Proposition 47 Grant Program

Two-Year Preliminary Evaluation Report

The San Joaquin County Homeward Bound Initiative

Executive Summary

The aim of the Homeward Bound Initiative is to significantly expand the delivery of community-based care to residents of San Joaquin County, with an emphasis on reducing recidivism and providing behavioral healthcare to historically underserved groups. These include individuals who are either homeless or at risk of homelessness; non-serious, non-violent offenders with frequent contacts with the criminal justice system; individuals with substance-use disorders; and Latinx and African American individuals who have been an underserved group in the region. The initiative plans to achieve these goals by delivering respite services, case management, psychotherapy, and medication-assisted treatment (MAT). These services will be delivered by Community Medical Centers (CMC), a federally qualified health center (FQHC) with an established track record in providing health and social care to San Joaquin County residents. The services will be accessible via a multitude of pathways, and supported by extensive links with other community and governmental agencies. The provision of these additional services is expected to lead to improved functional and recovery outcomes for consumers, in turn leading to the reduced incidence of recidivism and contacts with the criminal justice system in the San Joaquin area.

Major Findings

The Homeward Bound Initiative is successfully delivering a range of behavioral healthcare services to individuals with mild-to-moderate mental health concerns and co-occurring substance use disorders (SUD). To date, the Homeward Bound Initiative has enrolled 169 consumers who meet Proposition-47 eligibility requirements. Of these, 125 consumers have received case management, 135 have been referred to receive mental health treatment, 84 have received substance use disorder (SUD) treatment from a recovery counselor, 29 have received employment assistance, and 25 have received MAT. From the point of referral, consumers were assessed and engaged in care promptly, and consumer engagement appeared high, indicating that these services are working as intended. Since 12/2018, the range of services has been expanded to include sobering beds, and additional CMC clinics have been incorporated into the program, consistent with the proposed “hub and spoke” model.

Notable early successes of the project include enrolling 49 individuals who are homeless into care, and the large proportion of these individuals that then go on to receive housing support either via Homeward Bound providers directly, or via community partners (n=27, 54.5% in total). Another notable success is the high proportion of individuals who are enrolled in care that report a history of interaction with the criminal justice system (69%). Together, this suggests considerable success in engaging historically underserved groups in the San Joaquin County region. These successes are likely to be attributable, at least in part, to the significant

efforts of the Homeward Bound clinical team to engage with external community partners, including law enforcement, homeless charities, local hospitals, and the courts.

Some factors which have impeded the successful implementation of the program include the challenges of recruiting trained, qualified service providers. However, these open positions have now been successfully filled and project services are currently being delivered as intended. Additionally, preliminary evidence indicates that there have been challenges in engaging and enrolling Latinx populations into care. This challenge is consistent with the ongoing engagement difficulties experienced by San Joaquin County Behavioral Health Services.

Conclusions

Overall, the Homeward Bound Initiative is successfully delivering a broad range of behavioral healthcare services to individuals with mild-to-moderate behavioral health conditions, the majority of whom report having a history of interaction with the criminal justice system. These findings suggest that the Homeward Bound Initiative may represent a preliminary but important step forward in closing a significant gap in the San Joaquin County system-of-care. There is evidence to suggest that Homeward Bound providers are having considerable success in reaching a number of historically underserved groups. Future evaluations of Homeward Bound services will be extended to evaluate the impact of these services on symptoms experienced, functioning, and recidivism.

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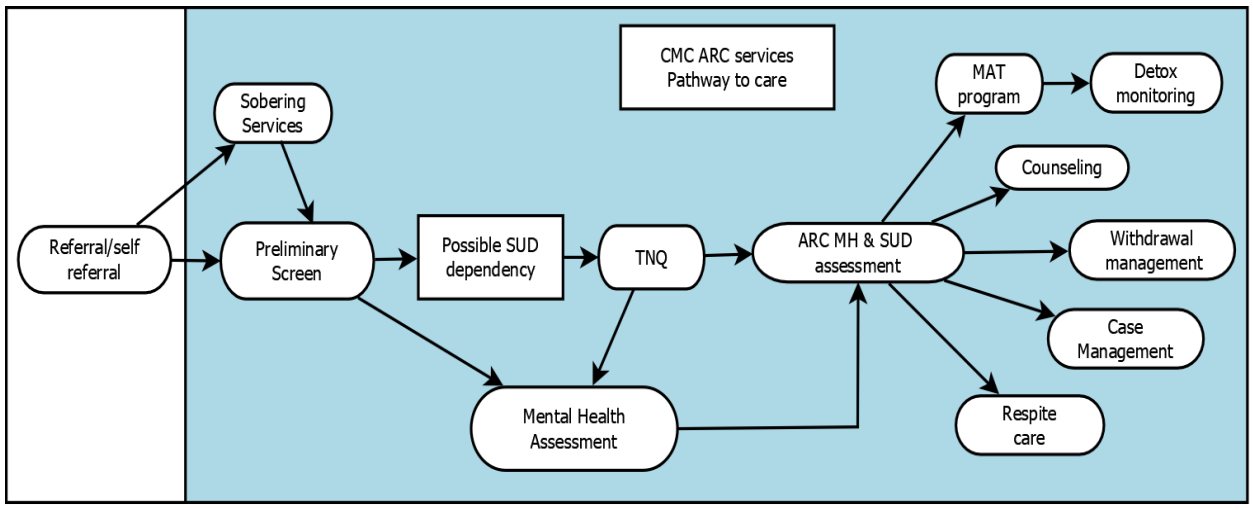
Project Description

The Homeward Bound Initiative represents a significant expansion of community-based behavioral health services, designed to improve population behavioral health outcomes for the residents of San Joaquin County. The overarching goal of the Homeward Bound Initiative is to improve access to behavioral health care services for all county residents by increasing pathways to care. The program places an emphasis on supporting vulnerable and underserved populations, including: 1) non-serious, non-violent offenders with trauma or other mental health concerns, 2) high-risk individuals with SUD who are homeless, and/or who have frequent contacts with law enforcement, and 3) African American and Latinx individuals who are underserved through traditional, existing behavioral health services.

The Homeward Bound Initiative focuses on 1) *service expansion* through the creation of the Assessment and Respite Center (ARC) with co-located withdrawal management services; 2) *system strengthening* through shared data use agreements and expedited referral pathways between providers; and 3) *service enhancement* by delivering wrap-around housing and case management services for those individuals that require intensive services to achieve recovery from behavioral health conditions. The ARC is a community-based treatment facility managed by Community Medical Centers (CMC), a not-for-profit healthcare network with an established track record of delivering health and social care services to individuals in the Stockton area for over 50 years. A conceptual model detailing the new system of care delivered by CMC via the Homeward Bound Initiative is presented below in Figure 1.

Figure 1: The Homeward Bound Initiative CMC/ARC Pathway to Care

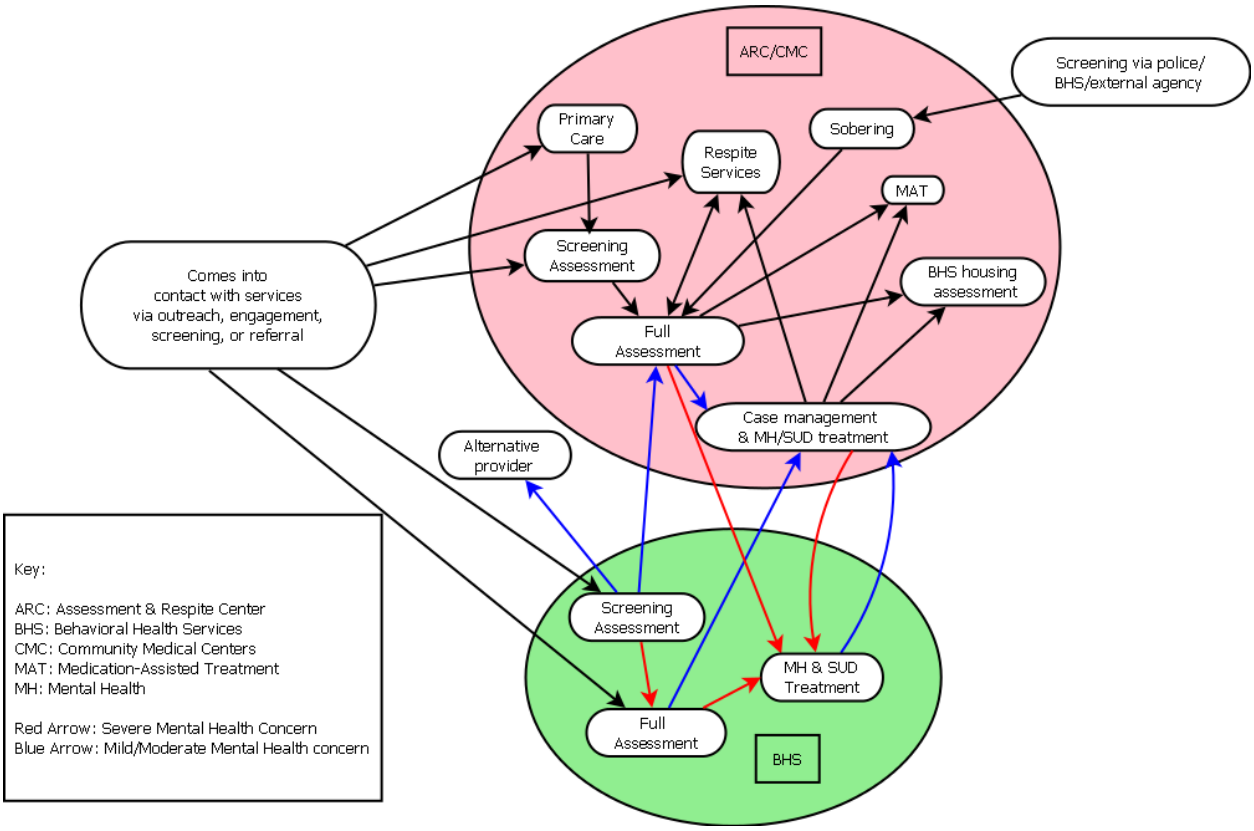


ARC = Assessment and Respite Center; CMC = Community Medical Centers; MAT = Medication Assisted Treatment; SUD = Substance Use Disorder; TNQ = Treatment Needs Questionnaire.

The Homeward Bound system-of-care allows consumers to access services delivered by the ARC via a multitude of entry pathways. These include services referrals via community partners (e.g., Stockton Shelter for the Homeless, St. Marys' Dining Room), emergency services, San Joaquin County Behavioral Health Services (BHS), law enforcement, and self-referral. If the individual accesses CMC services while intoxicated, they will be offered sobering services, which consists of sobering beds available on the premises. Once sober, or if they access services when not intoxicated, they will be offered a brief screening assessment to identify treatment needs, in addition to access to respite services to address any immediate basic needs (thirst, hunger, hygiene). In the event of a positive screen, or on the basis of the clinician's clinical judgment, the individual will then be offered a full behavioral health assessment, followed by services which could include MAT, withdrawal management, case management, and/or other forms of therapy, dependent upon need. Individuals in receipt of services delivered within the ARC will also be eligible for both physical and mental health care, delivered by existing CMC co-located primary care services.

In addition to the expansion and enhancement of services offered by CMC, a second critical component of the Homeward Bound Initiative includes the establishment of expedited referral pathways between CMC and San Joaquin County Behavioral Health Services (BHS). Figure 2 depicts how ARC services fit within the broader context of available care delivered under the Homeward Bound Initiative. If an individual with a severe mental health condition engages with services at CMC, they will receive an expedited referral to San Joaquin County BHS including a "warm handoff," with details from the CMC assessment passed on to BHS to minimize any duplicate assessment. In cases where a screening or full assessment at San Joaquin County BHS takes place, and the individual is deemed to be experiencing a mild-to-moderate behavioral health concern, the individual will then be referred directly to CMC with a "warm hand-off." Minimizing these barriers to appropriate care should, in turn, improve access and engagement to appropriate treatment, potentially leading to better outcomes overall.

Figure 2: The Homeward Bound Initiative Full System of Care



Defining Mild-to-Moderate and Severe Mental Health Concerns

One component of the Homeward Bound Initiative involves a direct referral pathway between CMC and BHS to ensure each consumer receives the appropriate level of care for their behavioral health concern promptly. Under this model, individuals determined to have mild-to-moderate mental health diagnosis, or have a primary diagnosis of SUD, will receive treatment at CMC. Individuals identified as having a severe mental health diagnosis will typically receive treatment at San Joaquin County BHS. Individuals are identified as meeting the criteria for a severe mental health concern based upon the Beacon criteria, which are as follows:

> The individual will be considered to have a severe mental health concern if:
>
> 1) The consumer has at least one mental health disorder diagnosis.
>
> AND

2a) If the duration of illness is less than one year, then they must exhibit at least four moderate, two severe or one extreme impairment in the following domains:

i. Feeling, mood, affect
ii. Thinking
iii. Family/living environment
iv. Interpersonal relationships
v. Performance of daily activities
vi. Social and legal
vii. Basic needs and self-care

OR

2b) If the consumer is identified as having a duration of mental illness of over one year, then they must exhibit at least two moderate, or one severe impairment in the domains lists above.

Indicators of Severe or Extreme Impairment

Indicators of severe or extreme impairment include mental health symptoms that substantially interfere with daily activities; highly disorganized, impulsive, or aggressive behaviors with a decline in self-control; suicidal or self-harming behaviors; disruptions in self-care; and substantial disruptions in interpersonal relationships.

Indicators of Mild-to-Moderate Impairment

Indicators of mild-to-moderate impairments may include manageable mental health symptoms that are attributable to social stressors (i.e. loss of job, bereavement, management of a chronic medical condition); an expectation of a resolution of symptoms within 6 months; an ability to manage daily activities despite the presence of symptoms; no or minimal impact on interpersonal relationships; the absence of emergency psychiatric admissions in the past 12 months; stable adherence to medication for over 12 months, or medications no longer required.

Goals and Objectives

The Homeward Bound Initiative combines project goals as stated in the "Project Evaluation Plan" section of the Proposition 47 grant proposal (Proposition 47), submitted to the California Board of State and Community Corrections in February 2017, and the goals and objectives stated in the *Purpose of the Innovation* section of the Assessment and Respite Center Innovation Plan Document, submitted to the California Mental Health Services Oversight and

Accountability Commission (MHSOAC). Where goals and objectives are closely related or overlap each other they have been combined and synthesized for clarity.

Goal 1. Reduce systemic gaps which lead to the underutilization of mental health services.
Objectives:

- To address structural limitations of the current model of care that leads to the underutilization of appropriate services in people with mental illnesses and co-morbid substance use disorders.
- To provide stabilization services, respite care, withdrawal management, housing, and case management, when necessary, to facilitate consumer engagement in mental health treatment.

Goal 2. Improve access to mental health services for underserved groups.
Objectives:

- To provide mental health services to non-violent offenders with trauma or other mental health concerns.
- To provide mental health services to high-risk individuals with substance use disorders who are homeless, and/or have frequent law enforcement contact associated with their behavioral health concerns.
- To increase the number and proportion of African American and Latinx individuals who utilize community behavioral health services.

Goal 3. Reduce gaps in the substance use disorder continuum of care.
Objectives:

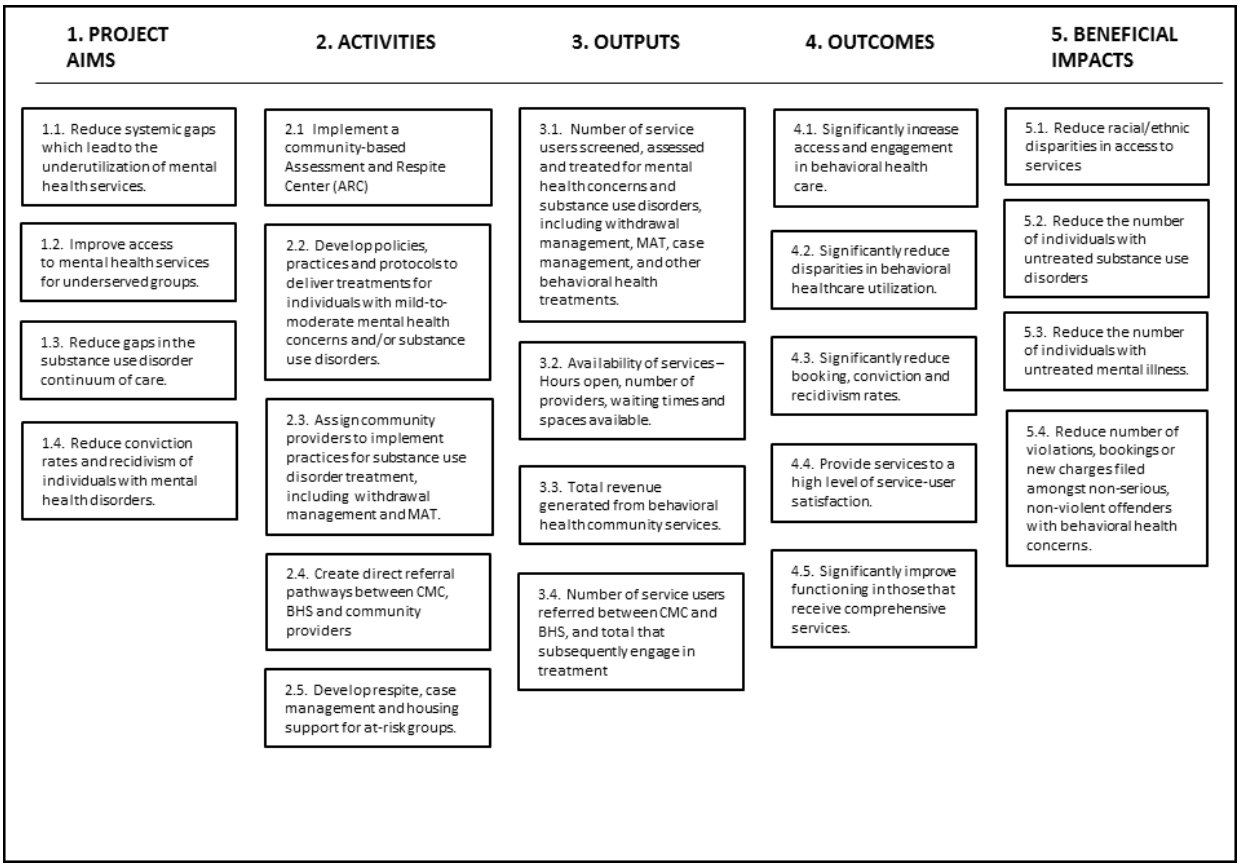
- To provide effective substance use treatment services, ensuring that providers are trained in effective treatment practices, and are assigned to deliver services.
- To provide effective substance use treatment services, allowing former offenders to receive diversion programming and/or direct their own recovery efforts.

Goal 4. Reduce conviction rates and recidivism of individuals with mental health disorders.
Objectives:

- Improve the quality of life of non-violent consumers with prior convictions; individuals with substance use disorders; those that are homeless or at risk of homelessness; and any other populations that have frequent contact with law enforcement associated with their behavioral health concerns.
- Reduce the number of incarcerations among non-violent offenders with untreated mental health and/or substance use disorders, and reduce the rate of recidivism in this population.

Logic Model

Figure 3: Logic model of the Homeward Bound Initiative



Key: ARC, Assessment and Respite Center; BHS, Behavioral Health Service; CMC, Community Medical Centers; MAT, Medication-Assisted Treatment.

Methods

Study Design

This report represents a formative evaluation of the Homeward Bound Initiative. The analysis will consist of 1) a brief qualitative summary of the project implementation from the perspectives of the clinical and evaluation team; 2) a summary of the current program capacity in terms of number of beds, providers, and opening hours; 3) a cross-sectional analysis of the number and nature of services delivered to date; 4) a cross-sectional analysis of services delivered to historically underserved groups, including those who report being homeless, and those who identify as Latinx or African American; and 5) a comparison in service utilization and

engagement between those that do and do not report a criminal history, consist with Proposition 47 eligibility criteria.

Target Population

All adults who access services delivered through the Homeward Bound Initiative will be included in the first part of the analysis. The analysis will include all service data collected between the opening of the ARC on 1/1/2018, until 5/30/2019. The consumers included in this evaluation will include everyone who is either referred or self-referred to the ARC for treatment for a suspected SUD, or utilizes the sobering facilities during a period of intoxication. Additional analysis will be completed on a subset of individuals who meet criteria for the Proposition 47 grant, namely, individuals presenting with a criminal history and a current behavioral health disorder. In future reports, the sample of consumers included in the evaluation will be extended to include individuals referred to the ARC by providers at San Joaquin County BHS, which will be conducted to evaluate the expedited referral pathway system between these two providers.

Data Collection Procedures

In line with current practices, if the consumer does not already have an electronic medical record (EMR) at CMC, one is created at the first appointment. The EMR contains all of the consumer's demographic information and an ongoing record of their care. During their first appointment the consumer will complete the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Scale (GAD-7). During this, or any subsequent appointments, if it becomes evident the consumer may be experiencing a SUD, they are encouraged to complete the Treatment Needs Questionnaire (TNQ). If this screening form identifies any intravenous drug use, prior receipt of MAT, use of cocaine or benzodiazepines, or alcohol misuse, then the consumer is referred to complete a full behavioral health assessment. During the assessment, the consumer is instructed to complete the Client Satisfaction Questionnaire (CSQ-8), the Drug Abuse Screening Test (DAST) for a more detailed exploration of their drug use history if they reported prior drug use, and the CAGE Substance Abuse Screening Tool (CAGE) if they report a history of alcohol problems. The individual will then be referred to receive either withdrawal management, MAT, counseling, case management, and/or respite care, based on the outcome of the assessment. Individuals referred to receive MAT will complete the Office-Based Opioid Treatment Stability Index (OBOT) at initiation of treatment, and then at monthly intervals to review patient stability and recovery outcomes. As part of ongoing care all consumers will complete the PHQ-9 and the GAD-7 every six months. These data are used to both inform care, and track symptom progression over time. All the data will be stored within the CMC EMR, and at each reporting stage this data will be extracted by CMC analysts and provided to the evaluation team for analysis.

In addition to the data stored in the EMR, for each referral or self-referral to the ARC, CMC providers will track basic demographic information and ongoing care information for each

Homeward Bound consumer in a dedicated tracking sheet specifically designed for the evaluation. For the purposes of this evaluation, only the data collected using these tracking sheets will be used. In subsequent evaluations the primary data used to track consumer demographics, service use over time, and outcomes will be obtained from the CMC EMR and augmented by the tracking sheets where necessary. In future evaluation reports this data will also be linked to data provided by the San Joaquin County Justice Department and San Joaquin County BHS to track recidivism outcomes over time and to evaluate the effectiveness of the referral pathway between CMC and BHS.

Measures

In the current evaluation the analysis will focus on the data collected in the clinical assessment, and as part of ongoing clinical care. In later evaluations, the data sources will be extended to include the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), the Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006), the Drug Abuse Screening Test (DAST; Skinner 1982), the CAGE Substance Abuse Screening Tool (Ewing, 1984), the Office-Based Opioid Treatment Stability Index (OBOT; Nordstrom et al., 2016), the Treatment Needs Questionnaire (TNQ, Brooklyn and Sigmon, 2017), and the Client Satisfaction Questionnaire (CSQ-8; Larsen et al., 1979).

Intervention

Components to be delivered as part of the Homeward Bound initiative include MAT, withdrawal management, sobering, case management, respite services, mental health treatment, and SUD counseling from a recovery counselor. These services are delivered consistent with the American Society of Addiction Medicine (ASAM) guidelines at both level 1 and level 2 degrees of intensity ("ambulatory withdrawal management with and without extended on-site monitoring"). In conjunction with these additional services, consumers will be eligible, based on need, to receive ongoing co-located physical and mental health care as part of CMC's existing services.

MAT is the use of medications in combination with supportive therapies to treat SUD. The ARC primarily administers two medications; suboxone (buprenorphine and naloxone) for the treatment of opioid use disorders and naltrexone for the treatment of alcohol use disorders. Buprenorphine suppresses the physical signs and symptoms associated with opioid withdrawal and has been found to be an effective intervention in maintenance treatment of opioid dependence (Mattick et al., 2014). Naltrexone blocks feelings of intoxication and euphoria and has been found to reduce self-reported cravings and alcohol use (Hendershot et al., 2017).

The recovery counseling component of care is typically delivered both in a group format and in individual sessions. Both treatment formats are delivered by qualified recovery counselors, and the focus of these treatments are to support the individual in their recovery for SUD dependency. If either during the course of the assessment or during ongoing SUD treatment the

consumer is identified as having additional mental health needs, then they are referred to a CMC behavioral health clinician to receive additional services.

For those who present to the ARC intoxicated either via a self-referral, or a referral from law enforcement or other community partners, they will be offered a safe space to achieve sobriety. Once sober, an assessment and additional care services will be offered, based on need.

In addition to mental health and substance use treatment, the Homeward Bound Initiative will aim to provide a range of additional supportive services delivered as part of case management and respite care. This may extend from addressing immediate basic needs (i.e. providing food, basic hygiene support, etc.) to providing long-term case management, housing support, and employment assistance. Depending upon the nature of the support required, these services will be delivered by ARC providers or referred out to community partners.

By addressing immediate needs and engaging consumers in SUD treatment, this should in turn facilitate engagement with mental health services also delivered by CMC. For consumers who meet criteria for the receipt of behavioral health services but are not yet ready to fully engage in treatment at the time, case management services will be provided by CMC providers to build rapport, engage the consumer, address basic needs, and provide an additional pathway to treatment for SUD or mental health treatment.

Analysis Plan

This evaluation is comprised of two distinct parts; a brief qualitative summary of the project implementation from the perspectives of the provider and evaluation team, and a quantitative summary of service provision and capacity building using ongoing service records collected by the providers delivering Homeward Bound services.

For the qualitative summary, one participant from the clinical team and one from the project team was tasked with detailing any modifications to the project, any problems or unexpected events, and any steps taken to address these events. Additionally, the participants were asked to explain any barriers and facilitators to progress of the project goals. These responses are summarized in the *Project Modifications and Factors Affecting Progress* section.

The quantitative analysis focused on the service delivery, expansion and receipt of services; the access and engagement in care amongst historically underserved groups, including individuals who are homeless, Latinx and African American populations, and those with a history of involvement with the criminal justice system.

The first part of the quantitative analysis utilized program-level data to summarize the current structure of the service, including when the clinics opened, their hours of operation, how services changed over time, and the number and type of different providers currently delivering services. Next, a summary of all individuals referred to the Homeward Bound program was

presented to examine the rate of referrals over time, including how many individuals met Proposition 47 eligibility criteria. All subsequent analysis was completed exclusively on individuals who met Proposition 47 eligibility criteria unless otherwise stated (i.e., where non-eligible consumers were used as a comparison group). This included the calculation of mean waiting times, a summary of basic demographic information, counts of the types of services received, and the mean length of treatment retention.

In the second part of the analysis referral and engagement rates of consumers from historically underserved groups was compared to the total population. In the context of this evaluation, historically underserved groups included homeless individuals, African American and Latinx individuals, and individuals who report a history of interaction with the criminal justice system. Engagement was defined as the consumer attending the first session of the program, with plans made to receive ongoing care. To evaluate the efforts to engage underserved populations, the total proportion of individuals that identify as belonging to each of these groups were reported. With regards to race/ethnicity, this was compared to population rate and the service utilization rate at San Joaquin BHS, based on the assumption the behavioral health needs across the different racial and ethnic groups would be broadly consistent. To evaluate efforts to engage individuals from these underserved groups into different components of care, engagement rates of each sub-group were compared to the remaining population using Chi-square tests.

In this evaluation analysis focused exclusively on the data collected by providers based at CMC. In future formative and summative reports, the evaluations will be extended to include data obtained from San Joaquin County BHS, and the San Joaquin County District Attorney to enable a review of the expedited referral system, and to evaluate outcomes including changes in symptoms, functioning, and recidivism.

Project Modifications and Factors Affecting Progress

A review of project modifications and factors affecting progress were explored utilizing a brief, email-based qualitative interview with two participants: one participant responsible for the day-to-day implementation of the project at CMC (the project lead) and one participant responsible for conducting the Homeward Bound evaluation (the evaluator). The findings from these interviews are summarized below:

The project lead at CMC reported two factors that affected progress of the project. First, they reported significant challenges to hiring the appropriate staff and providers with the necessary experience and background to successfully deliver the proposed services. While these positions are now filled, this resulted in delays in initial projected timelines. Second, the implementation of the Homeward Bound Initiative has coincided with a significant EMR upgrade, presenting

both challenges and opportunities. During the first 18-months of the project, data required to evaluate the services could not be extracted directly from the EMR. To address this challenge, providers at CMC have been manually collecting and inputting data into a dedicated Microsoft Excel spreadsheet. This process has been successful, but required considerable provider time and resources to maintain data collection, and has led to a greater degree of missing data than if this data had been collected via the EMR. In addition, data relating to symptom severity, treatment outcomes, service satisfaction, and details of the mental health services the consumers received beyond being referred to these services were not available for analysis. To mitigate the issue of missing data, once the new EMR is operational, the plan is to merge data collected from the EMR with data collected via the Excel spreadsheets, where possible. Going forward, the advantage of the EMR upgrade coinciding with the setup of the Homeward Bound Initiative has meant that the system will be built with the data collection requirements of the Homeward Bound Initiative in mind. Consequently, the data will be collected and structured in a way to address the primary outcomes of the project. Additionally, this means that data that has not been available for this evaluation will be available in future reports.

Regarding project modifications, changes in budget allocations, workflows, and process were implemented to improve the services offered and to better meet the needs of the consumers. In particular, these modifications included additional time and resources spent on relationship building efforts with external agencies such as hospitals, law enforcement, the judicial system, and other community partners to boost referrals rates and improve inter-agency working.

From the perspective of the evaluator, the main factor affecting progress relates to challenge of defining, measuring, and collecting data on recidivism consist with BSCC definitions. In the original plan recidivism was to be measured using existing data collected by CMC and the San Joaquin County BHS. CMC and San Joaquin BHS tracks each consumers' history of involvement with the criminal justice system via self-report. However, this question does not include a timescale and does not provide any specifics regarding the type of criminal justice involvement (e.g., being held in custody, being placed under supervision due to a previous conviction). In addition, there were instances when individuals refused to disclose their history of criminal justice involvement, leading to possible underreporting. Finally, CMC data recording systems cannot track recidivism in consumers that disengage with services, which would again lead to significantly under-reporting. To address these challenges, the evaluation team plans to source recidivism data from the San Joaquin County District Attorney. This data will represents a significant improvement to the reliability and accuracy of the recidivism data. However, this plan involves additional challenges relating to identifying the nature and appropriate source of the required data, compiling the necessary paperwork to obtain the data, and then the successful linkage of this data with the existing CMC dataset. This represents a significant expansion of work that was not achievable at the time of the completion of this report. Consequently, this data will rely on the criminal history data collected by CMC, recognizing the

inherent limitations (as mentioned above) of this data. Progress in obtaining San Joaquin County Justice Department data is currently ongoing.

Project Performance

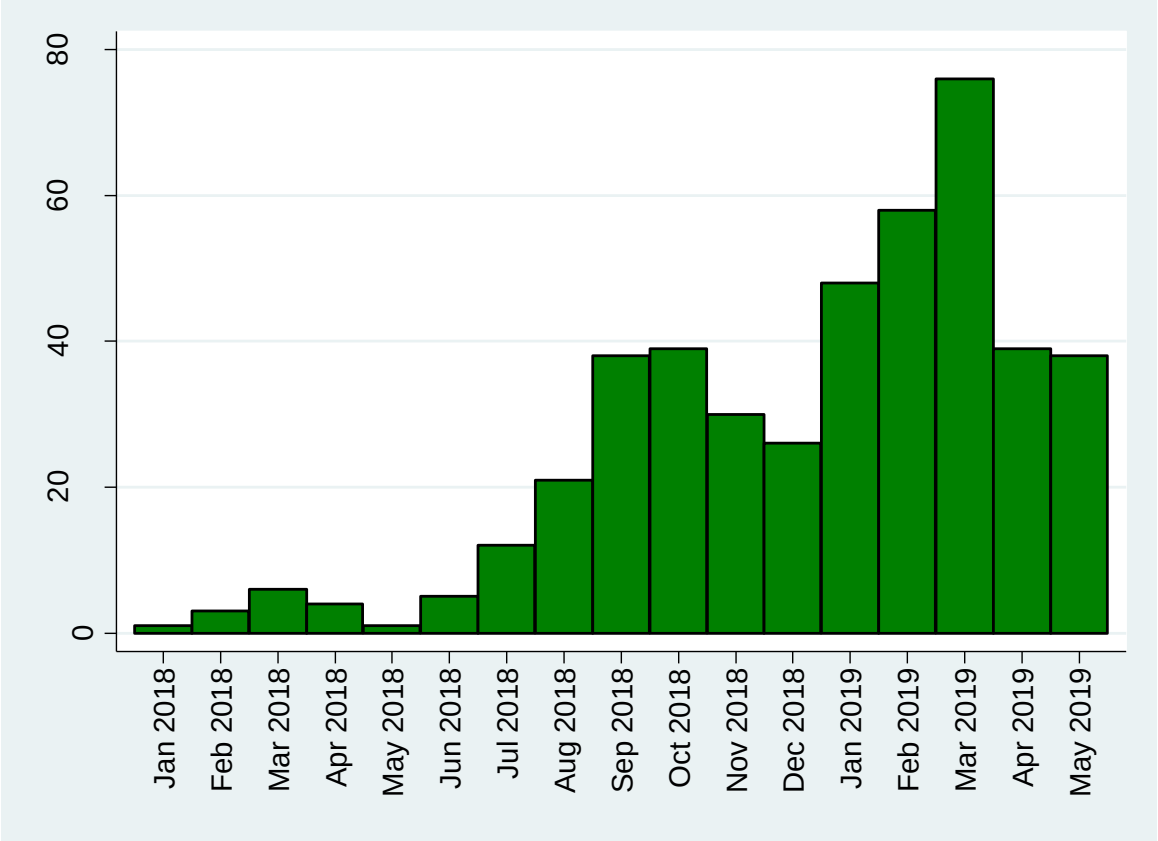
Service Delivery and Expansion over Time

The ARC based at the Waterloo Road CMC Primary Care Clinic (PCC) officially opened on 01/01/2018. The site is currently open on weekdays from 8:00am – 8:00pm, with plans to extend these hours soon.

In the preliminary phase, Homeward Bound services delivered from the Waterloo Road PCC included a full behavioral health assessment, case management, psychological therapies, withdrawal management, respite care, and MAT. In 12/2018, the range of services was expanded to include sobering beds, with clinical follow-up implemented to encourage engagement into longer term care. Consistent with the 'hub and spoke' model proposed in the initial application, since the opening of the Waterloo Road PCC three additional CMC satellite clinics have since started delivering Homeward Bound services. These include Manteca Clinic which started delivering services in 11/2018, and the Tracy Grant Line and Lodi Clinics which started delivering services in 03/2019. As of 05/2019, Homeward Bound services are delivered at four sites by three case managers, two SUD counselors, and seven providers licensed to deliver MAT.

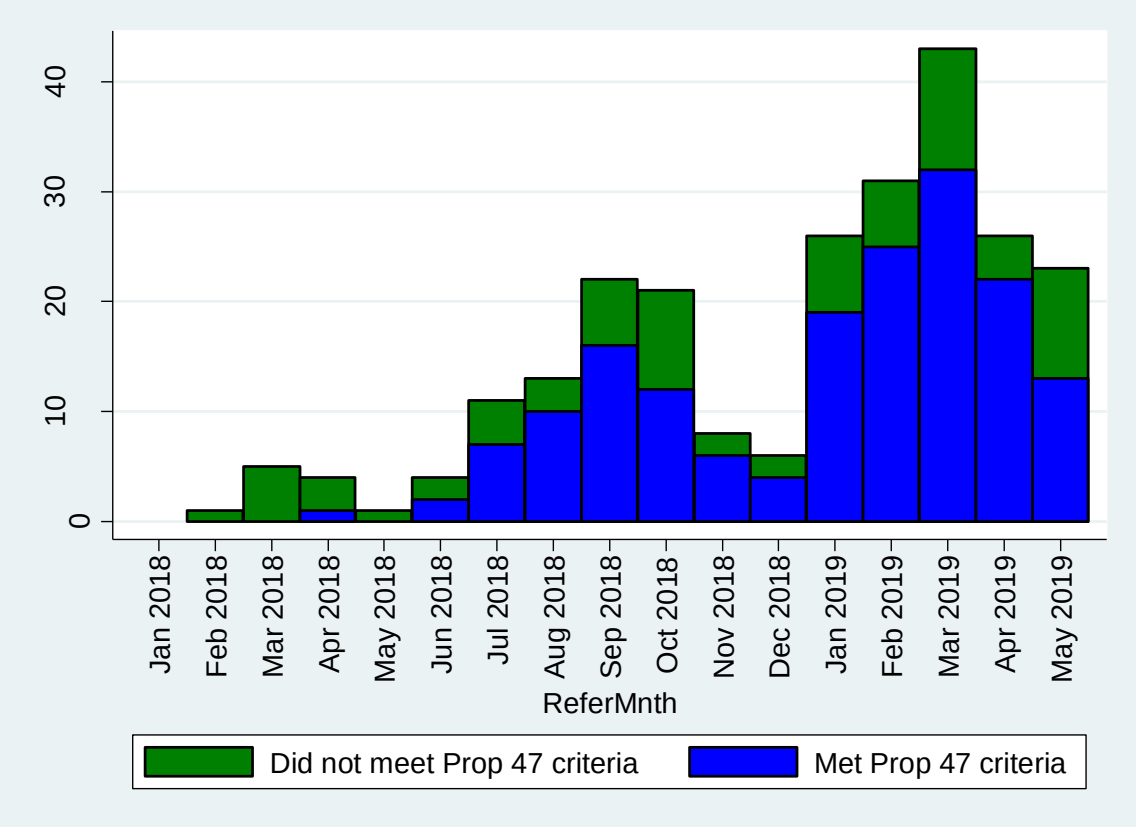
As of 05/30/2019, a total of 445 unique individuals have either been referred or self-referred to receive services delivered as part of the Homeward Bound Initiative. Between 01/2018 and 05/2019, the Homeward Bound initiative has seen a substantial increase in the number of referrals received over time, as indicated in Figure 4. Over the past 6 months, CMC have received a mean of 43.5 referrals per month (SD= 17.6). Based on the assumption that this level of recruitment will be consistent for the duration of the project, this would suggest that CMC may expect approximately 2,055 referrals and self-referrals over the program evaluation period, ending in June 2022.

Figure 4: Referral and Self-Referral Rates for Homeward Bound Services over Time.



Of those referred, 245 were enrolled into Homeward Bound services by 05/2019, with a retention rate of 55.1%. Of these enrolled consumers, 169 (69.0%) reported having a past interaction with the criminal justice system and having a behavioral health concern, consistent with the Board of State and Community Corrections Proposition 47 eligibility criteria. The proportion of consumers each month that met this eligibility criteria to date has generally remained consistent over time (see Figure 5).

Figure 5: Enrollees in Homeward Bound Services with and without a History of Criminal Justice Involvement over Time



Of the Proposition 47 eligible consumers that were either referred or self-referred to receive Homeward Bound services, 159 (94.1%) were seen within one calendar month. Of the remaining 10, five consumers were assessed within two calendar months of referral, three within three months, and two within four months. CMC has a policy of contacting individuals to schedule an appointment within 48 hours of a referral, and so the reported timelines are consistent with expectations.

The sociodemographic details of the consumers that met Proposition 47 eligibility requirements are presented in Table 1.

Table 1. Sociodemographic Data of All Individuals Who Met Proposition 47 Criteria and Received Homeward Bound Initiative Services

Sociodemographic Variables n=169			
Sex (n, %)			
	Male	123	72.8%
	Female	46	27.2%
	Other	0	0.0%
Age (mn, SD)		43.02	11.81
Race/Ethnicity (n, %)			
	White	72	42.6%
	Hispanic/Latinx	40	23.7%
	Black/African American	18	10.7%
	Asian	4	2.4%
	American Indian/Alaskan Native	2	1.2%
	Native Hawaiian	1	0.6%
	More than 1 Race	18	10.7%
	Missing/Declined	14	8.3%
Primary Substance Dependence (n, %)			
	ETOH	70	41.4%
	Opioids	28	16.6%
	Other Illicit drugs	62	36.7%
	N/A	9	5.3%
Homeless (n, %)			
	Yes	49	29.0%
	No	99	58.6%
	Unknown/missing	21	12.4%
Key: ETOH = alcohol; n = number; mn = mean; sd = standard deviation			

In total, 167 consumers with a history of involvement with the criminal justice system completed a full psychological assessment. Of these, 103 consumers were identified as having a mild-to-moderate behavioral health concern, 32 were found to have a severe and persistent behavioral health concern, and 29 were found not to have a behavioral health problem (data missing in three cases).

Of the 169 Proposition 47 eligible consumers, four consumers presented and received sobering services, and 165 presented and received a full clinical assessment to determine treatment eligibility. Additionally, nine consumers received sobering services for which their full eligibility for Proposition 47 could not be determined. Of the 13 consumers whose initial contact with

Homeward Bound services came via sobering services, seven (53.8%) agreed to complete a full assessment of their clinical need, six (46.1%) were assigned a case manager, and four (30.7%) successfully completed a full psychological assessment. However, only four consumers agreed to a clinical referral, with the other three consumers declining a referral to SUD treatment. These findings are consistent with previous data on individuals at various Stages of Change, including the precontemplation stage, where individuals may not be ready to receive treatment services (Proshaska et al., 2015). The findings suggest that while the post-sobering engagement process has been relatively successful at engaging consumers, additional attention should be paid to moving individuals through the Stages of Change. One notable success is the rate in which consumers agreed to case management services, as it may demonstrate a progression through the Stages of Change. In later evaluations the impact of this preliminary engagement on the likelihood of consumers later transitioning into more intensive treatment will be explored.

As of 5/30/2019, the total number of services delivered to Proposition 47 eligible consumers indicates that:

- 125 have received case management services
- 135 were referred to the CMC behavioral health team to receive mental health treatment.
- 84 consumers have received brief SUD treatment from a recovery counselor
- 29 consumers have received employment assistance as part of their ongoing care
- 25 consumers have consented to receive MAT

With those that were referred to receive mental health treatment from a CMC behavioral health clinician, data regarding the proportion of those that went on to successfully engage with care was not available for the current report, but will be available for subsequent evaluations. Of those who received MAT, 15 reported their primary substance used was opioids, and 10 reported their primary substance used was alcohol. Eighteen consumers (72%) started their MAT treatment within one calendar month of a referral/self-referral to Homeward Bound ARC services, one initiated treatment within two calendar months, three within three calendar months, one within four calendar months, and one within five calendar months (with one case of missing data).

At 3-months follow-up, 11 of 13 participants were continuing to receive MAT, representing a retention rate of 84.6%. This figure is towards the top end of the retention ranges previously reported in the literature, where a recent systematic review found 3-month retention rates ranged between 19-94% for MAT for opioid dependence (Timko et al., 2016). As of 05/2019, 25 Proposition 47 eligible consumers have started MAT, 18 consumers (72%) are still receiving MAT, and seven (28%) have terminated treatment. Of those that discontinued treatment, the mean length of treatment was 3.7 months (SD= 2.13 months).

Improving Access and Engagement in Underserved Populations

Of the 155 consumers who met Proposition 47 criteria that were asked about their housing status, 49 (31.6%) reported that they were homeless. Of the 49 consumers that reported experiencing homelessness during the initial assessment, 12 consumers (24.5%) received housing support through the Homeward Bound Initiative, 15 (30.6%) received housing assistance from another agency, either via direct referral from Homeward Bound providers or via self-referral, and 20 (40.8%) reported not receiving any housing support. The impact of these findings on changes in housing status will be explored in subsequent evaluations.

In addition to increasing access to behavioral healthcare to those who identify as homeless, another aim of the project is to increase access and engagement in care in Latinx and African American populations. The racial and ethnic population of San Joaquin County as reported in the US Census from 2012 to 2016, the racial/ethnic demographic data of service users who utilize San Joaquin Country BHS, and the racial/ethnic demographic data of individuals referred or self-referred to Homeward Bound Services are presented below in Table 2. Assuming the treatment needs for services delivered by the Homeward Bound initiative are broadly consistent across racial and ethnic groups, the preliminary findings suggest that Latinx individuals continue to be underrepresented in receipt of clinical services. This is consistent with the challenges experienced by San Joaquin County BHS. Secondly, it is notable that substantially fewer consumers who identify as Asian are utilizing Homeward Bound services, both relative to the population average across San Joaquin County, and in those that utilize San Joaquin County BHS. These data may suggest that additional efforts to engage Latinx and Asian populations may be needed. Additional exploration of these findings will occur in future evaluations.

Table 2: Population rate of selected Races and Ethnicities in San Joaquin County, and Service Utilization Rates across BHS and the Homeward Bound Initiative

Race and Ethnicity in San Joaquin County	Population rate across San Joaquin County[1]	San Joaquin BHS Service Utilization	Homeward Bound Service Utilization
White (non-Hispanic)	34%	38%	46%
Latinx	41%	24%	26%
Asian	15%	11%	3%
African American	7%	19%	12%
Other	4%	8%	14%

Key: BHS, Behavioral Health Services
[1]San Joaquin Population source: US Census Bureau 2012-2016.

Of the 39 Proposition 47 eligible Latinx consumers that completed an assessment, 11 (28.2%) declined services. This compares with 24 consumers (19.0%) of non-Latinx ethnicity that declined services.). This rate of refusal was broadly comparable in those that identified as African American, relative to those who identified as belonging to other racial or ethnic groups (5 of 17, 29.4%, relative to 30 of 148, 20.3%). The sample sizes reported are too small for meaningful statistical comparisons, but will be explored in subsequent evaluations.

Reducing Recidivism and Reconviction Rates through Engagement in Care

In addition to improving access to services for individuals who report a history of involvement with the criminal justice system, another important component in reducing recidivism is subsequent engagement in treatment. A comparison of the rates of engagement in different types of Homeward Bound services across individuals is presented in Table 3.

Table 3: A Comparison of the Engagement Rate Homeward Bound Services for Proposition 47 Eligible and Ineligible Consumers

	Engaged vs. Did Not Engage in Services				χ^2	p
	Engaged		Did not Engage			
	n	%	n	%		
Referral to BHS services					0.423	0.516
Proposition 47 eligible consumers	130	79.1%	35	21.2%		
Proposition 47 ineligible consumers	61	82.4%	13	17.6%		
Engagement in Case Management					1.48	0.223
Proposition 47 eligible consumers	124	75.2%	41	24.9%		
Proposition 47 ineligible consumers	50	67.6%	24	32.4%		
Engagement with recovery counselor					0.504	0.478
Proposition 47 eligible consumers	84	50.9%	81	49.1%		
Proposition 47 ineligible consumers	40	54.1%	34	46.0%		
Engagement with MAT					2.91	0.088
Proposition 47 eligible consumers	25	15.2%	140	84.9%		
Proposition 47 ineligible consumers	18	24.3%	56	75.7%		

Of the 165 enrolled consumers that reported a history of involvement with the criminal justice system, 35 refused a referral (21.2%), compared to 13 of 74 consumers that did not report a criminal history (17.6%). This difference was not statistically significant (χ^2=0.42, p=.516). Additionally, no differences in the rate of engagement in case management (Proposition 47 eligible consumers: 41 of 165 consumers, 24.9%; relative to 24 of 74 non-Proposition 47 eligible consumers, 32.4%; χ^2=1.48, p=.223), or treatment with a recovery counselor (Proposition 47 eligible consumers: 84 of 165 consumers, 50.9%; relative to 40 of 74 non-Proposition 47 eligible consumers, 46.0%; χ^2=0.50, p=.478) was detected between individuals that did and did not report a history of involvement with the criminal justice system. With regards to MAT, there was a trend suggesting that a higher proportion of individuals without a history of involvement in the criminal justice system engage in this form of treatment, relative to those that do have a history of involvement in the criminal justice system (Proposition 47 eligible consumers: 25 of 165, 84.9%, relative to 18 of 74 non Proposition 47 eligible consumers, 24.3%; χ^2=2.91, p=.088). These findings suggest that while individuals who report a history of involvement in the criminal justice system may be equally likely to engage in Homeward Bound services such as case management and brief withdrawal management, they may be somewhat less likely to engage in MAT. However, due to missing data, small sample sizes, and the lack of a statistically significant result at $p<0.05$, in the case of MAT, considerable caution should be exercised in drawing firm conclusions from this data. In subsequent analyses where data will be extracted directly from CMC, it is anticipated that there will be fewer missing data and larger sample sizes, which may provide more accurate estimates.

Goals and Objectives Achieved

Over the past 17 months, CMC, San Joaquin County BHS, and the Homeward Bound Initiative's community partners have met a number of their early goals and objectives. The primary site was successfully opened with all key personnel recruited. Respite care, case management, brief withdrawal management from a trained recovery counselor, and MAT are now available to residents of San Joaquin County, based on need and regardless of an individual's ability to pay. The service has successfully expanded from the primary site (Waterloo Road PCC) to satellite clinics (Manteca, Tracy Grant Line and Lodi PCCs), consistent with the proposed "hub and spoke" model. Over past 17 months, CMC has received a large number of referrals, with a notable spike in summer 2018 and then a second spike in early 2019, as outreach efforts with external agencies were expanded. Referrals have steadily increased over the duration of the project, and based on current projections, this could result in approximately 2,000 referrals by June 2022. Given the known barriers to engaging individuals with SUD in treatment (i.e. Palmer et al., 2009) preliminary findings of rates of successfully enrolled individuals is encouraging.

Of those consumers receiving treatment via the Homeward Bound Initiative, the majority report having a criminal history (69%), consistent with Proposition 47 eligibility criteria. Once referred, 94% were assessed within 1 month, and of those referred to receive MAT, 72% start within 1 month of a referral. Due to limitations in the data, at present it is not possible to determine the proportion of individuals that are seen within the 10 business day recommendations (California Department of Managed Healthcare, 2019). However, this will be explored in subsequent evaluations.

Many of these consumers have subsequently engaged in a range of services including case management, withdrawal management, respite care, and MAT. Preliminary evidence suggests that once engaged in these services, short-term treatment retention (i.e., 3 months) is high. Finally, in subsequent evaluations the impact of these interventions on symptoms, functioning, and recidivism outcomes will be evaluated as follow-up data becomes available. These early findings suggest that the project is successfully working towards two of its four primary goals, namely to reduce systemic gaps which lead to the underutilization of mental health services (Goal 1), and to reduce gaps in the SUD continuum of care (Goal 3).

Preliminary findings regarding the impact of sobering facilities and the pathway from sobering to comprehensive SUD treatment are mixed. One notable success of the project is the high proportion of individuals that originally present for sobering services, subsequently agree to an assessment, and engage in receive case management services (53.8% and 46.1% respectively). This represents a significant advance compared to other models where no post-sobering follow-up is conducted. However, the evidence to date suggests that this does not appear to have led to engagement in either MAT or psychological treatment with a recovery support counselor. It is important to note that the initiation of the sobering stations was later in the course of project development (starting in 12/2018) and sample size is small (n=25). Furthermore, given the sobering service has only been operational for 5 months, it is unclear if this low engagement rate is just consistent with individuals with SUD being in the pre-contemplation phase of treatment. The engagement rate of consumers who present via sobering services will be explored in future evaluations.

With regards to the second goal of the project, namely, to improve access to behavioral health services for underserved groups, some notable preliminary successes are evident. First, while the initiative is not exclusively designed to serve individuals with a history of involvement in the criminal justice system, a high proportion of those receiving services do report a criminal history (69%), indicating the project is successful at engaging this traditionally underserved group. Second, a high proportion of consumers meeting Proposition 47 eligibility criteria report experiencing homelessness (29%), suggesting outstanding engagement with community partners who specialize in providing services for homeless individuals. Furthermore, over half of these consumers are receiving housing support either via Homeward Bound services, or

through external agencies (55.1%). Once follow-up data is available, we will explore the impact of this support on homelessness in Homeward Bound consumers.

More challenging has been increasing engagement across different racial and ethnic groups, assuming the need for Homeward Bound services across these groups is somewhat similar. As highlighted in the original proposal, the proportion of Latinx consumers who utilize San Joaquin County BHS is significantly lower than the San Joaquin population average (24% of BHS consumers are Latinx, relative to the San Joaquin population of 41%). The preliminary findings presented here suggest that the Homeward Bound Initiative is experiencing comparable levels of under-engagement (26% of Proposition 47 eligible consumers reporting being of Latinx ethnicity). Based on the feedback from CMC providers it is possible that at least part of this difference may be attributable to a greater number of Latinx consumers refusing to answer questions regarding their race and ethnicity. However, even factoring this into consideration engagement with Latinx populations appears relatively low. Additionally, the proportion of consumers of Latinx ethnicity who were assessed but declined services was slightly higher relative to other racial and ethnic groups. These differences were evident despite 10 of the 15 members who deliver SUD services at CMC being Spanish speaking (67%); translation services being available where necessary; CMC's historical track record of providing physical, behavioral, and social care to migrant farm workers and their families dating back to the 1960's; and extensive current outreach efforts. One example of such outreach efforts include a questionnaire distributed to the local community to better understand the needs of the population. Notably, a number of individuals of Latinx ethnicity initially requested additional information, but when called back either declined to engage or denied requesting such information. The engagement rates reported were calculated on relatively small sample sizes, so at this stage no firm conclusions can be drawn. Nevertheless, these findings suggest that even more extensive outreach efforts to engage a greater number of people of Latinx (and Asian) race and ethnicity may be merited.

Regarding the final goal, to "Reduce conviction rates and recidivism of individuals with behavioral health disorders", outcome data were not available. As a result, progress toward this goal could not be determined at this time. In future evaluations, outcomes data collected by CMC will be used in conjunction with data available from the San Joaquin County Justice Department, which will enable the evaluation of treatment impact on symptoms, functioning, and recidivism. However, based on the data available for this evaluation, there is evidence of early success in engaging a high proportion of individuals that report a history of involvement in the criminal justice system. Additionally, once in contact with services, a high proportion of these individuals go on to engage in treatment.

Overall, the formative evaluation of the Homeward Bound Initiative as detailed in this report suggests that the program is successfully delivering a wide range of services to a growing number of consumers, and successfully addressing previous gaps in San Joaquin County's

behavioral healthcare system. In particular, the program has been highly successful in engaging previously underserved groups such as individuals with a history of involvement in the criminal justice system, and individuals who are homeless. Future efforts to engage consumers of Latinx and Asian race and ethnicity may be warranted. Ongoing data collection and linkage activates will enable an evaluation of projects which focus on improving symptoms, functioning, and reducing recidivism.

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