Proposition 47
Integrated Care Behavioral Health
Full Service Partnership Program
Evaluation Report
For the
Board of State and Community Corrections
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RUHS-BH established an Integrated Care Full Service Partnership program for justice involved individuals with mental health diagnoses, substance use disorders or co-occurring disorders in two regions of Riverside County.

Despite initial program implementation challenges, RUHS-BH after an initial ramp up period was able to contract with a well respected community based provider, Recovery International, to deliver integrated mental health and substance use disorder services in a new program called De Novo which means “New Beginnings.” During the grant period, while there had been setbacks in the initial opening of the two sites, there was a rapid enrollment to near capacity census once the programs were fully open. In total by the end of the grant period, June 30th, 2021, 515 unduplicated consumers were served in the program at the two sites. This total is greater than the grant proposed 180 people served between the two sites.

The program served the appropriate target population of criminal justice involved consumers with mental health and/or substance use disorders. In total 83% of the consumers with a mental health diagnosis had a Serious Mental Illness (SMI) and 46% had a co-occurring mental health and substance use disorder diagnosis. The SMI diagnoses included Schizophrenia, Bipolar, and Major Depression. The substance use disorder diagnoses were primarily methamphetamine and alcohol addiction disorders. The population was mostly middle-age to older middle aged males with significant chronicity in their behavioral health challenges. Key life domain areas also showed significant challenges with homelessness, housing instability and low to no financial resources.

Despite a challenging high need population, the program was able to engage consumers into substance use and mental health treatment services. A total of 36,627 hours of service was provided over the course of the grant. Substance use services accounted for 17,149 hours of service and mental health accounted for 19,478 hours of service. Consumers in substance use services received mostly outpatient group services. Similarly, a high proportion of mental health services were group services. Consumers also received psychiatric medications as appropriate and case management. Significant housing supports were provided as homeless consumers were provided with emergency housing. A total of 2,388 bed days of emergency housing was provided to De Novo consumers. Furthermore, rent assistance was provided to nine consumers. Securing appropriate housing was a significant challenge as supportive and more permanent supportive housing is relatively scarce in the County.

Outcomes showed some improvements in the number of days consumers spent in jail. Jail days and arrests prior to participation in the program were high. Jail days showed a 64% reduction in follow-up data. Recidivism was low. Positive outcomes were also found for a reduction in hospitalizations and a reduction in the number of crisis emergency room visits when comparing the year prior to the period of program services. Overall, both mental health emergency room use and acute hospitalizations were reduced for consumers. Mental health emergency room use was reduced by 88% and acute hospitalizations were reduced by 91%. Some consumers were able to make gains in employment. Although the total number of consumers becoming employed was low, employment during participation in the program increased 34%. Housing satisfaction increased slightly from 46% satisfied at intake to 56% satisfied at follow-up. Overall days spent homeless did not decrease, but as noted previously housing supports were provided.
The Following Consumer Highlight is the result of a client phone interview conducted after the larger focus group series. The goal of the interview was to further elicit information from a client that had reported making progress in recovery. He noted the support he received from the De Novo program. The following is the consumer’s perspective on his experience with the De Novo Proposition 47 program:

At the age of 11, he got high for the first time. By the time he was 17, he had already experimented with Cocaine, LSD, and Marijuana. He reflected, “I wish I hadn’t used drugs, it made things worse.” When he would argue with his mother constantly, he thought it was only an anger issue. During this time, he mentioned cycling through various mental health hospitals and jails. It culminated in a criminal charge. When he was arrested, he reported that he was still under the influence.

As a result of the most recent experience with the justice system, he began receiving proposition 47 program services at De Novo. There he reported getting the help that he needed. He knows that he has a diagnosis of bipolar disorder. “I feel more educated about it.” He learned to identify the symptoms. When he feels that he is at the top of the world, that everyone wants to help him, that he is a supreme leader, he now recognizes it as his mania. “They taught me how to keep up my medication, and how to manage my thoughts. Take it day by day.” He learned new coping skills and abilities and began to apply them. “Take steps back and evaluate. I was with my dad, he was getting mad at me. So instead of me getting angry, I walked away, and sat down and calmed down.”

De Novo instilled in him simple goal setting to help him achieve his long term ambitions. He is held accountable. As part of the program, he entered a sober living facility. Down the line, he wants to get a Bachelor’s degree in Business. He has already begun the process of applying to schools. He dreams of opening a Colombian and Puerto Rican Restaurant. In preparation, he spends time with his grandparents cooking with them, learning how to make the cuisines. After sober living, he’ll stay with them. Eventually, he wants to return to his mother’s home.

De Novo has impacted his life significantly. “I’m more careful, I think about stuff before I do them. I don’t rush into things. I make smarter choices.” De Novo has empowered him. “I have been meeting my goals.” De Novo has supported him. “They’re friendly. They’re helpful. They’re there for us.” Now, he has a plan and direction. He sees a future for himself. As he continues in the program, he will only continue to learn and grow.
Riverside County established an Integrated Care Behavioral Health Full Service Partnership (FSP) program designed to provide integrated behavioral health services consisting of both specialty mental health (MH) services and substance use disorder (SUD) services. Service locations were established at two sites in high need areas of Riverside County, the Coachella Valley (Desert Region) and the area of Perris/Moreno Valley (Mid-county region). Recovery International, a non-profit community based organization, was contracted to provide the Integrated Care FSP program. The program sites were named De Novo which means “new beginnings.” The program is designed to serve justice involved participants with serious mental health disorders, substance use disorders, or co-occurring disorders. Recovery International’s (RI) mission is “Empowering people to recover, succeed in accomplishing their goals, find meaning and purpose in life, and reconnect with themselves and others.”

The Integrated Health FSP model included: psychiatric and medication support, evidence based interventions such as DBT, CBT, Seeking Safety, and Motivational Interviewing. Services included interventions that supported skill building across the consumer’s life domains (e.g. anger management, family therapy), system navigation and access (e.g. housing, transportation, benefit assistance), household management (e.g. budgeting, household maintenance, retaining housing), health and wellness training and support (e.g. money management, importance of coordinated physical health care, nutrition and exercise, nutrition and exercise, meal planning etc.), peer support, family counseling, and targeted case management. The Integrated Care FSP model also included integration and close coordination with physical health care as a standard of service. Furthermore, the FSP programs provided after-hours support for participants in crisis. Consumers also have access to vocational services such as, computers to help search for and fill out applications for jobs as well as email access. Additionally, these programs included Peer Support employees that had direct lived experience with mental health challenges and/or substance use challenges as part of their own recovery journey. The Peer Support workforce was essential to the process of engagement (trust) and safety (empowerment, voice, choice). Peer Support staff taught self-management skills and mentored consumers as they moved through the program and community re-integration. RUHS-BH leveraged the Homeless, Housing, Opportunities, Partnership and Education (HHOPE) housing program to provide emergency shelter and other housing options as they become available.

Each individual referred received a full comprehensive assessment based on consumer need. Consumers referred for substance use receive an ASAM (American Society of Addiction Medicine) criteria screening tool to assess the level of SUD care needed. When Intensive Outpatient SUD treatment or Outpatient SUD treatment was indicated the consumer was enrolled in the program. Those needing a higher level of SUD care (Residential Rehabilitation, Detox) were referred into those services to return to the FSP when the level of care could be stepped down. A mental health clinical assessment was completed for those with any mental health disorders. Based on assessments, a recovery-based care plan was developed from a trauma-informed perspective.

After grant award significant ramp up time was necessary to hire staff, train staff and secure program sites to deliver services.

The COVID pandemic did have an impact on services delivery. After the initial shutdown in March 2020, a virtual service delivery were put in place and safety protocols and measures were implemented at the sites. This resulted in some loss of contact with consumers as they struggled to adjust to both the pandemic and virtual services. In person services were re-introduced with a hybrid model of both virtual and in-person services depending on consumer’s comfort with in-person services.
This report examines data collected from both De Novo program sites from January 2018 to June 30th, 2021. This time frame is inclusive of when the program began operations to the end of the 2020-2021 fiscal year.

**Project Goals:**
- Divert individuals with Serious Mental Illness and/or Substance Abuse disorders seen in Veterans court, Homeless Court, or identified by probation into an Integrated Care FSP program and ensure program enrollees satisfy court requirements.
- Reduce recidivism of program enrollees by providing a comprehensive Integrated care FSP program with a “wrap-around” approach focused on recovery.
- Reduce the likelihood of recidivism by increasing program enrollees success in other life domains such as housing stability and behavioral health stability.

As described in the Local Evaluation Plan, evaluation questions to be addressed include; 1). Can collaboration with the courts and probation result in successful diversions of consumers into the program through recruitment by outreach and engagement teams? 2). Will the Integrated FSP program reduce recidivism for enrolled consumers? 3). Will consumers maintain participation in the program? 4). Will consumers mental health or substance abuse issues be stabilized with reductions in crisis or psychiatric hospitalizations? 5). Will consumers housing stability be maintained or improve?

**Methodology:**
As a part of the local evaluation plan a protocol was established to collect the necessary data to answer key evaluation questions. A pre to post quasi–experimental design is being utilized to compare program enrollees improvements in key outcome domains. Baseline data is collected on multiple variables across these domains at intake into the program. Follow-up data is collected quarterly through-out the consumers program participation. Data collection utilizes a baseline intake form and a quarterly follow-up form for each client. The baseline and follow-up measure are designed to collect the same information so that the data can be used as a pre to post measure on key outcomes. The baseline outcomes data collection form includes information on consumers in the year prior to their enrollment in the program, and includes arrests/law enforcement contacts, jail days, probation legal status, housing status, sources of financial support, employment, health insurance and other benefits. Follow-up forms cover the same variables as the baseline and are used to track changes in the key domains. Consumer program closure forms are used to document the reason a consumer closed out or left the program (successful completion, new law violation, unable to locate etc…).

RUHS-BH is using the RUHS-BH ELMR electronic health record (EHR) to collect and maintain information on a significant portion of the consumer level data. The EHR contains the treatment episodes, consumer demographics and the service data necessary to describe the consumer and the services provided. The contractor providing the program enters all the consumers' data and service records into the ELMR EHR including the intake and follow-up outcome forms. Data was collected and entered by De Novo staff working within the programs. Evaluations staff have direct access to query the necessary data electronically from the EHR for analysis done in SPSS.
Referral form Submitted.

Client meets criteria and is enrolled into the program through ELMR EHR.

Screening tools and measures utilized as applicable (e.g. ASAM).

Integrated Care FSP Baseline Intake form is competed.

Episode, Client Integrated Assessment, Care Plan, are created in EHR.

Services Recorded in ELMR EHR.

Process data from EHR provided in reports including: Unduplicated consumers enrolled, demographics, service utilization timeliness.

Follow-up outcome data collected on key life domains. (e.g. housing, crisis and psychiatric hospitalization, housing stability).

Qualitative data collection from consumer and staff.

Satisfaction collected bi-annually.

=Represents a data collection point
Project Performance-Challenges and Implementation

Project Modifications

The first modification to the project involved the delay in program roll-out due to establishing site locations. The program services and goals have not undergone modifications. The second modification involved adjusting to the COVID pandemic and providing services virtually, setting up safety protocols, and a re-adjustment to in-person services with a combination of telehealth/virtual service delivery and on site services.

Implementation Challenges

Procurement for a community-based contracted organization to provide the program took longer than anticipated. During the first year of implementation a request for proposals (RFP) was released, submissions were reviewed, and a contract was awarded. This RFP process took longer than anticipated due to the development of an RFP that incorporated integrated mental health and substance use disorder services. During year two, Recovery International, the awarded provider hired staff and worked to secure adequate program space and County certifications to deliver services. While administration staff worked to secure program space, newly hired staff received both Recovery International required trainings and Riverside County trainings, including evidence based models. Due to building location the Mid-County site was able to begin some services a few months earlier than the Desert location. For the Desert De Novo location, a building structural issue delayed the program start date until a new location was ready. Given significant program start-up time the County accepted the year extension offered to grantees that experienced implementation delays. The programs began enrollment in 2019 with a few consumers in the third quarter. Program enrollments occurred more rapidly in the fourth quarter of the fiscal year April through June of 2019.

Establishing referral streams were also time intensive in the beginning. Referrals started with a slow stream and then flooded the program to near capacity census. Multiple justice related referral sources were established including the grant-funded Justice Outreach Teams, County Probation, and Whole Person Care. Enrollment into the program jumped to 122 unduplicated consumer in a few months in the fourth quarter of FY2018-2019. This rapid influx of consumer produced some challenges for the new program resulting in attrition of consumers due to inappropriate referrals, or referrals of consumer with a low motivation to attend programming. Initial implementation challenges were also associated with transportation needs. Consumers often needed transportation to access the De Novo locations. Transportation by De Novo staff was difficult and time consuming particularly for the Desert location. The availability of public transportation was also a challenge as the frequency and route availability to site locations took significant amounts of time for consumers to travel to and from the program if they did not already have transportation available.

By the start of FY2019-2020 the program sites had established their referral streams and collaborations to receive consumers for screening and intake into the program. Whole Person Care (WPC) public health nurses began to work with both program sites to coordinate the referral of detention and probation consumers with behavioral health and physical health challenges. This collaboration supported the engagement and referral process which allowed the program to serve the targeted number of consumers. As noted previously the COVID pandemic impacted the program in the last quarter of FY 2019-2020 and throughout FY 2020-2021.
Figure 2 shows the referral process of the Justice Outreach teams who screen consumer to determine preliminary eligibility. These can include setting appointments and assisting consumer with accessing the program, for example transportation to the intake. In addition to grant funded outreach teams, Whole Person Care (WPC) detention screening teams are also facilitating the referral of consumer into the program. Whole Person Care are public health nurses that assist with navigation for behavioral health services and physical health needs for justice involved individuals.

**Figure 2 Referral Process**

![Referral Process Diagram]

Figure 3 shows the referral source into the De Novo program sites for 511 of the consumers served by the program. In total, the highest number of referrals came from Probation/Justice Outreach/Parole sources. This is followed by WPC and then Detention/Collaborative Courts/PD. Data was derived from most recent Prop47 intake form completed as some consumers left the program and then returned to re-enroll.

**Figure 3 Referral Sources by Agency**

![Referral Sources by Agency Chart]
**Enrollment – Diversion into the Program**

*Evaluation Question: Can collaboration with the courts and probation result in successful diversions of consumer into the program through recruitment by outreach and engagement teams?*

As previously described the two De Novo sites had significant ramp up activities that delayed entry of consumers into the program. However, once building space was secured and occupancy clearances completed both sites received a rapid and steady influx of consumers. Figure 4 shows this increase of consumers during the three fiscal years it was operational. By the conclusion of the contract the program was able to successfully divert 515 total unduplicated consumers into the program. The consumers were enrolled across the two sites, exceeding the goal of 180 consumers enrolled. New enrollees dipped when the COVID pandemic began in the fourth quarter of FY19/20 the trend of fewer new consumers continued through FY20/21.

*Figure 4 Enrollments into Program*
Consumer Demographics-Gender and Age

The number of males (392) enrolled in the program was significantly greater than the number of females (123). This was true in both the Mid-County and Desert Regions.

*Figure 5 Consumer Gender*

**Gender Overall**

- **Male**
  - 76%
  - (n=392)

- **Female**
  - 24%
  - (n=123)

*Figure 6 Consumer Age Groups*

The majority of consumers were older than the age of 30 (74%). More than a third of consumers were older than 40 years of age. This population has different needs than a more youthful population given the length of time substance use disorders and mental health issues have been present in their lives.
The largest proportion of consumer served in the program were Hispanic/Latinx (35.9%) this is consistent with the overall Riverside County population. Caucasian was the next largest group (32.6%) followed by Black/African American (14.4%), other (9.5%) and finally, Asian/Pacific Islander (2.9%). The distribution of race/ethnicity indicates there are not significant disparities with regards to who was served in the program.

**Table 1 Consumer Race/Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Desert De Novo</th>
<th>Desert De Novo %</th>
<th>Mid-County De Novo</th>
<th>Mid-County De Novo %</th>
<th>Total</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>2</td>
<td>0.8%</td>
<td>4</td>
<td>1.6%</td>
<td>6</td>
<td>1.2%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>7</td>
<td>2.7%</td>
<td>8</td>
<td>3.2%</td>
<td>15</td>
<td>2.9%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>43</td>
<td>16.4%</td>
<td>31</td>
<td>12.3%</td>
<td>74</td>
<td>14.4%</td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>83</td>
<td>31.7%</td>
<td>102</td>
<td>40.3%</td>
<td>185</td>
<td>35.9%</td>
</tr>
<tr>
<td>Multi Racial</td>
<td>6</td>
<td>2.3%</td>
<td>5</td>
<td>2.0%</td>
<td>11</td>
<td>2.1%</td>
</tr>
<tr>
<td>Other Race</td>
<td>24</td>
<td>9.2%</td>
<td>25</td>
<td>9.9%</td>
<td>49</td>
<td>9.5%</td>
</tr>
<tr>
<td>Unknown / Not Reported</td>
<td>3</td>
<td>1.1%</td>
<td>4</td>
<td>1.6%</td>
<td>7</td>
<td>1.4%</td>
</tr>
<tr>
<td>White/ Caucasian</td>
<td>94</td>
<td>35.9%</td>
<td>74</td>
<td>29.2%</td>
<td>168</td>
<td>32.6%</td>
</tr>
</tbody>
</table>
In total, 150 consumers had only a primary mental health diagnosis, and 115 consumers had only a substance use diagnosis. For those with only a mental health diagnosis the majority were diagnosed with Schizophrenia/Psychosis (40%), Major Depression (24%), or a Bipolar disorder (19%).

For the 115 individuals with only a substance use diagnosis the majority were diagnosed with an Amphetamines (57%) or Alcohol diagnoses (20%).
Out of all consumers served 46% were co-occurring, diagnosed with both a mental health and a substance use disorder. The co-occurring consumers in the program have addictions that are compounded by serious mental health issues. The diagnoses for the co-occurring consumers are shown in figures 9 and 10. Figure 9 shows the mental health diagnosis of the co-occurring consumers. The mental health diagnoses recorded were similar to those with no co-occurring disorder. The majority of consumers had a serious mental illness. Nearly 70% of consumers had either a Schizophrenia/Psychosis, Bipolar or Major Depression diagnosis.

Figure 9 Mental Health Diagnosis Co-Occurring Consumers

- Mood
- AD/D
- Anxiety
- BiPolar
- Major Depression
- Other
- Adjustment
- SchizPsych

Figure 10 shows the co-occurring consumers substance use disorders which were mostly Amphetamines and Alcohol addiction.

Figure 10 Substance Use diagnosis Co-occurring Consumer

- Alcohol
- Opiod
- Cannabis
- Sedative/ Hypnotic
- Cocaine
- Amphetamines
Enrolled consumers participated in a total of 36,627 hours of service. These hours were split between the program components with 17,149 hours in substance use disorder (SUD) services, and 19,478 hours in mental health services.

Figure 11 shows the SUD service distribution by type and the average hours of service per consumer. The highest average hours of service was for SUD group outpatient services (on average 62 hours per client). Intensive group outpatient services at an average of 47 hours per client was also a frequent service type.

The distribution of mental health (MH) services is shown in figure 8. The highest average hours of MH services was MH group which on average was 30 hours per consumer. Case Management was also a frequent service at 11 hours per client.
Program Services

The tables below summarize services received by service type and the proportion of consumers receiving that service. It details the number and percent of consumers who received each type of service as well as the total count and average number of services those consumers received during the three fiscal year period (note: In the first year there was a late start to the program and consumers mostly began services in the last quarter during the first fiscal year).

**Table 2 Service Count by Type Mental Health Services**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Number of Consumers</th>
<th>% of Consumers</th>
<th>Count of Service</th>
<th>Avg # of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart Review</td>
<td>2</td>
<td>&lt; 1%</td>
<td>2</td>
<td>1.00</td>
</tr>
<tr>
<td>SUD Case Management</td>
<td>250</td>
<td>49%</td>
<td>1643</td>
<td>6.57</td>
</tr>
<tr>
<td>SUD Counseling</td>
<td>14</td>
<td>3%</td>
<td>105</td>
<td>7.50</td>
</tr>
<tr>
<td>SUD Group IOT</td>
<td>176</td>
<td>34%</td>
<td>4717</td>
<td>26.80</td>
</tr>
<tr>
<td>SUD Group ODF</td>
<td>80</td>
<td>16%</td>
<td>2794</td>
<td>34.93</td>
</tr>
<tr>
<td>SUD Individual IOT</td>
<td>203</td>
<td>39%</td>
<td>2417</td>
<td>11.91</td>
</tr>
<tr>
<td>SUD Individual ODF</td>
<td>111</td>
<td>22%</td>
<td>1742</td>
<td>15.69</td>
</tr>
<tr>
<td>SUD Individual Support</td>
<td>4</td>
<td>1%</td>
<td>10</td>
<td>2.50</td>
</tr>
</tbody>
</table>

For Mental Health services Group Outpatient services at 62% were the most frequently occurring services.

**Table 3 Service Count by Type Mental Health Services**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Number of Consumers</th>
<th>% of Consumers</th>
<th>Count of Service</th>
<th>Avg # of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Intervention</td>
<td>26</td>
<td>5%</td>
<td>96</td>
<td>3.69</td>
</tr>
<tr>
<td>MH Case Management</td>
<td>343</td>
<td>67%</td>
<td>5494</td>
<td>16.02</td>
</tr>
<tr>
<td>MH Clinical Assessment</td>
<td>374</td>
<td>73%</td>
<td>2072</td>
<td>5.54</td>
</tr>
<tr>
<td>MH Family Therapy</td>
<td>3</td>
<td>1%</td>
<td>4</td>
<td>1.33</td>
</tr>
<tr>
<td>MH Group</td>
<td>320</td>
<td>62%</td>
<td>7188</td>
<td>22.46</td>
</tr>
<tr>
<td>MH Individual Therapy</td>
<td>275</td>
<td>53%</td>
<td>2218</td>
<td>8.07</td>
</tr>
<tr>
<td>MH Medications</td>
<td>139</td>
<td>27%</td>
<td>595</td>
<td>4.28</td>
</tr>
<tr>
<td>MH Service</td>
<td>251</td>
<td>49%</td>
<td>2720</td>
<td>10.84</td>
</tr>
</tbody>
</table>
In total, consumers received 33,805 services from December 2018 to June 2021. The majority of consumers received over 32 services (44%). In addition 11% received 20–31 services. Combined a total of 55% of consumers received more than 20 services. Consumers with fewer services included 14% who received 4-7 services and those who received 1-3 services at 12% of consumers. Some of the consumer with 1-3 services are those that left the program quickly which is not unexpected given the high need population referred to the program.

Figure 13 Service Frequency
Consumer Challenges-Living Situation (Housing Stability)

The population served in this program had significant challenges with regards to key life domains (living situation, financial resources, etc.). Housing stability was a significant challenge. In the year prior to entering the program consumers spent a total of 39,286 days homeless (on average 76 days homeless per consumer). Many consumers were coming out of a detention setting to homelessness. So the average days homeless in the year prior could have been skewed by the time spent in jail.

At intake, a high percentage of consumers (67%) reported their housing situation was unstable or they were unsure of the their housing stability. Also, 56% of consumers reported being homeless at some point in their lives. At intake, many consumer were homeless or living in temporary settings see Figure 14.

Figure 14 shows enrolled consumers living situation at intake into the program. Only 13% of consumer were living in their own place. Most were either living in someone else’s place (38%), were homeless (24%), or were in an emergency shelter (8%).

Note: Intake living situation collected where consumers were mostly living in the 90 days prior to intake.

Figure 15 shows consumer’s satisfaction with their housing situation. Nearly a third of consumer (28%) report being unsatisfied with their housing situation, on follow-up only 15% were unsatisfied. On intake, nearly half (48%) reported they were satisfied or very satisfied. On follow-up, it was found that over half (54%) were satisfied or very satisfied with their housing situation.

Figure 15 Satisfaction with Living Situation
Outcomes—Living Situation and Primary Care

Living Situation
Data collection included supports for living situation. Proposition 47 assisted consumers with some direct housing assistance to support housing stability.

- 76 consumers received direct housing supports through Prop 47. Mostly in the form of emergency housing motel vouchers.
- 2,388 days of housing were provided.
- Rental Assistance was provided to nine consumers with assistance on deposits, or rent.

Housing was a significant challenge for some program enrollees. A lack of income and financial resources made it difficult to obtain housing. The ability to support this population with housing was limited by the availability of subsidized and low income housing. Affordable housing availability is an acute problem Countywide.

Primary Care
As an integrated care program, primary care and connection to health resources is part of the program activities. Data was collected at intake on the number of consumer with health insurance and a primary care doctor. At intake only 59% had a primary care physician. During the follow-up period, 73% had access to a primary care physician. The number of consumer with a primary care physician increased by 14% at follow-up. Access to Primary care may have been impacted by the connection to Whole Person Care (WPC) as a referral source as they may have linked consumers just prior to their entry into the program.

Figure 16 Primary Care Physician
Consumer Challenges-Financial Resources

Financial Resources

Program consumers had significant challenges with financial resources. Part of the program activities were to support consumers with building their connection to supports in the community. Many entered the program with no financial resources. Upon intake very few consumers were employed. At follow-up, employment increased by 37%. Additionally, for those reporting some financial resources, most reported only CalFresh (food stamps) at intake into the program. The program was able to provide some resources directly to consumer such as transportation to services, hygiene supplies, and assistance with gaining identification, or personal items needed to function like eye glasses or medication. At intake consumers mostly had resources for food from CalFresh which decreased somewhat at follow-up. Follow-up data also showed a 74% increase in consumers who reported relying on their own wages. However, the number of consumers gaining financial support from employment was relatively low. Consumers length of stay in the program may have impacted the programs ability to connect consumers to financial resources. Length of stay is discussed further in following sections of this report.

Figure 17 Financial Resources Intake and Follow-Up
**Consumer Challenges-Legal Status**

*Evaluation Question: Will the Integrated FSP program reduce recidivism for enrolled consumer?*

**Legal Status at Time of Intake**

The population of consumers served in the program fit the target population of those with criminal justice involvement. At intake into the program, data on consumers criminal justice system involvement was collected for the year prior to enrollment date.

At intake into the program:
- In total, consumers spent 46,584 days in jail in the year prior to program (on average 5,225 jail days per month, an average of 122 days per client).
- Consumers reported in total 735 arrests in the year prior to starting the program.
- 43% were in jail 90 days prior to entering the program.
- 79% were on probation upon entering the program.

**Recidivism**

BSCC definition of recidivism: “*Recidivism is defined as 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 (PC Sec. 6046.2(d)). Committed refers to the date of the offense, not the date of conviction.*”

BSCC Recidivism data was requested for those consumers that completed program services. According to the BSCC definition of recidivism the recidivism overall at the end of the program was zero since consumers that were re-arrested had not completed program services.

**Legal Outcomes**

*Jail Days and Arrests*

At the follow-up period, data was collected on the number of arrests and the number of days consumer spent in jail during participation in the program. This data was collected quarterly.

**Outcome at follow-up**

- Zero Recidivism was found using the BSCC definition. However, additional incarceration/arrest and jail data was collected for consumer that did not meet the BSCC definition of recidivism. Twenty-four consumers of the 515 served had an arrest and conviction which calculated to a 4.6% recidivism rate.
- Overall, only 44 consumers left the program due to incarceration some of which were not a new law violations and conviction. Even though some consumers were arrested, two consumers returned to the program and went on to successfully complete treatment, thus the total consumers leaving due to arrest was 42 (8%).
- Days spent in jail and arrests dropped. In total there was a 64% decrease in the amount of days consumers spent in jail compared to jail days in the year prior to participation in the program. Jail days were measured during their time in the program.
Consumers Hospitalizations—Outcomes

Overall, both mental health emergency room use and acute hospitalizations were reduced for consumers. Mental health emergency room use was reduced by 88% and acute hospitalizations were reduced by 91%. The following figure shows acute psychiatric hospitalizations and crisis emergency room use for the year prior to program and during participation in the program as an event rate. The number of events in the 12 months prior to FSP enrollment are compared with the rate of ‘number of events per person-year’ in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled were summed and divided by the number of years all individuals had been in the program.

*Figure 18 Decreases in Acute Psychiatric and Psychiatric Emergency Room Use*
Enrolled consumers had significant challenges with housing, financial resources and serious mental illness and co-occurring disorders. Challenges were also found with continued engagement in the program. The following figures show the length of stay (LOS) and the reason consumers closed from the program. Sixty-four percent closed from the program in six months or less, and more than a third had 90 days or less in the program. However, 22% percent closed in 6 months to a year in the program. Some consumers had a longer LOS with 14% of enrollee’s staying over a year in the program, while 3 consumer stayed in the program over two years. COVID could have impacted program closing as consumers may not have felt comfortable with accessing services.

The most frequent reason for closing in the program was the consumer choosing to discontinue services which accounted for 74% of the close reasons. The next most frequent reason was successful completion of the program (11.5%). Other reasons for leaving the program included incarceration (8%), transferred to another provider (4%), Moved out of area (2%) and finally Death (1%). Transferred to another provider can also be considered a positive reason for close from the program as it shows a step down from intensive services to continuing in less intensive outpatient care. Incarceration as the reason for close was relatively low and the majority did not fit the BSCC definition of completion from program and a new law violation and conviction.
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Collaborative Partnerships and Strategic Coordinated Work
Local Advisory Committee

Inputs
- Collaborations with Probation, Veterans and Homeless Courts
- Establishment of two regional Integrated Full Service Partnership Treatment programs
- Training on Evidenced-based Practice & Trauma Informed Care Leveraging Resources Technical Assistance Fidelity Monitoring

Engagement and Screening
- Outreach and Engagement Teams
  - Identifying clients in target population
  - Prioritizing for engagement and enrollment into Integrated Care FSP
  - Focusing on people with frequent law enforcement contacts, mental health and/or substance abuse, and housing instability

Comprehensive Treatment Services
- Mental Health (MH) Treatment
- Substance Abuse (SA) Services
- Evidenced-Based Interventions
- Psychiatric Evaluations
- Medication Support
- Linkage to Housing
- Linkage to Substance Abuse Residential Medication Assisted Treatment

Integrated Care
- Integration of whole health needs including physical health needs.
- Co-Occurring mental health and substance abuse treatment integration
- Trauma-informed care
- Peer-supports integrated into service
- Legal aid as needed
- Opportunities for restorative justice

Outputs

Outcomes
- Diversion into Program Services
- Retention In Services
- Improvement In Key Life Domains jail, hospital, crisis
- Housing Stability
- Reduced Recidivism
- Symptom Stabilization MH and/or SA