Placer County Prop 47 Two-Year Preliminary Evaluation Report

EXECUTIVE SUMMARY

1. Is the project working as intended? Explain.

The Placer County ACTion Team (AT) began delivering services in February 2018 and has achieved many positive outcomes for individuals enrolled in the program. The AT is a multidisciplinary team that offers an array of services and resources, including substance use disorder (SUD) and mental health (MH) treatment services, to promote health and wellbeing and to reduce criminal recidivism in justice-involved young adults (ages 18-32), with histories of MH and/or SUD issues. The AT is a collaboration between Granite Wellness Centers (GWC, formerly Community Recovery Resources (CoRR)), Placer County Probation Department (PD) and Placer County Health and Human Services (HHS). Services are available at GWC's sites in Roseville, Auburn, and Lincoln, as well as in community settings including the member's home. This collaboration has proved to work well to deliver services to this complex, high-risk population. There have been no major modifications of the program since its start. Staff regularly receive referrals of potential new members to the program and current members achieve positive outcomes, which include placement in and successful completion of residential SUD treatment, maintaining stable housing, obtaining education and/or employment, and reducing recidivism. Outcomes from the program are described in detail below.

2. What are the project accomplishments to date?

The Placer County ACTion Team (AT) began delivering services in February 2018 and has achieved many positive outcomes for individuals enrolled in the program. The AT is a multidisciplinary team that offers an array of services and resources, including substance use disorder (SUD) and mental health (MH) treatment services, to promote health and wellbeing and to reduce criminal recidivism in justice-involved young adults (ages 18-32), with histories of MH

and/or SUD issues. The AT is a collaboration between Granite Wellness Centers (GWC, formerly Community Recovery Resources (CoRR)), Placer County Probation Department (PD) and Placer County Health and Human Services (HHS). Services are available at GWC's sites in Roseville, Auburn, and Lincoln, as well as in community settings including the participant's home.

As of April 30, 2019, a total of 65 unduplicated individuals have been enrolled with the AT: 43 (66.2%) current members and 22 (33.8%) who were discharged prior to April 30, 2019. The AT determined that members who were enrolled for less than two (2) months in the program and did not fully engage in services are excluded from analysis in this report. Of the 22 discharged members, six (6) were enrolled for less than two (2) months and are excluded from the following report, leaving a total of 59 current and discharged members (as of April 30, 2019).

The success of this program is evident in the outcomes for members. The AT is a multidisciplinary team that offers a range of coordinated and integrated services. All 59 (100%) of these young adult members have multiple and varied needs and receive MH and/or SUD services while in the program. GWC quickly and efficiently connects members to residential treatment, as needed. GWC has placed 22 (37.2%) members into residential SUD treatment. Of those 22 members, eight (36.4%) have been successfully discharged from residential treatment.

This population is at high risk of experiencing homelessness. The AT offers housing support to all members. As of April 30, 2019, 35 (59.3%) members achieved a stable living situation (e.g., living with family or friends). There were six (10.2%) members living in a transitional housing program and eight (13.6%) in residential SUD treatment. Only seven (11.9%) were homeless and/or living in a shelter.

This population has difficulties with obtaining education and employment. The AT offers education and employment support to all members; as of April 30, 2019, 33 (55.9%) members had obtained a high school diploma or an equivalent degree and seven (11.9%) were enrolled in school. About half, 30 (50.8%), were employed part- or full-time, one (1.7%) was volunteering, and 10 (16.9%) were actively looking for work. In addition, nine (15.3%) members have been referred to the Probation Department Placer Re-Entry Program (PREP) Center and enrolled in this highly successful work-training program.

The population the AT works with is at high risk of recidivism. As of April 30, 2019, of the 59 total members served, only two (3.4%) members were convicted of new charges. This shows the positive outcomes of the AT, with 57 (96.6%) of the 59 total members successfully remaining in the community and not recidivating. This clearly demonstrates the positive outcomes achieved by the AT. The program is meeting, and exceeding, the identified goals.

3. What progress has been made towards your intended goals?

As described above, the members who are enrolled in the AT, are achieving positive outcomes, like placement in and successful completion of residential SUD treatment, maintaining stable housing, obtaining education and/or employment, and remaining out of jail and/or prison.

4. What problems/barriers were faced and how where they addressed?

As the AT becomes more established and more individuals successfully graduate from the program, the number of people referred for services continues to increase. With a limited number of staff, it is difficult to assess and enroll members within the AT goal of 1-2 weeks. The AT continues to identify ways to expedite the intake process while still maintaining a warm, welcoming intake process that engages the member and their family.

Challenges for the program include providing housing support while there is a lack of available and affordable housing in the county and engaging potential members who identify as African American/Black, American Indian/Alaska Native, and/or Hispanic.

The AT strives to help members find independent living opportunities. The AT communicates with landlords encouraging their willingness to rent to the members, who tend to have more difficulty in being accepted as tenants. The AT has reached out to organizational providers in the community, including the Advocates for Mentally Ill Housing (AMIH), to help identify independent living situations that support members to successfully move into safe and stable housing.

GWC has been extremely proactive at identifying the needs of members with SUD, quickly enrolling members in SUD residential and/or outpatient services, depending on their needs. The AT utilized a list of available resources and provided ongoing training on how to access community resources. In addition, the extensive array of services offered by GWC across the region has been a valuable resource for the AT and members.

To facilitate enrollment and retention of Hispanic and/or Spanish-speaking members, the AT now has a Spanish-English bilingual, bicultural advocate. It is anticipated that this advocate will help improve access to the AT and retention of persons who are Hispanic and/or Spanish-speaking in the program. The program will continue to identify strategies to reach out to individuals who identify as African American/Black and/or American Indian/Alaska Native to improve access for these populations.

PROJECT DESCRIPTION

Project Overview.

The Placer County ACTion Team (AT) is a multidisciplinary team that offers an array of services and resources, including substance use disorder (SUD) and mental health (MH) treatment services, to promote health and wellbeing and to reduce criminal recidivism in justice-involved young adults (ages 18-32), with histories of MH or SUD issues. The AT is a collaboration between Granite Wellness Centers (GWC, formerly Community Recovery Resources (CoRR)), Placer County Probation Department (PD) and Placer County Health and Human Services (HHS). Services are available at GWC's sites in Roseville, Auburn, and Lincoln, as well as in community settings including the participant's home.

Referral to AT begins with Probation reviewing the individual's criminal history and conducting the Juvenile Assessment and Intervention System (JAIS) or the Correctional Assessment and Intervention System (CAIS) to assess risk and needs, which identifies a supervision strategy and service needs associated to criminal conduct. The Probation Manager determines if the individual meets the AT target population criteria. Those meeting the criteria are referred to AT and are scheduled for a Family Mapping meeting. During the Family Mapping, the individual identifies who they consider their "family" and other natural and community supports. In addition, 19 domains, based upon the JAIS/CAIS and Wraparound, are reviewed and discussed, and areas of needs are identified and prioritized, according to the member's wishes. Following the Family Mapping, a comprehensive assessment of MH and SUD needs is completed to identify treatment needs. With the needs identified, a unified Case Plan is developed with the member and the AT and used to design their treatment and service goals. If residential SUD treatment is indicated, AT staff obtain authorization for services. All

other members are linked to outpatient treatment services to help them meet their goals, including, but not limited to, housing coordination, training and/or education, employment, and MH and/or SUD services. The AT includes peer and family advocates who are integrated into all components of this process. AT staff meet weekly to discuss new referrals, ongoing members, and persons who are nearing graduation, to coordinate services, identify needs, and celebrate successes. This coordinated, multidisciplinary integration creates a consistent safety net to help members meet their goals. This trust and consistency have been valuable in supporting members in their recovery. One AT member noted that AT staff, especially the Probation Officers (PO), serve as a "pillar of accountability" in their lives.

The AT uses a harm-reduction model that is trauma-informed, meets the member's holistic needs, and is delivered in the community. The POs support positive behavior change; expect and model accountability; and ensure compliance with court orders. The MH and SUD counselors deliver treatment, individually and in groups. Advocates provide case management and supportive services; provide transportation to appointments; work with the families; and link members to other services. Advocates have lived experience and help members see that it is possible to make positive changes and to succeed. The effectiveness of the AT is found in the collaboration of the team, in working together to know each member, and engaging them to be active participants. MH and SUD counselors are embedded in PD, are developing the capacity to have access to the Probation Department's Caseload Explorer data management system, and share timely assessments and diagnoses with team mates to make informed decisions about the member and their needs. This collaboration and integration of services works at all levels to serve the member holistically, creating a safety net for the member, family, and AT, while

holding each person accountable. One AT member noted, *"AT never let me down, not even once."*

GWC offers a full array of SUD services, including SUD counseling, intensive outpatient treatment, withdrawal management (detox), and residential SUD treatment. AT members are referred to the appropriate level of treatment. AT also offers MH treatment for the member and family, with referrals to other providers as appropriate. AT works closely with the System of Care (SOC) to support the needs of high-risk juveniles, and adults with a serious mental illness who may need psychiatric medications. AT works with the Diversion Courts to help members meet the court requirements. Financial assistance (flex funding) is also available to support recovery. Flex funds are used to meet goals, reinforce positive progress, and promote healthy activities. This includes flex funds to offer housing support and funds for first and last month rent, security deposit, and/or basic furnishings; support for additional treatment needs; and coverage of other one-time expenses. Through these services, AT helps promote communication skills and healthy life choices. One AT member said, "*I was in a dark place. AT changed my life: I am now sober, going to school, and have a job. Now, everything is possible.*"

Goals and objectives.

Goal 1: Transition young adults who have been arrested for non-serious, nonviolent crimes from jail and deliver MH and/or SUD treatment. The AT works toward this goal by: 1) Increasing identification and assessment of arrested young adults with MH and/or SUD issues; 2) Increasing the number of young adults who receive and complete MH and/or SUD treatment and avoid relapse; 3) Coordinating collaborative diversion services with PD and Diversion Courts to increase use of treatment services and remain arrest free; and 4) Linking young adults to community support groups to achieve and sustain positive outcomes.

Goal 2: Reduce homelessness of young adults arrested for or convicted of non-serious, nonviolent crimes. The AT works toward this goal by: 1) Increasing the number and percent of young adults who are living in stable housing; 2) Delivering housing support services to increase the number and percent of young adults living independently; and 3) Working collaboratively with family members to create a stable living environment.

Goal 3: Reduce recidivism of young adults who are arrested for or convicted of non-serious, nonviolent crimes. The AT works toward this goal by: 1) Increasing the number of young adults who complete vocational/educational activities; 2) Increasing the number of employed young adults; 3) Teaching healthy communication skills; and 4) Delivering support services to family members.

Process measures: a) Annual number of young adults enrolled in AT who meet the target population criteria, with a priority to enroll individuals who are underserved (i.e., Black, Hispanic, and/or Native American individuals); b) Number of MH and SUD services treatment hours delivered annually; c) Number of young adults enrolled in Diversion Courts; and d) Number of young adults participating in vocational training.

Outcome Measures: a) Number and percent of young adults living in a stable housing situation; b) Number and percent of young adults with improved MH and SUD indicators; c) Number and percent of young adults who avoid relapse; d) Number and percent of young adults employed and/or in school; e) Number and percent of young adults with reduced number of arrests, reduced days in jail; f) Number and percent of young adults who remain arrest free; and g) Number of young adults involved in healthy social activities.

Collecting and evaluating data.

The AT completes an assessment to identify needs of the young adults and family and provide baseline data. Data on key outcome measures are collected at intake, throughout enrollment in the program, and at discharge. HIPAA and 42 CFR standards are followed. Data collection tools developed for this project are used to evaluate the success of AT and to meet grant reporting requirements.

Monitoring program fidelity.

AT, the Local Advisory Committee (LAC), and the evaluation process monitors service activities to ensure the evidence-based practices (EBP) are implemented with fidelity to the model. Monitoring program fidelity begins by selecting programs that meet the needs of AT population and by training AT members to implement services effectively. Evaluation activities identify positive outcomes and opportunities to share successes, and modify programs, to best meet the needs of the member and families. A Quality Improvement process is used, including the Plan Do Study Act model, to modify programs as needed. In addition, periodic focus groups with the members and family identify what is effective as well as opportunities to strengthen services.

Methodology.

A pre-post evaluation design is utilized to compare outcome indicators at baseline and periodically throughout enrollment in AT. Data for the evaluation activities will utilize Electronic Health Record (EHR) data from HHS and PD, as well as data collected by the AT. The evaluation activities meet or exceed the state performance measurement requirements. In addition, local evaluation activities are conducted throughout the grant period. Data is evaluated to identify differences in access, service utilization, and outcomes, to determine whether AT

services are effective at promoting community health and safety. AT adheres to the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Sharing outcomes.

Data reports are distributed to AT, HHS and PD managers, Community Corrections Partnership Advisory Committee (CCP), Campaign for Community Wellness (CCW), LAC, and participating entities. In addition, outcome data is used to inform AT, Behavioral Health and Probation managers, CCP, LAC, CCW, and participating entities about the need to develop, coordinate, and modify services to improve individual and system-level outcomes.

PROJECT PERFORMANCE

Project Progress.

The Placer County Action Team (AT) enrolled its first member in February 2018 and as of April 30, 2019, have enrolled a total of 65 unduplicated individuals: 43 (66.2%) current members and 22 (33.8%) who were discharged prior to April 30, 2019. The AT defines " total unduplicated individuals" as the number of unique individuals who have been enrolled in the AT since the start of the program, regardless of the number of times an individual has entered into the program. The AT determined that members who were enrolled for less than two (2) months in the program and did not fully engage in services are excluded from analysis in this report. Of the 22 discharged members, six (6) were enrolled for less than two (2) months and are excluded from the analysis of outcomes, leaving a total of 59 current and discharged members (as of April 30, 2019).

Of the 59 total members, 46 (78.0%) identify as Caucasian/White, 10 (16.9%) as Hispanic, and one (1.7%) as American Indian/Alaska Native. Two (3.4%) did not indicate

race/ethnicity. Of the 59 total members, three (5.1%) speak Spanish as their primary language. There were 37 (62.7%) members who identify as male and 22 (37.3%) who identify as female.

No major modifications have been implemented to the process of identifying and referring new members to the AT. The enrollment and intake process include a Family Mapping meeting to help identify the relationship between each family member and historical and current use of substances, MH issues, and incarceration. This information, along with the Correctional Assessment and Intervention System (CAIS) and BH assessment help develop the Integrated Case Plan. Minor changes to data collection forms and training of staff have occurred to facilitate accurate and efficient recording of services and outcomes for members.

Each person referred to AT is screened and, if initial criteria are met, receives a thorough MH and SUD assessment. The individual participates in a Family Mapping meeting, which documents family life chronology and identifies generational and cultural patterns in the individual's life, as well as historical and current significant sources of support. In addition, each person is assessed using the CAIS and BH Assessment.

From these activities, each member develops his or her goals and identifies activities to accomplish those goals. The individuals develop goals for both the Probation plan and the AT plan, which demonstrates strong collaboration between agencies. Individuals are linked to the appropriate level of service, including residential services for SUD and outpatient treatment for MH and/or SUD, to help meet their treatment goals. Housing support services are also offered to ensure the individual is living in a stable living situation in the community.

A Spanish-English bilingual, bicultural advocate was hired in Quarter 5 and has been an excellent addition to AT. She has helped expand the capacity of AT by delivering services in Spanish-speaking members' primary language, as well as coordinating services and supports

with Spanish-speaking monolingual family members.

All (100%) members receive MH and/or SUD services. As of April 30, 2019, of the 59 total members, 22 (37.3%) were placed into residential SUD treatment. Of those 22 members, eight (36.4%) have been successfully discharged from residential treatment. The AT population is complex and have multiple needs. Delivering MH and/or SUD services to all (100%) members and quickly placing members in residential treatment, when necessary, demonstrates the effectiveness of the AT delivering much-needed services to this high-risk population.

Once each member has completed the Family Mapping and assessment, the member and AT staff identifies key goals. For members who are homeless, or at risk of homelessness, the AT provides housing support services to find a safe and stable living situation and provides ongoing support to remain in their house or apartment. The AT helps the member to have basic needs met, such as signing up for benefits and setting up the apartment (e.g., kitchen, linens, basic furniture), as well as teaches them basic skills, such as shopping, nutrition, using public transportation, and budgeting. The AT also offers supportive services to the family, when needed, to help stabilize the living situation and resolve any issues to promote a healthy support system. Several staff have been trained in the Ready to Rent model, which has been effective in helping individuals find stable housing.

By April 30, 2019, 35 (59.3%) of the 59 total members gained or maintained a stable living situation by living with family or friends. Of these 35 members, the AT helped four (11.4%) financially in obtaining stable housing (e.g., first/last month rent, security deposit). There were six (10.2%) members living in a transitional housing program and eight (13.6%) in residential SUD treatment, as of April 30, 2019. The AT population is at high risk of experiencing homelessness. Only 7 (11.9%) of the 59 total members were experiencing

homelessness as of April 30, 2019 or as of their discharge from the program (three current members and three discharged members). This demonstrates the success of AT efforts to find and secure safe and stable housing for the majority of AT members.

Once each member has completed the Family Mapping and assessment, the member and AT identify key goals. For members who have a goal of attending a vocational training program, obtaining their GED, or attending college, AT helps coordinate the admission process and find the appropriate educational setting to help them achieve their goals. As of April 30, 2019, 33 (55.9%) of the 59 total members had obtained a high school diploma or an equivalent degree and seven (11.9%) were enrolled in school. In addition, 30 (50.8%) of the 59 total members were employed part- or full-time, one (1.7%) was volunteering, and 10 (16.9%) were actively looking for work.

There are a number of programs in Placer County that are available as resources. For example, the Probation Department offers the Placer Re-Entry Program (PREP) Center. The PREP Center provides individuals with one-on-one and group-level services to assist with their successful transition into the community. This includes educational and employment opportunities. This program has a very high success rate and is an important resource for the AT members. As of April 30, 2019, nine (15.3%) members had been referred to the PREP Center and enrolled in the program.

As of April 30, 2019, of the 59 total members served, only two (3.4%) members were convicted of new charges. The AT population is at high risk of recidivism and the majority of members, 57 (96.6%), have not recidivated. This clearly demonstrates the positive outcomes achieved by the AT.

In addition to these outcomes, the AT supports members in other ways. The AT has supported five (8.5%) members to connect to Mental Health Court and one (1.7%) to connect to Drug Court. These courts allow the member to take responsibility for their past involvement with law enforcement in an environment that supports their efforts to remain substance-free and/or access mental health services.

A barrier to employment for many of the members is the erosion or complete loss of some of their teeth. The AT has supported 11 (18.6%) of the members to access dental work. This helps the members feel more confident in social situations and they are better able to apply for jobs and obtain employment.

Project Challenges and Solutions.

As the AT becomes more established and more individuals successfully graduate from the program, the number of people referred for services continues to increase. With a limited number of staff, it is difficult to assess and enroll members within the AT goal of 1-2 weeks. The AT continues to identify ways to expedite the intake process while still maintaining a warm, welcoming intake process that engages the member and their family.

The biggest challenge regarding providing housing support is the lack of available apartments that are affordable in the county. Placer County has a vacancy rate of less than 1%. This creates a challenge for the AT and members to find a safe and affordable living situation. Currently, several of the members continue to live in transitional housing, as they learn how to manage their recovery and develop wellness skills. The AT strives to help members find independent living opportunities, as they become available. The AT communicates with landlords and offers to provide ongoing support for the member to help resolve any situations that may occur at the apartment. This often helps encourage landlords' willingness to rent to the

members, who tend to have more difficulty in being accepted as tenants. The AT also has reached out to organizational providers in the community, including the Advocates for Mentally Ill Housing (AMIH), to help identify independent living situations that support members to successfully move into safe and stable housing.

An ongoing challenge is that these members are complex with multiple needs. Many of the individuals enrolled in the program have SUD. GWC has been extremely proactive at identifying the needs of these individuals and often after the intake is completed, they immediately enroll them in SUD residential and/or outpatient services, depending on their needs. This has been highly effective at helping the members begin developing the skills needed to achieve recovery and wellness. The AT utilized a list of available resources and provided ongoing training on how to access community resources. In addition, the extensive array of services offered by GWC across the region has been a valuable resource for the AT and members.

Another challenge is enrollment and retention of members who identify as African American/Black, American Indian/Alaska Native, or Hispanic. Through April 30, 2019, no current or discharged member identified as African American/Black, only one (1.7%) identified as American Indian/Alaska Native, and 10 (16.9%) as Hispanic. Of those 10 Hispanic-identified members, five (50%) were discharged before April 30, 2019. To facilitate enrollment and retention of Hispanic and Spanish-speaking members, the AT now has a Spanish-English bilingual, bicultural advocate.

Placer County Prop 47 ACTion Team – 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 Team; 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	• GW delivers coordinated, culturally competent evidence-based services in collaboration with Probation, Behavioral Health, and housing organizations • Probation and AT conducts comprehensive risk and needs assessment and develops an Integrated Case Plan • AT delivers services using principles of restorative justice to reduce recidivism • Identify, refer, and enroll persons (ages 18-32) who have been arrested, charged, or convicted of an offense AND have MH or SUD issues • Coordinated and collaborative 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 young adults and family members • Utilize bilingual, bicultural staff to increase access and retention • Conduct weekly AT meetings • Gather data on utilization and outcomes • Evaluate program through data analysis, share outcomes with AT and partners • Celebrate successes	<u>Young Adult Outcomes</u> • Employed and/or in school • Reduced number of arrests • 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 • Implementation of culturally competent, trauma-informed wellness and recovery • Delivery of engagement activities, timely access to services; development of positive social community for young adults 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 client and family satisfaction with access, services, and outcomes	• Persons (ages 18-32) who have been arrested, charged with, or convicted of a criminal offense AND who have MH and/or SUD issues; have increased access to intensive, coordinated, collaborative, and individualized AT services to successfully redirect their lives, engage in a healthy social community, and achieve positive outcomes • A vibrant learning collaborative is developed and maintained • Integrated services offer seamless, coordinated care • Evaluation and shared data across MH, SUD, and Probation to demonstrate improved quality and integration of care

Placer County Prop 47 Two-Year PER Grantee Highlight

The Placer County ACTion Team (AT) utilizes an integrated multidisciplinary team to achieve positive outcomes for justice-involved young adults (ages 18-32), with a history of substance use disorder (SUD) and/or mental health (MH) issues. The AT is a collaboration between the Placer County Probation Department, Placer County Health and Human Services, and Granite Wellness Centers (GWC), an organizational provider with a specialization in SUD and MH treatment. The AT is comprised of probation officers, SUD counselors, MH therapists, and peer and family advocates. This integrated team works closely together with each of the AT members to provide support and achieve their goals. This approach creates an environment where each member knows that the AT will provide ongoing support to promote health and wellbeing, and to reduce criminal recidivism. Of the 59 persons served in the first two years, only two have been convicted of a new crime.

Most members are referred to the AT by probation. Probation uses the Juvenile/Correctional Assessment and Intervention System (JAIS/CAIS) to assess risk and needs, as well as to identify MH and/or SUD issues. Upon referral to the AT, the individual, family members, and representatives from the AT participate in a Family Mapping session to identify key historical events in the family, including criminal history, substance use, mental health, and other stressors across generations. Each individual also receives a Behavioral Health clinical assessment to identify treatment needs and goals as part of an Integrated Case Plan that is shared across all agencies. GWC has the capacity for different levels of SUD and MH treatment, from outpatient to residential treatment, so each member can immediately begin developing the skills needed to reduce substance use and manage MH symptoms. Approximately one third of the members received residential SUD treatment following intake. The AT also includes peer and family advocates who actively support each member, and their family, to achieve their goals. Another important component of the AT is the availability of flexible funds to help support member goals. These flex funds may be used to help address barriers to success, such as purchasing new tires so the member can get to work; obtaining dental work/dentures so the member feels more confident in social interactions; and/or providing housing support to live independently. The AT meets weekly to discuss new referrals, coordinate services for ongoing members, and identify opportunities to support each other to provide consistency across the team. This coordinated, multidisciplinary integration creates a consistent safety net to help members meet their goals and support them in their recovery.

The achievements of the AT are best illustrated with a member success story. This member was in jail when probation told her about the AT. She was immediately motivated to apply, and she completed her application and intake while in jail. During Family Mapping, she and the AT identified that family conflict and trust issues were limiting her ability to achieve her goals. From the assessments, the AT identified that Intensive Outpatient Treatment (IOT) was appropriate and she began treatment immediately upon release from jail. When she finished IOT, she began outpatient treatment and complied with drug testing three days each week. The member and her family worked extensively with the AT to re-establish trust and work through conflicts, which created a strong network to support the member's goals. She was also enrolled in the Placer Re-Entry Program (PREP), where she learned job skills and how to manage stress to help her achieve success. The AT utilized flex funds for an eye exam and two new pairs of glasses, which she had been without for five years. The AT also paid to repair her computer. These funds empowered her to enroll in community college to pursue a career. After her graduation from the program, she was hired as a Peer Mentor with the AT. Her experience allows her to serve as an exemplary role model for other AT members.