Placer County Proposition 47 Cohort 3
LOCAL EVALUATION PLAN

FINAL 01/17/2023

Project Background

- *What information can you provide that is essential to understanding the need for the project and the project itself?*

The Placer County Proposition 47 Cohort 3 Action Team (AT) is modeled after our first 6 years of AT services, which deliver strengths-based, individual- and family-driven, solution-focused wraparound-type services to address the mental health, substance use, and diversion needs of the individuals served. The Cohort 1 AT served young adults, ages 18-32. The Cohort 2 AT expanded and adapted strategies to meet the needs of all adults, ages 18 and older, and diverse cultures. The AT offers an array of services and supports to engage members in services and achieve each individual's goals. Cohort 3 AT will utilize the successful collaborative model developed during Cohort 1 and Cohort 2, and enhance strategies to support diversity and inclusion to meet the needs of the whole community. All aspects of the program support positive behavior change to help members address their behavioral health (BH) needs, with an overall goal to prevent recidivism. Cohort 3 will also expand the AT services to include a Pre-File Diversion Program to support prevention and early intervention in collaboration with the District Attorney's (DA) office.

- *What is the scope of the project?*

The Pre-File Program (PFP) is a new and innovative program that is designed to divert individuals with first-time (low level) citations from the court and legal system. The District Attorney' (DA) will review citations and arrests and identify individuals ages 18 and older who have a first-time offense with a low level crime, such as petty theft including shoplifting. Individuals meeting these qualifications will be immediately referred to the PFP to schedule and attend a four-hour training on Theft Education and Personal Responsibility, offered by the Placer Re-Entry Program (PREP). On the same day as the training, individuals will also receive a mental health (MH) and substance use disorder (SUD) screening. Individuals who are screened and identified to have MH and/or SUD needs will be immediately referred to the Action Team (AT) for a full assessment, identification of goals, and ongoing, individualized AT services and treatment.

Following the day of training and screening, if the individual completes these two requirements, the DA will "decline to file charges" and the individual will have a clean criminal record. The individual will not need to attend court and no charges will be brought against them. This strategy will help meet the goals of improving outcomes and public safety. It is also anticipated that it will reduce court costs and recidivism. It will give the individual an opportunity to return to the community with no arrest history. When needed, the individual will receive MH and/or SUD treatment services through the AT, and/or receive other appropriate referrals.

- *What activities and/or services will the project provide?*

The Placer County Action Team (AT) is a multidisciplinary team, with representatives from Granite Wellness Center, Probation Department, Health and Human Services (HHS), Placer Re-Entry Program (PREP), District Attorney (DA), and IDEA Consulting (evaluator) that collaborates and integrates services to meet the needs of AT members and supports them to achieve their individual goals. The AT provides immediate, timely, individualized integrated case planning and services to meet the needs of each program member and their family. Services are culturally competent and trauma informed, and are tailored to the individual's needs.

The AT staff and probation officers will deliver an array of services, as well as utilize other existing services in the community. AT members will receive mental health (MH) and substance use disorder (SUD) services to help them improve functioning and meet their goals. For AT members on probation, diversion courts will be utilized, when appropriate, to support the member and family to meet goals.

The AT is 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' MH and/or 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.

Peer and family advocates on the AT will create a welcoming, recovery and strength-based environment to support success and positive choices. The AT 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 housing vouchers, when available, to support stable, safe housing in the community. Members will move through Phases (1 through 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 AT will meet regularly to discuss members' progress through the program to ensure members' successful progress through the four phases of the program and meet their goals.

Services treat members' MH and/or SUD symptoms and stabilize members' lives by securing housing, employment, and supporting social connections to help them 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.

- *How will the project's activities and/or services address the problem(s)/need(s) described?*

As noted above, the Cohort 3 Action Team (AT) is modeled after the Cohorts 1 and 2 ATs, which delivers strengths-based, individual- and family-driven, solution-focused, collaborative, multi-agency, wraparound-type services to address the mental health, substance use, and diversion needs of adults ages 18 and older. In Cohort 3, the AT will also utilize the Pre-File Program (PFP), in collaboration with the Placer County District Attorney (DA).

AT staff, probation officers, and when available PFP staff, will also be trained to identify and mitigate any potential barriers that AT participants may face while in the PFP or receiving AT services. Transportation issues are a major barrier to accessing services and maintaining employment. Many people coming out of jail do not own a car and/or have lost their licenses to DUI convictions. The AT provides transportation to ensure that members keep appointments and uses flex funds and other supports to achieve client goals. In addition, the AT will collaborate with PFP and Placer Re-Entry Program (PREP) to support the DA in diverting individuals and providing needed services, for individuals who enter through the PFP and need additional, ongoing services.

- *Who is the target of the project? What is the criteria for participant eligibility and comparison group(s)?*

Cohort 3 has two components: 1) the Action Team (AT) and 2) the Pre-File Program (PFP). The target population for the AT is adults, ages 18 and older, who have been arrested; charged with, or convicted, of a nonviolent, non-serious criminal offense; and who have a history of mental health (MH) and/or substance use disorder (SUD) issues that limit one or more life functions. Individuals will be identified in jail and/or in the community and are at risk for recidivism. 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. All persons referred to the AT will receive a comprehensive assessment. If they are referred from the Probation Department, the individual also receives a complete CAIS assessment to determine if they meet the initial criteria for referral to the AT. All persons referred will receive a comprehensive MH and SUD assessment; a Family Mapping meeting; and identification of individual goals to address housing and treatment needs.

The PFP will expand services to engage individuals at the time of first offense/citation. The new PFP will identify individuals, ages 18 and older, with a first citation of a non-violent offense, such as petty theft with a low monetary value. This project will expand the target population for the AT to include those who are at risk for becoming involved in the criminal justice system and provide early training and education. This expansion will meet the needs of an underserved population and support an early case resolution. Following a four-hour training and MH and SUD screening, the District Attorney (DA) will "decline to file charges", and the individual will have no history of the arrest. For those in the PFP program who have identified MH and/or substance use disorders, the individual will be referred to the AT for additional assessment and

expedited access to behavioral health (BH) treatment and coordinated services. This strategy will help support improved outcomes and reduce recidivism.

During Cohort 3, it will be essential to continually adapt the AT model to engage, improve access, and meet the diverse needs of members. As the PFP is implemented, evaluation activities will monitor the MH and SUD needs of this new populations of persons served. While there is no comparison group for the PFP, when possible, data on individuals enrolled in PFP and those identified but not enrolled in PFP, will be analyzed to help understand the effectiveness of the PFP on rates of recidivism.

The Cohort 3 AT will utilize the same collaborative model that has been successful with the Cohorts 1 and 2 programs, as well as introduce the addition of the PFP. The AT will continue to adapt strategies to meet the needs of all ages and diverse cultures. The AT will offer an array of services and supports to engage members in services and achieve each individual's goals. These activities will help achieve the Cohort 3 goal is to promote diversity, equity, and inclusion to ensure equal access.

- *How many participants is the project expected to serve?*

The Cohort 3 Action Team (AT) target population is individuals 18 years of age or older who have been arrested, charged with, or convicted of a criminal offense, and who have a mental health (MH) and/or substance use disorder (SUD). Cohort 3 expects to serve approximately 150 persons per year, with a total of 350-400 across the three years. 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. It is also anticipated that the Pre-File Program (PFP) will serve an additional 100 persons per year. Some of these individuals will be referred and enrolled in the AT.

- *What are the project's goals and objectives?*

<u>Goal 1: Transition individuals from jail, and deliver multidisciplinary, integrated Action Team services, and implement a Pre-File Diversion Program.</u> Objectives: By the end of the grant period, the Action Team (AT) will: a) Increase identification and assessment of culturally-diverse individuals who meet AT criteria; b) Increase the number of individuals and families who receive and complete AT services; c) Increase the number of individuals who avoid new offenses and convictions; d) Enroll individuals with a first-time citation into the Pre-File Program (PFP), deliver training and screening, and increase the number of individuals who are diverted from jail; and e) Link individuals to needed services to achieve and sustain positive outcomes.

<u>Goal 2: Reduce homelessness of Action Team members.</u> Objectives: By the end of the grant period, the AT 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; and c) Deliver AT advocacy services to build and sustain positive social

connections.

Goal 3: Reduce recidivism of Action Team and Pre-File Program members. Objectives: By the end of the grant period, the AT 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; d) Deliver support services to family members, and e) Increase the number of first-time offenders enrolled in PFP, conduct training and MH/SUD screening, and refer to AT Services, when needed, to reduce recidivism.

Logic Model

The Placer County Prop 47 Cohort 3 Logic Model is shown on the next page.

Logic Model – Placer County Prop 47 Cohort 3

INPUTS	ACTIVITIES / OUTPUTS	GOALS / OUTCOMES		IMPACTS
		Individual Outcomes	System Outcomes	
• Granite Wellness (GW), a community-based organization, contracts with Health and Human Services (HHS) to continue implementing the Action Team (AT) and utilizing the principles of Assertive Community Treatment (ACT) and Wraparound • AT ensures collaboration and coordination with GW; HHS; Probation; Behavioral Health (BH); District Attorney (DA); Placer Re-Entry Program (PREP); Peer and Family Advocates; Courts; housing resources; education agencies; community providers; and family members • Time • Leverage funding: Grant dollars; HHS; Probation; DA; mental health services act (MHSA); HUD; in-kind contributions • Mental health (MH) and substance use disorder (SUD) Medi-Cal revenue • Local community partners help identify, inform, and shape policies, goals, services, and solutions • Demographic, service utilization, outcome, and cost data	• Deliver coordinated, collaborative, culturally congruent, trauma-informed, evidence-based, and healing strategies in partnership with GW, Probation, BH, DA, PREP, and partner agencies • Offer treatment, case management, training, and civil legal services • Conduct comprehensive screening and assessment; identify barriers • Refer persons to AT who have been arrested, charged, or convicted of an offense AND have MH or SUD; persons from Pre-File Program (PFP) • Conduct Family Mapping and BH assessment; identify services needed • Develop a coordinated Treatment Plan across partners • Utilize Peer and Family Advocates to support individuals and families • Deliver services using principles of restorative justice to reduce recidivism • Implement a PFP for persons with a misdemeanor • Link persons to PREP; housing; education; etc. • Utilize MHSA Flex Funds • Utilize collaborative Courts to support program goals • Conduct weekly AT meetings • Gather data on service utilization and outcomes, including PFP • Evaluate program through data analysis, share outcomes with AT, community partners, and LAC • Celebrate successes	• Achieved/sustained stable employment • Living in safe and stable housing • Reduced number of arrests and convictions • Reduced number of days in jail • Reduced recidivism • Reduced MH symptoms • Reduced SUD • Early case resolution for persons with a misdemeanor when Pre-File requirements are met • Early linkage to PREP, treatment, and informal supervision • Increased diversion from Courts • Involved in healthy social activities • Improved access to vocational/educational training • Improved health, MH, and SUD indicators • Long-term lasting support networks • Improved relationship with family, when appropriate • Improved offender outcomes • Improved public safety	• Enhanced coordination, collaboration, and integration services between GW; Probation, BH, DA, PREP, Courts, jail, and partner agencies • Early case resolution for persons with a misdemeanor • Improved access to AT services for diverse cultures through Promotor/a linkage • Implementation of culturally congruent, trauma-informed wellness and recovery services • Coordinated MH and SUD treatment; case management; housing; employment skills; civil legal; transportation; and MHSA Flex Funds • Increased diversion and expedited dispositions • Reduced court time/no court time if PFP completed • Evaluation of key health, MH, and SUD indicators; arrests; diversions; recidivism; cost-effectiveness • Shared reports to improve services; promote individual and family satisfaction with access, services, and outcomes	• Persons (ages 18+) arrested, charged with, or convicted of a criminal offense AND with MH and/or SUD issues have increased access to assessment and individualized services to support positive outcomes • Increased diversion from Courts • Reduced Court costs • Improved participant outcomes with reduction in recidivism • Improved public safety • Supported learning collaborative across partner agencies • Integrated services offer seamless, coordinated care • Shared evaluation data across MH, SUD, Probation, DA, PREP, and partner agencies demonstrates improved outcomes, quality, cost-effectiveness, and integration of care

Process and Outcome Evaluation Methods and Design

- *What is the research design for the process and outcome evaluation?*

Granite Wellness (GW), a community-based organization, will continue to contract with Health and Human Services (HHS) to implement the Action Team (AT). The AT is comprised of mental health (MH) and substance use disorder (SUD) clinical staff and parent/family advocates who work in coordination with probation officers to provide screening, assessment, treatment, family support, and linkage to needed services. Upon hire, staff from GW and the probation officers for the Cohort 3 AT are trained in a number of areas including the evaluation /data collection forms. This training provides guidance on the collection of the MH and SUD assessment tools, identifies potential members who meet the target population criteria, and ensures timely access to the program. In addition, staff and probation officers are trained in the identified Evidence-Based Practices (EBPs) to create core skills for providing wellness, recovery, and strength-based services. New in Cohort 3 will be individuals who receive training through the Pre-File Program (PFP) and are referred to AT for ongoing services. Data will also be collected on individuals who receive the PFP training and screening.

Data will be used to identify and evaluate differences in access, service utilization, and outcomes, to determine if AT and PFP services were effective at promoting community safety and reducing recidivism. Demographic data is collected on each person served; services delivered; and outcomes of each component of the program.

The AT utilizes EBPs and applies them in a collaborative, person-centered manner to engage individuals, families, and multiple agencies to support positive outcomes. The partnership, daily communication, and team accountability have been essential in building trust and a consistent network for members, which helps reduce behavioral health (BH) symptoms, develop positive decision making, and reduce recidivism.

- *What are the inputs/resources, activities, outputs, and outcomes that you will be assessing?*
- *What is the specific data element used to measure each of those inputs/resources, activities, and outputs?*
- *What is your definition of the outcome(s)?*

Process measures include a) Annual number of adults enrolled in Action Team (AT) 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 mental health (MH) and substance use disorder (SUD) service hours delivered; d) Number of members enrolled in vocational/educational services annually; e) Hours of transportation; f) Amount of flex funds; g) Number of members receiving housing services; and, h) Number of Pre-File Program (PFP) persons referred; trained; and screened; i) Number of PFP persons referred to AT; and j) number of AT members who have new citations.

Outcome measures include the number and percent of AT members who: a) attain stable housing; b) reduce MH symptoms; c) reduce substance use; d) achieve employment or education

goals; and f) do not recidivate (no new convictions). For PFP, the number and percent of persons: a) whose criminal charges are not filed; b) referred to services, including AT; and c) are not convicted of a new crime.

The process and outcome measures align with the grant and measure progress on each goal: to transition individuals from jail or receiving a citation, deliver AT services, and implement PFP; to reduce homelessness of AT members; and to reduce recidivism of AT members and PFP participants.

- *What data sources will you use for each data element?*
- *How often will the data be collected?*

Data collection tools developed for Cohorts 1 and 2 will be used for this project, with modifications to evaluate the success of the Action Team (AT) and the Pre-File Program (PFP), as well as to meet Cohort 3 reporting requirements. Probation and AT staff conduct assessments to identify risks and needs, which provide baseline data. AT staff will collect data daily, documenting enrollment to, discharge from, and hours of services delivered, by date. This data documents services delivered, and "key events" as they happen, by date; type and change in living situation; employment; education; arrests; convictions; training and rehabilitation activities.

A pre-post design will be utilized to compare outcomes at baseline and discharge, using data from AT; Health and Human Services (HHS); Probation; District Attorney (DA); and Placer Re-Entry Program (PREP). Recidivism data will be provided by the DA and/or Probation. Shared data between agencies complies with HIPAA and 42 CFR protections.

In addition, we are working with the DA's office to determine if there is an opportunity to analyze similar data for persons who received the PFP's one-day training and screening. Obtaining this information would provide valuable information on the effectiveness of this innovative program.

The AT collects extensive BSCC data on each person referred, enrolled, served, and discharged. Recidivism is analyzed annually.

- *How will you define successful program completion for the participants?*

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 mental health (MH) and/or substance use disorder (SUD) symptoms, housing situation, and/or employment/education, they move through the Phases. Persons in the Pre-File Program (PFP) who are referred to the Action Team (AT) will be assessed and enrolled in the appropriate phase, depending upon the person's needs.

The AT will meet regularly to discuss members' progress throughout 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, and meet employment and education goals.

Upon completion of the program, staff 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.

Members who successfully complete the program are discharged and graduate from the AT when they meet their goals and/or leave the program. Some members may leave the program before completing all their goals because they have found full time employment. Others may be reunited their children and move out of the area to live with their families; and others may be entering college or a training program, or have other life events. All of these examples are considered success!

- *How will you determine whether recidivism was lower at the end of the project relative to before the project began?*

Recidivism is analyzed annually with data and support from the Probation Department. The probation department will collect information on all convictions that occur in Placer County prior to admission to the Action Team (AT), and for up to three (3) years following graduation from the AT. For each AT member who engages in the program for more than two (2) months, the number of citations prior to admission will be compared to the number of citations 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.

The percent of recidivism is calculated by dividing the number of persons who received AT services and had a new citation with the total number of persons who received AT services. Cohort 1 had 10% with new citations (10 out of 100 served) and Cohort 2 had 20% with new citations (41 out of 203). We anticipate similar results for Cohort 3.

- *How will you analyze data, if relevant? Will you simply compare over time? Do you have staff capability or expertise that would allow for any more sophisticated statistical analysis?*

Evaluation data is entered into a database, analyzed monthly, and reviewed in summary format with Cohort 3 agencies, stakeholders, and the Action Team (AT) Local Advisory Committee (LAC) to ensure that interventions are implemented as intended. Data from the Probation Department provides historical and current arrest data to evaluate recidivism over time. Data from the District Attorney (DA), Probation, and Placer Re-Entry Program (PREP) will document Pre-File Program (PFP) services and outcomes, including number of referrals; number trained; and number of individuals with charges not filed. HIPAA and 42 CFR standards are followed.

Evaluation activities will continue to be designed, analyzed, and reported by the same organization that conducted the Cohorts 1 and 2 evaluations (IDEA Consulting). The number of different analyses is conducted, including, but not limited to the following: number of persons who access services, by demographics; number of services delivered to each person, by type of

service; length of time in treatment; outcomes over time (e.g., stable housing; employed; vocational training; education; medical and dental; positive social supports; and improved family relationships).

- *If implementation goes as expected, how will you document the factors that were in place that helped you to be able to execute this project (e.g., presence of certain staff members, availability of funding, collaboration with external partners)?*
- *How will you know that the change was due to the project, and are there any limitations to your approach?*

In addition to the overall reduction in arrests and citations demonstrated through Probation Department data, self-reports from Action Team (AT) members will be used to help demonstrate the impact of the AT 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 AT 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.

- *If implementation does not go as expected, how will you document project barriers or challenges?*

The Action Team (AT) model is effective at addressing challenges on a weekly basis, through the AT meetings. This multidisciplinary team, that includes Granite Wellness (GW) staff, management, Probation Department staff and management; Health and Human Services (HHS) / Behavioral Health (BH) staff and management, and evaluation staff. During these weekly meetings, the team quickly identifies issues and challenges, discusses options for resolution, agrees on strategies, and identify specific AT members to help resolve the issue. The issue is discussed throughout the week, and is also discussed during the weekly meeting, until it is resolved. When the challenge and/or barrier is a system-level issue, management staff from each of the agencies discuss the issue and support the team to identify a solution.

This collaborative teamwork was initially established during the implementation of Cohort 1 and provides the exemplary foundation and model for continuing to address barriers and identify solutions as the team has expanded over the years. Ongoing management support from all agencies ensure that barriers are addressed and resolve quickly. In addition, management from these agencies also provide support and celebration of graduating members. Managers often attend graduations of members to help celebrate the person's and the AT's success. The Local Advisory Committee (LAC) has also provided ongoing support to the AT for the past 6 years.

This multidisciplinary, collaborative AT management style has created the opportunity to achieve positive outcomes and change the lives of the individuals served, and to support community safety and reduce recidivism for Placer County.