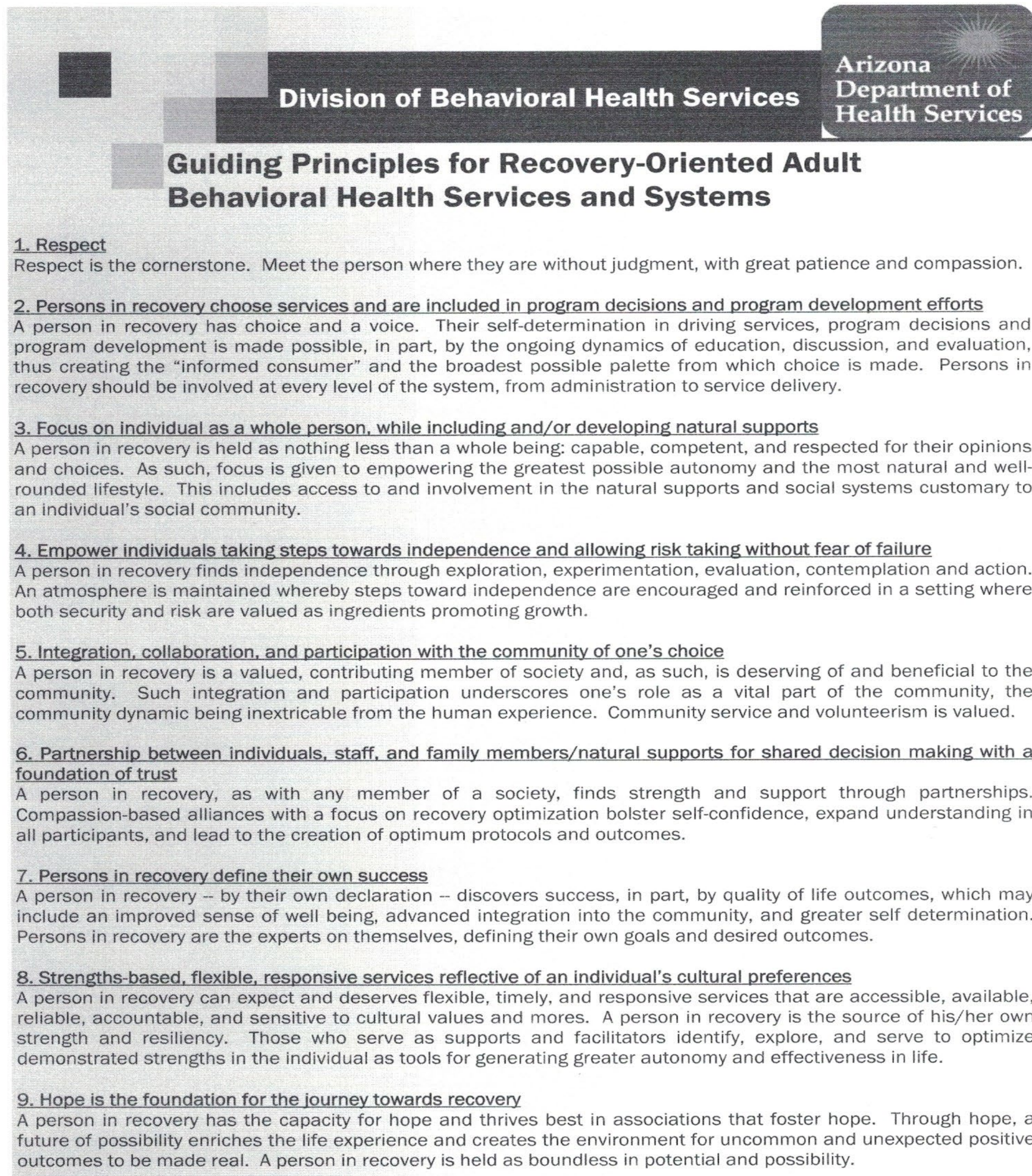
In the small-sample case study of a high-support housing setting, total average costs per person decreased 12.1% over two to three years of residence in that setting. Behavioral health costs declined 36%, while spending on physical health, pharmacy, and skills training increased, demonstrating a shift in spending away from crisis management toward recovery and personal development. The tenants in this setting had no criminal justice interactions during the study period.

Interview participants widely agreed that there is a need for more housing and in-home supports for individuals with chronic mental illness in Maricopa County. Housing and in-home supports were seen as critical for stability and recovery and as effective strategies for reducing homelessness, crisis episodes, interactions with the criminal justice system, and costs. The results of the quantitative cost analysis support interviewees' perspectives that providing permanent supportive housing to individuals with CMI reduces overall costs.

4 ASU Morrison Institute for Public Policy Arizona State University

(Bausch et al., *Housing is health care* 2021)

Appendix D - Nine Guiding Principles for Recovery



Division of Behavioral Health Services

Arizona Department of Health Services

Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

1. Respect

Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts

A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports

A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure

A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one's choice

A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust

A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Persons in recovery define their own success

A person in recovery -- by their own declaration -- discovers success, in part, by quality of life outcomes, which may include an improved sense of well being, advanced integration into the community, and greater self determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences

A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope is the foundation for the journey towards recovery

A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

(*Arizona Statutes, codes, and regulations* 2023)