Nevada County Prop 47 Local Evaluation Plan

Proposition 47 Homeless and Justice Involved Project Background

Overview of the Project

The Nevada County Behavioral Health Department (NCBHD) and its dedicated community service partners will utilize Prop 47 funding to expand and enhance the existing Homeless Outreach and Medical Engagement (HOME) Team to better meet the needs of homeless individuals within our community who are chronically involved in the criminal justice system. The HOME Team deploys throughout the community to conduct targeted outreach and engage homeless individuals where they are located. The Team conducts outreach to people at their campsites in the forests and farther reaches of our rural county and collaborates with these individuals to identify and address their pressing needs in a welcoming and destigmatizing manner. The acute individual needs addressed include physical health, mental health, substance use disorder, housing, transportation, and justice involvement.

While Nevada County has taken a proactive approach to address the needs of our homeless population, many justice involved homeless individuals experiencing mental illness and substance use disorders are falling through the cracks. This is especially true for the target population for this project: mentally ill and/or addicted homeless individuals who are continuously arrested for low level misdemeanors and infractions. Homeless individuals arrested for felonies are generally diverted into established programs, like Adult Drug Court, where they are incentivized to engage in services and housing support. However, the target population, committing lesser charges, has traditionally been underserved and has few or no options for diversion into much needed treatment, and little incentive to engage in services. The current gaps in services and funding addressed by this project include:

- Targeted outreach efforts to identify and locate justice involved, homeless individuals;
- Providing targeted intensive case management support; and
- Providing low barrier housing with support as many local housing programs and the local shelter have sobriety requirements that limit access, or cannot provide enough low barrier beds to accommodate this population.

Through a strategic outreach effort, the target population for this project will be selected from approximately 150 homeless individuals in Nevada County who have been arrested, charged with, or convicted of a criminal offense and have a history of mental health issues and/or substance use disorders. From that group, a cohort of 30 program participants will be selected to receive intensive services.

This project will add a Personal Services Coordinator (PSC) to the HOME Team in order to provide a specific focus on engaging homeless individuals with a high rate of criminal justice involvement. The Personal Services Coordinator will collaborate closely with local law enforcement to engage these individuals and divert them from arrest whenever possible. In addition, the Personal Services Coordinator will be embedded in the Public Defender's Office in

order to quickly connect justice involved homeless people to services upon discharge from jail. The PSC will provide ongoing engagement and case management with Project Participants.

In addition to the Personal Services Coordinator, funding for this project will fund new low-barrier and sober living housing supports in order to expand that type of housing opportunity available to participants. This will also add the option for direct placement from a camping or unsheltered setting into this housing. In line with the "Housing First" principles, this project assumes that housing should be the first step in breaking down barriers that individuals may be experiencing, including physical health needs, mental health needs, or substance use disorder needs. These strategies draw off recent success through a small pilot program of utilizing low barrier housing. This effort houses vulnerable individuals with a focus on behavioral expectations as opposed to traditional house rules of sobriety and engagement in treatment. According to a recent SAMHSA publication, trauma is both the cause and a consequence of homelessness. With this in mind, NCBHD gives employees and partner agencies the tools they need to effectively serve this community by including the implementation of trauma-informed care into their organizations.

Specific strategies the HOME Team and Personal Services Coordinator will utilize include: building rapport through Motivational Interviewing and other engagement strategies; connecting individuals to trauma informed mental health services; providing screenings and access to substance use disorder assessments and treatment; housing navigation; and targeted case management. In addition to the Personal Services Coordinator, the HOME Team includes a nurse who will be helpful in engaging people in direct medical evaluation and treatment, and a Peer Coordinator (someone with lived experience of homelessness and justice involvement) who will help break down the stigma and distrust around engaging in behavioral health services.

Project Goals and Objectives

The overarching goal of the Homeless and Justice Involved Project is to break a cycle of low-level criminal activity and short term incarceration through building rapport and engagement with a targeted cohort of traditionally service-resistant, justice-involved, homeless individuals. By working proactively to divert these individuals from jail into mental health and substance use disorder treatment with targeted housing supports the County supports a long term goal to conserve community resources and reduce recidivism.

The strategic goals and objectives outlined for this Project are:

Goal 1	
Conduct outreach to establish a relationship with justice involved homeless individuals.	
Objectives:	HOME Team will use the Coordinated Entry System to establish contact and provide outreach to 150 justice involved homeless individuals.

Goal 2
Decrease recidivism for homeless individuals who are justice involved by increasing engagement in mental health and substance use disorder treatment for the program participants.

Objectives:	A. From the larger cohort, 30 individuals with MI, CODs, or SUDs will be identified and provided with mental/behavioral health and/or substance use treatment, intensive case management, housing navigation, employment and support services each year.
	B. 80% of these program participants will remain engaged with case management and treatment services at minimum six months.
	C. 75% of these program participants will spend fewer days incarcerated.

Goal 3	
Increase housing stability for program participants.	
Objectives:	A. 50% of the 30 program participants will secure transitional or permanent housing.
	B. 50% of program participants will secure or increase monthly income through employment or mainstream benefit programs.

Process Measures utilized to help meet these goals and objectives are to:

- Hire a 1.0 FTE Personal Services Coordinator to join the HOME Team;
- Hire a 1.0 FTE Housing Personal Services Manager to join the HOME Team;
- Hire a 0.20 FTE Housing Specialist;
- Increase the number of individuals connected to services and treatment;
- Provide sober living recovery house funding;
- Provide rental assistance funds; and
- Secure a master lease on a home.

Evaluation Methods and Designs

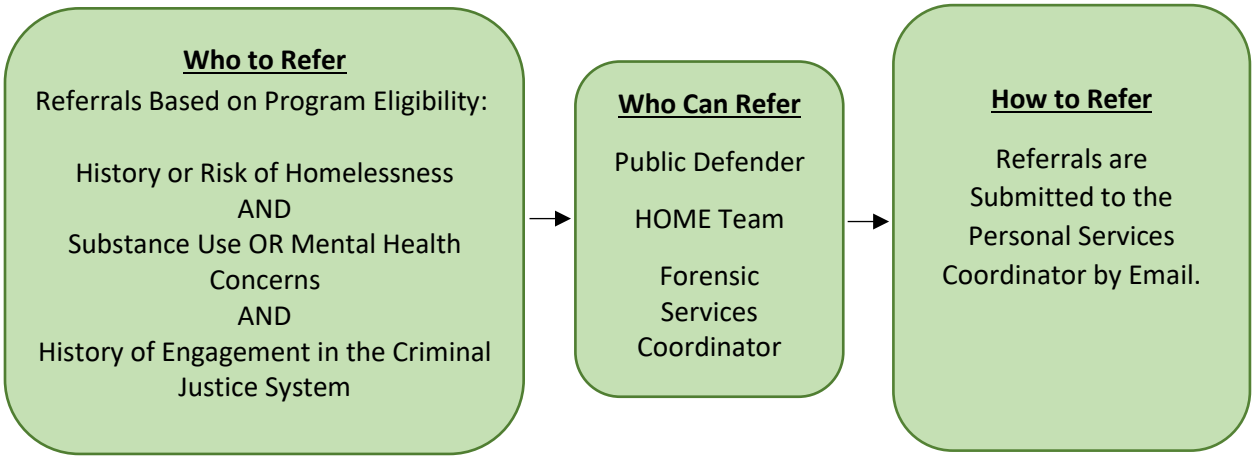
Overview of Applied Method

The HOME Team deploys into the community in order to meet and serve the community's homeless population where there are located. After initial contact and once some connection is established, willing participants will be provided with a vulnerability and needs assessment. The HOME Team's standard of practice identifies that those with self-identified substance use disorders will be brought to Nevada County Behavioral Health for evaluation for eligibility for residential treatment, or be referred to one of the local partner substance use disorder agencies for less intensive outpatient treatment based on their individual level of need. Those with identified mental health challenges will be brought to Nevada County Behavioral Health for a formal assessment, including coordination of other needed mental health interventions. It is during this step of the process that a gap in services was identified and the need for alternative options for engagement became apparent, as many individuals are resistant to engage in traditional County offered services.

The Prop 47 funded HOME Team expansion will now allow for an alternative option for service resistant homeless individuals who are identified as having justice involvement. Those identified by the HOME Team as having mental health or substance use concerns and justice involvement will be referred to the Personal Services Coordinator for further rapport building, ongoing case management, connection to legal services, navigation of mainstream benefits, employment support, education support, and targeted housing supports, with the long-term goal of engagement in more traditional services. The Personal Services Coordinator offers a unique and flexible opportunity to engage with the target population; to work collaboratively with these individuals to identify and work toward meeting their pressing needs; and to work to rebuild trust between the individual and the County and Partner Agency Service Providers.

The Personal Services Coordinator will work hand in hand with clients to identify immediate, short term, and long-term needs in order to create a plan and skill development to meet those needs with the goal of improving their self-sufficiency. The Personal Services Coordinator will be embedded in the Public Defender's Office which will allow for increased communication and a timely continuum of services between the criminal justice and support service efforts. The PSC will work collaboratively with cohort clients to provide scheduling and follow through with court dates and court mandated appointments, as well as a consistent presence to provide moral support during what can be difficult processes. The PSC will work with clients to follow through with mandated and/or voluntary mental health and substance use disorder treatment. Nevada County has joined the California Drug Medi-Cal waiver and will be able to leverage this funding for both residential and outpatient substance use disorder treatment for Medi-Cal eligible clients. Finally, the PSC will have access to additional options for housing support for the project involved cohort of individuals including rental assistance funds, low barrier beds, and master leased housing. These options provide the ability for these individuals to secure housing when they otherwise may not be eligible due to poor credit, rental history, or lack of references.

Project Referral Process



Project Intake Process

Proposition 47 Intake Process
1. Referral received by the Personal Services Coordinator (PSC).
2. PSC verifies basic eligibility requirements, confirms homeless status in HMIS, and entered information into HMIS if appropriate.
3. PSC establishes initial contact with individual referred and schedules intake assessment at the preferred location of the referral.
4. Intake questionnaire completed by individual referred in cooperation with PSC. Intake includes demographic information and referral's self-report of current services.
5. At intake, PSC reviews project content and goals with individuals, confirms interest in Project participation, obtains ROIs, and assigns a unique participant identifying number, that confirms enrollment in the Prop 47 Project Cohort.
6. When participant is open, PSC provides a warm hand off to Behavioral health for SUD/MH assessment.
7. Behavioral Health reviews previous contact with referral, provides SUD and MH assessment as needed, and referral for services.
8. Behavioral Health reports recommendations to PSC for follow up.
9. PSC provides ongoing intensive case management for Project Participants. This includes referral and support with housing, assistance obtaining employment and/or public benefits, referral for medical needs, assistance with scheduling, overcoming transportation barriers, connection to legal services, and warm hand off for SUD/MH activities.
10. PSC completes ongoing data collection and data entry. Reports collected quarterly.

Process Evaluation

Process measures focused on tracking the project's implementation, operations, and service delivery will be reviewed quarterly in order to ensure the efficacy and fidelity of the project. In order to provide a multi-faceted perspective during review, the County will utilize a mixed-method process for ongoing program evaluation. This method provides for consideration of diverse perspectives on complex social issues by utilizing both quantitative and qualitative approaches to provide analysis and insight that one method alone may overlook. Progress reports documenting progress toward measurable objectives and goals (quantitative data) will be shared and reviewed for trends quarterly by the local Prop 47 Advisory Committee to gain feedback. This information will be presented and open for feedback both in closed quarterly meetings with the Prop 47 Local Advisory Committee Meetings and to the public during the quarterly Stepping Up Initiative Community Meetings. This will allow the County to gain qualitative feedback from key informants and stakeholders to identify potential areas for adjustment and improvement. Quarterly evaluations will document: numerical data on program participation, challenges and successes of the program to date, and any intentional shifts or changes to the program's implementation in order to better meet the needs of participants, as well as monitor that changes are not incidental or unaccounted for.

Outcome Evaluation

Quantitative measures through an analysis of tracking program data will be examined and reviewed on a quarterly basis with project reports comparing pre-/post- participation data completed on an annual basis (Table 2). The Project will utilize a Double Difference Project Participation analysis, where data from the 12 months prior to Project participation will be compared to data from the 12 months subsequent to Project participation to identify any pre-/post- participation differences in the areas of: frequency of mental health, substance use disorder, and/or case management service engagement; income or mainstream benefits; the number of days spent in transitional or permanent housing; the number of days the individual spent in jail; and the participant's recidivism rates. This data will be tracked and graphed to identify any trends in program participation with correlating outcomes and a descriptive analysis provided pertaining to the results. These reports and outcomes will be compared to outcomes of similar models as well as to local trends, and feedback will be gathered from key informants within the Local Advisory Committee and stakeholders to help attribute causality of outcomes to program participation.

Outcome Measures

Homeless Outreach	
Objective:	Provide Outreach to 150 justice involved homeless individuals.
Measure:	Data will be compiled from HMIS to determine the number of individuals that the HOME Team contacted during the project implementation dates, and of those individuals how many had reported previous justice involvement.
Objective:	30 individuals from larger cohort will be connected to services through program participation.
Measure:	A minimum of 30 individuals meeting the program criteria (homeless, MH and/or SUD concerns, and justice involvement) for participation in the Proposition 47 Project will be enrolled in the program and provided intensive services. Information from this cohort of individuals will be collected and tracked for the purpose of the program's outcome evaluation and BSCC reporting.
Program Participation	
Objective:	80% of participants will remain engaged with case management and treatment for a minimum of 6 months.
Measure:	From the cohort selected for program participation, the number of individuals who engage in case management and SUD or MH services over a 6 month duration compared to the size of the cohort.
Housing	
Objective:	50% of program participants will secure transitional or permanent housing.
Measure:	Number of program participations to secure transitional or permanent housing during program participation, for a minimum of 6 consecutive months.

Income and Benefits	
Objective:	50% of program participants will secure or increase monthly income through employment or mainstream benefits.
Measure:	Number of participants to increase monthly income or mainstream benefits as demonstrated by individual proof of income or self-reported income. Measured at intake and annual point in time reporting intervals, and compared to previous year.
Justice Involvement	
Objective:	75% of engaged participants will spend fewer days in jail.
Measure:	Comparison of the number of days spent in jail from participants before and after program participation. Records from the jail will be collected to determine the number of days engaged program participants spent in jail the year prior to program participation vs. the subsequent year following the start date of program participation. Measured at annual point in time reporting intervals.
Objective:	50% of engaged participants will reduce their recidivism.
Measure:	Comparison of the number and type of charges (misdemeanor/felony) for participants before and after program participation. Records from the Public Defender's Office will be collected to determine the number and type of prior convictions in the year prior to program participation vs. the subsequent year following the start date of program participation. Measured at bi-annual reporting intervals.

Program Definitions

Mental Health Program Completion Definition - The stated goal as outlined in the Request for Proposal, is that program participants will "remain engaged in services for a minimum of 6 months", therefore the definition of Program completion will be that the program participant has continued engagement with mental health services, on some level, for a continuous 6 month time period.

Substance Use Disorder Program Completion Definition - The stated goal as outlined in the Request for Proposal, is that program participants will "remain engaged in services for a minimum of 6 months", therefore the definition of Program completion will be that the program participant has continued engagement with substance use disorder treatment services, on some level, for a continuous 6 month time period.

Diversion Program Completion Definition - The completion date for diversion programs will be defined as the date that the court determines that the participant has successfully completed all components set forth (or amended) at the onset of enrollment in the diversion program.

Recidivism Definition Local- Nevada County will utilize the BSCC's definition of recidivism, however will consider convictions within one-year intervals. Recidivism will be defined as a conviction of a new felony or misdemeanor committed within one year of previous release from custody or committed within one year of placement on supervision from a previous criminal conviction.

Days Incarcerated- Nevada County will also consider the number of days participants spend in jail on an annual basis. Length of stay for each inmate is defined as the number of days from date of intake to the date or release regardless of changes in classification, housing, or sentencing status during that period. Any part of a calendar day counts as one day.

Data Collection Procedures

As part of the Medi-Cal Drug Waiver Program, Nevada County Behavioral Health is the entry point for mental health and substance use disorder treatment programs in the county and utilizes a shared data base to input and track participant information and access to services. Data sharing agreements are in place between partnering agencies and a project-specific Release of Information (ROI) Form and Project Participation Acknowledgement will be signed by Project Participants at the time of intake. The Personal Services Coordinator is embedded in the Public Defender's office providing increased accessibility to the Project's target population and criminal justice data pertaining to those individuals. Data sharing agreements and privacy trainings are updated annually by the County's Privacy Officers.

County and contracted providers will be responsible for inputting and maintaining data within their standard data entry program (Table 1) on an ongoing basis as services are provided to program participants. Ongoing data collection by Project partners will help assure timeliness and accuracy of data entered. The information that is input into the data systems identified in Table 2 can be accessed and queried at any time and will be used to generate quarterly reports for the purpose of BSCC tracking and reporting. Ongoing access to reports allows for timeliness and consistency in tracking and analyzing Project progress toward goals and objectives and monitoring program fidelity.

Project data will be complied and restructured into an Excel Spreadsheet that has been customized for the purpose of tracking and analyzing de-identified Project Participant participation and data. Data will be collected and input into the spreadsheet at the intervals indicated in Table 2 for the purpose of evaluation and quarterly reporting to BCSS. All data will be maintained in password protected databases on the County's firewall protected network. All reported information will be presented in an aggregate form, free of any individual personal identifiers, and stored in a password protected, program specific folder on the County's secure network drive. All employees and contractors are required to complete an annual Privacy and Security Training.

Table 1:

Data Sources	
Data Source	**Description of Program**
HMIS	The Homeless Management Information System tracks individual homelessness status, use of services such as shelters, transition into temporary and/or permanent housing, and case management contact. The HOME Team has staff members who are licensed HMIS users and data collected by the HOME Team is entered into HMIS on an ongoing basis.
Anasazi	Anasazi is the shared service tracking and data collection software utilized by Nevada County Behavioral Health and Turning Point Staff. This program is used to track all client contacts, assessments, and services provided to individual's engaged with NCBH and/or Turning Point services.
SharePoint	SharePoint is the County maintained databased contained within the County's InfoNet, a web-based internal site. SharePoint is utilized by Nevada County Behavioral Health to track contact made with individuals who are not formally receiving services through NCBHD. Intake dates, assessments, appointments, contacts, and basic demographic information are collected and tracked in SharePoint for these individuals. SharePoint is also utilized by NCBHD to track basic SUD information (start/end date, type of service, frequency of services) from our Community Partners as part of the Medi-Cal Drug Waiver program.
Karpel	Karpel is the service tracking and data collection software utilized by the Nevada County Public Defender's Office. The program is used by the Public Defender staff to track client information including case management notes, court case work flow management, court calendars, investigation tracking, and document management. The program has the capacity to interface with the court and law enforcement in order to readily update any new criminal charges. Ad hoc reports can be run from this program.
AMIH	Advocates for the Mentally Ill Housing, Inc (AMIH) is a California 501c3 non-profit corporation that provides housing, employment, and life skills programs to residents of Placer & Nevada County, who otherwise might be homeless. AMIH tracks program participants start/end date of housing, type of housing, employment status, and program participation. The program is contracted by Nevada County Behavioral Health and data reports are provided to the County.

Jail Management Information System (JMIS) and/or Jail Records	Pertinent information that is tracked and reported by the Nevada County Jail for the purpose of this Project is the number of days in jail and length of stay in jail for each Project Participant. Other information that is tracked and reported through the jail as part of the Stepping Up Initiative are the number of Brief Jail Mental Health Screenings performed at the jail, and the percentage of individuals identified as mentally ill and severely mentally ill persons in relation to the total jail population as a result of those screenings.
Other Documents	In cases where income or participation cannot be verified through the aforementioned data sources, the PSC will request that the participant provide official documents to collaborate self-reported information. Documentation can include: Social Security Administration Income Letters, medical professional office visit verification print outs, Prop 47 Project Intake Form, or written statements from service professionals. Information will be requested and collected as needed as a last resort for verification. Self-report will be relied on as a last resort for information when other options have been exhausted.

Table 2:

Data Collection Chart			
Category of Service	**Data Source**	**Frequency of Collection**	**Description of Data Collected**
Contact/Outreach	HMIS	Bi-Annually	▪ # of individuals contacted by the HOME Team ▪ # with criminal justice involvement
MH/SUD Assessment	Anasazi, SharePoint	Quarterly	▪ # of individuals provided a Mental Health and/or Substance Use Disorder Assessment by Behavioral Health
Mental Health Services	Anasazi, SharePoint	Quarterly	▪ # of individuals receiving mental health services ▪ Start/end date of services ▪ Types of services received ▪ Frequency of attendance
Substance Use Disorder Services	Anasazi, Sharepoint	Quarterly	▪ # of individuals receiving substance use disorder services ▪ Start/end date of services ▪ Types of services received ▪ Frequency of attendance
Case Management Services	Karpel	Quarterly	▪ # of individuals receiving case management services ▪ Start/end date of services ▪ Types of support services received ▪ Types of referrals made ▪ Frequency of contact

Diversion Program	Karpel, Anasazi, Sharepoint	Quarterly	▪ Date of diversion program assessment ▪ Date of diversion program enrollment ▪ Participation status ▪ Date of completion of diversion program
Housing Support Services	HMIS, AMI	Quarterly	▪ Start/end date of housing ▪ Type of housing
Income/Benefit Updates	Client Documents	Annually	▪ Income/benefit source ▪ Income/benefit amount
Jail Time, Length of Stay	Jail Records	Annually	▪ # of days spent in jail
Recidivism Rate	Karpel	Quarterly	▪ Date of new conviction ▪ Type of conviction

Program Fidelity

Fidelity will be measured during implementation by analyzing outcomes and reviewing data tracked to ensure the program is in alignment with its intended outcomes. Progress reports will be shared and reviewed quarterly by the Prop 47 Local Advisory Committee to gain feedback from key informants and stakeholders in order to identify potential areas for adjustment and improvement. Quarterly evaluations will document any intentional shifts or changes to the program's implementation in order to better meet the needs of participants, as well as monitor that changes are not incidental or unaccounted for. Quarterly reports will be publicly shared and open for feedback at the Stepping Up Community Meeting to further assure that the implementation of the program is aligning with intended outcomes and values.

Prior to the Prop 47 funded project expansion and implementation, stakeholders worked to accurately define the program's core components, baseline data, gaps and/or areas in need of expansion, and what components to measure. In order to help assure overall program fidelity, Nevada County has chosen to utilize the Proposition 47 grant to expand on several proven strategies that are currently being utilized within the County by adding an emphasis on homeless individuals who are justice involved. The program expansion will draw on best practices from surrounding communities that effectively divert justice involved individuals and provide housing options under a Housing First Model. Research indicates that integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs. In addition, experience in other communities with similar characteristics has demonstrated that embedding medical care within an outreach team is an effective way to engage otherwise service resistant homeless individuals.

Additionally, the Nevada County Behavioral Health Department has carefully selected community-based organizations that align with the department's core values and deliver exceptional quality services to homeless individuals struggling with SUD and mental illness. The HOME Team and partnering agencies draw heavily on employees with lived experience and varying levels of education, as these individuals tend to relate and develop rapport with the target population and provide more compassionate services.

Reporting Results

Outcomes and data will be communicated to partner agencies, stakeholders, constituents and community-based organizations as they become available. Outcomes will be shared at Local Advisory Committee meetings and in reports. In addition, the Behavioral Health Director will share lessons learned from this project with the Small Counties sub-group of the California Behavioral Health Directors Association (CBHDA). The learnings from this project should be highly relevant to other rural counties struggling with a persistent population of homeless people who are difficult to engage in services and housing. Ongoing data and evaluation activities will help us to learn how to refine services.

Logic Model: Nevada County Homeless and Justice Involved Prop 47 Project

Need Statement: Justice involved homeless individuals experiencing mental illness and substance use disorders arrested for low level misdemeanors and infractions are being underserved and not incentivized to engage in serves. This cohort of chronic, low level offenders utilize a disproportionate amount of community resources and are not being effectively engaged in services in addition to having very few housing options.

INPUTS

Funding
- Prop 47 Grant Funding
- Leveraged Funds

County Partners
- HOME Team
- NC Behavioral Health
- Public Defender
- LE/CO

Community Partners
- Hospitality House
- Turning Point
- Granite Wellness
- Common Goals
- Advocates for the Mentally Ill

Oversight
- Prop 47 Local Advisory Committee
- Stepping Up Community Meeting

ACTIVITIES

Outreach-HOME Team
- Coordinated entry point
- Increase focus and engagement of justice involved homeless individuals
- Venerability Assessment

Referral
- HOME Team Nurse for Medical engagement
- MH/SUD Assessment and Treatment
- Identification of 30 individuals to refer for intensive case management
- Mainstream benefits

Case Management
- Intensive case management provided to cohort by Personal Services Coordinator
- Assessment and Support/Referral
- Provide MH and SUD Treatment

Housing Support
- Add Housing Specialists
- Provide additional low barrier housing options
- Provide rental assistance
- Master leased housing

OUTPUTS
- Expanded and enhanced HOME team
- Outreach to 150 homeless individuals
- Increase in number of individuals provided assessment and appropriate referral for services
- Increase in number and intensity of services provided to justice involved homeless individuals
- Increase in number of justice involved individuals engaged in services
- Increase in number of individuals diverted from jail to MH and SUD treatments
- Increase in connection to mainstream benefits
- Provision of 6 additional low barrier beds through master leased house
- Increase in low barrier short term beds

OUTCOMES (GOALS)
- Breaking a cycle of low-level criminal activity and short term incarnation
- 80% of participants will remain engaged with case management and treatment for a minimum of 6 months.
- 50% of program participants will secure transitional or permanent housing.
- 50% of program participants will secure or increase monthly income through employment or mainstream benefits.
- 75% of engaged program participants will spend fewer days in jail.
- 50% of engaged program participants will reduce their recidivism.