Placer County Proposition 47 Cohort 2
Local Evaluation Plan

Project Background

- *Information essential to understanding the grantee's project.*
- *A description of how the project matches the theory behind its development.*
- *A description of the goals and objectives identified in the Proposition 47 Project Work Plan of the proposal*

The Placer County Proposition 47 Cohort 2 Action Team is modeled after The Placer County Proposition 47 Cohort 1 Action Team, which delivers strengths-based, individual- and family-driven, solution-focused wraparound-type services to address the mental health, substance use, and diversion needs of young adults, ages 18-32.

The Cohort 2 Action Team will utilize the same collaborative model successful with the Cohort 1 program and adapt strategies to meet the needs of all ages and diverse cultures. The Action Team will offer an array of services and supports to engage members in services and achieve each individual's goals.

The Action Team will be an integrated and collaborative multidisciplinary team that provides immediate, timely, individualized integrated case planning and services to meet the needs of each program member and their family. Services will be culturally competent and trauma informed, and be tailored to the individual's needs. Delivering services to treat members' mental health (MH) and/or substance use disorder (SUD) issues and stabilizing members' lives by securing housing, employment, and supporting social connections helps them to develop skills to deter them from activities that cause recidivism. The project model is effective in achieving the overall goals of diverting individuals from the criminal justice system, preventing recidivism, and promoting safe and healthy communities.

Overview of Goals and Objectives

Goal 1: Transition individuals from jail, and deliver multidisciplinary, integrated Action Team services. Objectives: By the end of the grant period (September 2023), the Action Team will: a) Increase identification and assessment of culturally-diverse individuals who meet Action Team criteria; b) Increase the number of individuals and families who receive and complete Action Team services; c) Increase the number of individuals who avoid new offenses and convictions; d) Deliver Action Team services to improve outcomes and increase diversion from jail; and e) Link individuals to needed services to achieve and sustain positive outcomes.

Goal 2: Reduce homelessness of Action Team members. Objectives: By the end of the grant period, the Action Team will: a) Increase the number and percent of individuals who are living in stable housing; b) Deliver housing-related assistance and services to persons who are homeless or at risk of homelessness; c) Deliver Action Team advocacy services to build and sustain positive social connections.

Goal 3: Reduce recidivism of Action Team members. Objectives: By the end of the grant period, the Action Team will: a) Increase the number of individuals who complete vocational and educational activities; b) Increase the number of members who are employed, and help sustain their employment; c) Teach healthy communication skills; and d) Deliver support services to family members.

Evaluation Methods and Design

Describe the research design that will be used to evaluate the conduct (process evaluation) and the effectiveness (outcome evaluation) of the program. This section should include:

- *A description of the research design for the process evaluation.*
    - *Document how the activities in the proposal will be carried out.*
        - Once staff for the Cohort 2 Action Team are hired, they will be trained to collect data on the evaluation forms. This training will provide guidance on the collection of the MH and SUD assessment tools, identify potential members who meet the target population criteria and ensure timely access to the program. In addition, staff will be trained in the identified Evidence-Based Practices (EBPs) to create core skills for providing wellness, recovery, and strength-based services.

          The Action Team will deliver an array of services, as well as utilize other existing services in the community. Members will receive MH and SUD services to help them improve functioning. Diversion courts will be utilized, when appropriate, to support the member and family to meet goals.

          Peer and family advocates on the Action Team will create a welcoming, recovery and strength-based environment to support success and positive choices. The Action Team will help the member navigate through the system to help them achieve their goals, such as to attain employment and/or enroll in the local community college to gain skills to meet their goals.

          Housing support services will also be available, including a limited number of housing vouchers, to support stable, safe housing in the community. Members will move through Phases (1 – 4) while enrolled in the project. Most members will start in the engagement stage at Phase 1, working closely with staff to create plans, identify goals, and utilize the resources available to them.

          As members become stable in their MH and/or SUD symptoms, housing situation, and/or employment/education, they move up through the Phases. The Action Team will meet regularly to discuss members' progress through the program to ensure members' successful progress towards their goals.

    - *Describe the process variables and how they will be measured and defined.*
        - Process variables: a) Annual number of members (ages 14 and older) enrolled in the Action Team who meet the target population criteria, with a priority to

increase the number of racially- and culturally-diverse members; b) Number of staff hired, by language and culture; c) Number of outpatient MH and SUD service treatment hours delivered annually; d) Number of members who receive SUD residential treatment annually and length of stay; e) Number of members enrolled in Diversion Courts; f) Number of members enrolled in vocational/educational annually; g) Hours of transportation; h) Amount of flex funds; i) Number of members receiving housing services; and, j) Number of staff who attend cultural training annually.

- Data collection tools developed for Cohort 1 will be used for this project, with modifications to evaluate the success of the Action Team and to meet Cohort 2 reporting requirements. Action Team staff will collect data daily, documenting enrollment to, discharge from, and hours of services delivered as they happen, by date. HIPAA and 42 CFR standards will be followed. Evaluation activities will be designed, analyzed, and reported by the organization conducting Cohort 1 evaluation (IDEA Consulting).

- *Describe procedures ensuring that a program will be implemented to fidelity, when applicable.*
  - The Action Team will monitor service activities to ensure the EBPs are implemented with fidelity to the model. A Quality Improvement process will be used, including the Plan Do Study Act model, to modify programs as needed to help achieve positive outcomes. In addition, periodic focus groups with members and family served will identify opportunities to strengthen services.

- *A description of the research design for the outcome evaluation.*

  - *Describe criteria for participant eligibility and comparison group(s), including the comparison group eligibility criteria.*
    - The Cohort 2 Action Team target population is individuals 14 years of age or older who have been arrested, charged with, or convicted of a criminal offense, and who have a MH and/or SUD disorder. Cohort 2 will expand the service area of Cohort 1 to include all of Placer County. Cohort 2 expects to serve approximately 150 persons per year, with a total of 350-400. Individuals will be identified in jail and/or living in the community, and at risk for recidivism. These individuals will also have at least one of the following risk factors: 1) Homeless or unstable living situation; 2) School drop-out; 3) History of trauma/abuse; 4) Out-of-home placement; and/or 5) Unstable family support system. This project does not have a comparison group.

  - *Define outcome measures.*
    - Outcome measures: a) Number and percent of members living in stable housing; b) Number and percent of members with reduced MH symptoms; c) Number and percent of members with reduced substance use and avoid relapse; d) Number and percent of members employed and/or in training or school; complete GED; e) Number and percent of members with reduced

convictions; f) Number and percent of members who complete residential treatment; h) Number and percent of members with improved family relationships; and, i) Number of members involved in positive social activities.

- *Describe measurement instruments, programs and interventions.*
  - The Action Team will utilize evidence-based and promising practices (EBPs) to help individuals meet their goals. Staff will be trained in Motivational Interviewing to help engage persons in services; Eye Movement Desensitization and Reprocessing (EMDR) and Trauma-Focused Cognitive Behavioral Therapy to support health and wellness; and two Evidence-Based Practices including Seeking Safety and Living in Balance to support recovery from substances.

    The Wraparound Model will be used to build support networks for individuals and their families, and will ensure that the individual leads their treatment. A Housing First model will be used to help members find housing and the Action Team and a Housing Coordinator will provide support to help members stay housed. A vocational assistant will link members to employment opportunities, including the Placer Re-Entry Program (PREP), as well as link members to Sierra College or other educational settings to help them meet their goals. The Ready to Rent program will be utilized when appropriate.

- *Include a definition of successful program completion.*
  - Members will move through Phases (1 – 4) while enrolled in the project. Most members will start in the engagement stage at Phase 1, in which need the most assistance from staff to create plans and identify goals and to utilize the resources available to them. As members become stable in their MH and/or SUD symptoms, housing situation, and/or employment/education, they move through the Phases.

    The Action Team will meet regularly to discuss members' progress through the program to ensure members' successful progress towards their goals. Members are recommended for graduation (successful service completion) when they show stability in MH and/or SUD symptoms, housing situation, and meet employment and education goals.

- *Describe the strategy for determining whether recidivism may be lower at the end of the project relative to before the project began.*
  - *Definition from RFP:* "Recidivism" means a conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction.

We will be measuring all convictions that occur in Placer County prior to admission to the Action Team, and for up to three (3) years following graduation from the Action Team. For each Action Team member who engages in the program for more than two (2) months, the number of convictions prior to admission will be compared to the number of convictions after enrollment in the program. This measurement will provide information on whether members who participated, and completed, the program had a reduced rate of recidivism.

- *Provide a rationale for concluding that any reduction in recidivism will be due to the project and not some other factor unrelated to the project (e.g., over the last several years, there has been a statewide decline in juvenile arrests, bookings and juvenile hall detention; and any program to reduce these variables would have to show reductions over and above the current statewide trends).*
  - In addition to the overall reduction in arrests and convictions demonstrated through law enforcement data, self-reports from Action Team members will be used to help demonstrate the impact of the Action Team on each member's success. At each member's graduation, the member is given the opportunity to write a letter to describe their journey and the role of the Action Team in helping them change their lives. In addition, each member will be asked to complete a survey at the end of the program to document the most effective components of the program.

- *For both the process and outcome evaluation, describe what data will be collected, their data source(s), and data collection methods (tools used to collect the data, frequency, and who and where the data will be collected).*
  - Members will be tracked throughout the project through staff completion of data collection forms. Members will be recommended to the program upon review of a completed Referral Application form, which includes questions regarding the potential member's demographic information, including race/ethnicity and housing status, MH and SUD history, and reasons the potential member would like to be admitted. If admitted to the program, staff will complete an Admit form for each member, which contains more detailed demographic questions and recommendation of Phase for the member to begin services in.

    Throughout services, staff will complete an Individual Services Tracking form for each member, for each day of service. This form collects information on the date of service; types of services received; and key events (e.g., enrollment, discharge, successful completions, employment, educational activities, arrests, hospitalizations, and services received). The Individual Services Tracking form provides ongoing information on all services and events for each member and provides the foundation for the evaluation activities and outcomes.

    Upon completion of the program, staff will complete a Service Completion form for each member, which includes questions regarding reason for ending services, current housing situation and employment status, and current MH and SUD status. Staff

submit data collection materials monthly to the evaluation team (IDEA Consulting) for analysis and data quality checks. The evaluation team provides monthly feedback to staff to maintain quality of services and data collection.

- *If multiple types of interventions will be employed, describe how the separate effects on outcome variables of each type of the intervention will be determined, if possible. If not possible, explain how the results will be interpreted given that outcomes might be due to complex interactions among interventions.*
    - The Action Team will utilize evidence-based and promising practices (EBPs) to help individuals meet their goals. The types of interventions used for each member will be determined during each member's assessment and intake into the program. To ensure members receive the specific interventions they need and to ensure that members lead their own treatment, the Wraparound Model will be used and regular WRAP meetings will take place. Interventions will be determined successful as members become stable in MH and/or SUD symptoms, housing situation, and employment/education status.
    - The Action Team meets weekly to discuss all members, identify immediate and long-term needs, and discuss potential solutions and interventions, including which Action Team member can be available to support the member to resolve the issue. Daily communication with the team helps to ensure the issue is resolved as quickly as possible.

A Logic Model - *Provide a logic model - a visual representation of the project depicting the logical relationships between the input/resources, activities, outputs, outcomes and impacts of the project.*

Please see next page for the Placer County Prop 47 Cohort 2 Logic Model.

Placer County Prop 47 Cohort 2– Logic Model

INPUTS	ACTIVITIES / OUTPUTS	GOALS / OUTCOMES		IMPACTS
• Granite Wellness (GW) contracts with HHS to implement the Action Team (AT) and utilize the principles of Assertive Community Treatment (ACT) and Wraparound; in collaboration and partnership with HHS, Behavioral Health, probation, education, housing, courts, jail, and community providers; peer and family advocates/ mentors; volunteer mentors; young adults and family members • Time • Leverage Funding: Grant dollars; AB 109 funds; MHSA; HUD; JAG; Veterans; Whole Person Care; in-kind contributions; MH and SUD Medi-Cal revenue • Local Community Partners • Research	• Deliver countywide coordinated, culturally competent evidence-based services in collaboration with Probation, Behavioral Health, and partner agencies • Conduct conducts comprehensive risk and needs assessment and develop a coordinated Case Plan • Deliver services using principles of restorative justice to reduce recidivism • Identify, refer, and enroll persons who have been arrested, charged, or convicted of an offense AND have MH or SUD issues. • Outreach into jail and the community to identify and refer persons from diverse cultures • Coordinate services which are client-centered and trauma-informed, including MH and SUD treatment, housing, employment, transportation, and flex funds • Utilize collaborative courts to support program goals • Utilize Peer Mentor and Family Advocates to support individuals and family members • Conduct weekly AT meetings • Gather data on service utilization and outcomes • Evaluate program through data analysis, share outcomes with AT and partners • Celebrate successes	<u>Outcomes</u> • Employed and/or in school • Reduced number of arrests and convictions • Reduced number of days in jail • Reduced recidivism • Reduced MH symptoms • Reduced SUD • Living in safe and stable housing • Involved in healthy social activities • Improved health, MH, and SUD indicators • Long-term lasting support networks • Improved relationship with family, when appropriate	<u>System Outcomes</u> • Enhanced coordination and integration of probation, courts, jail, health, MH, SUD services, housing assistance, job skills and employment, civil legal services to reduce recidivism • Improved access for diverse cultures to AT through Promotor/a outreach and linkage • Implementation of culturally competent, trauma-informed wellness and recovery • Delivery of engagement activities, timely access to services; development of positive social community for individuals and family • Coordinated and individualized MH and SUD treatment; housing coordination; flex funds; employment; transportation • Evaluation of key health, MH, and SUD indicators, arrests, and recidivism • Shared reports to improve services over time, including individual and family satisfaction with access, services, and outcomes	• Persons (all ages) who have been arrested, charged with, or convicted of a criminal offense AND who have mental health and/or substance use issues; have increased access to intensive, coordinated, and individualized Action Team services to successfully redirect their lives, engage in a healthy social community, and achieve positive outcomes • A vibrant learning collaborative is maintained • Integrated services offer seamless, coordinated care • Evaluation and shared data across MH, SUD, Probation, and partner agencies to demonstrate improved quality and integration of care