The San Joaquin County Homeward Bound Initiative

California Board of State and Community Corrections (BSCC)
Formative and Outcomes Evaluation Final Report
Executive Summary

Background
The main aims of the Homeward Bound Initiative include: 1) improving access and engagement in behavioral healthcare amongst residents of San Joaquin County, 2) increasing behavioral healthcare utilization amongst historically underserved groups, 3) reducing convictions and recidivism, 4) improving consumer outcomes, and 5) delivering services with a high degree of consumer satisfaction. The Initiative aimed to achieve these goals by delivering a host of services including respite care, case management, psychotherapy, sobering services, substance use disorder (SUD) counseling, and medication-assisted treatment (MAT). These services were 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 in collaboration with San Joaquin County Behavioral Health Services (SJCBHS). These services were accessible via a multitude of pathways and were 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, high levels of treatment satisfaction amongst consumers, and reduced convictions and recidivism amongst those that receive care. The current report details the preliminary results of the Homeward Bound Initiative four years into the five-year project period.

Major Findings
Over the past four years, the Homeward Bound Initiative has continued its progress towards meeting the project goals and objectives. Between August 2018 – July 2021 994 unique Proposition 47 eligible individuals were enrolled in the Homeward Bound Initiative. Of those, 976 consumers have received mental health services, 569 have received SUD counseling, 322 have received MAT, and 777 have received a primary care appointment. In total, 11.47% of consumers identified as Black/African American, which is an over-representation relative to San Joaquin County population estimates. However, Asian and Hispanic/Latinx consumers were under-represented. To date, the program has been highly successful at engaging consumers who identify as homeless (n=284, 21.88% of the sample). Once engaged in care, individuals from these historically underserved groups engaged and remained in substance use disorder care at levels at least comparable to those who report not being homeless, and other racial and ethnic groups. However, consistent with the broader literature, disparities in access to MAT appear to be evident, with a lower proportion of Black/African American individuals initiating MAT. The 36-month recidivism rate from the point of release from prison or placement on supervision amongst Homeward Bound consumers was found to be 4.66%. This reconviction rate should be considered very low, although, due to the nature of the program initiation, the unique case-mix of consumers that elect to receive such services, and the limited period for follow up direct comparisons with recidivism rates published in the literature cannot be drawn.
Additionally, 12-month and 24-month recidivism rates from the point of Homeward Bound treatment initiation were found to be 8.1% and 15.4% respectively, which also appear low. Importantly, Homeward Bound consumers reported clinically and statistically significant reductions in depressive symptoms after one month of enrolling in Homeward Bound services, with further reductions evident the longer they remained in care over time. Additionally, there was some tentative evidence to suggest that ongoing engagement in MAT may reduce recidivism as measured over a 24-month period. Finally, amongst the 337 consumers assessed, satisfaction with the care delivered by the Homeward Bound Initiative was remarkably high, with 70.5% of consumers reporting the highest level of satisfaction possible, and 92.5% reporting at least moderately high level of satisfaction.

The successes of the Homeward Bound Initiative are particularly notable given the backdrop of the coronavirus disease-2019 (COVID-19) and the subsequent shelter-in-place mandates that significantly impacted consumer needs, the delivery of services, and the effectiveness of collaborations between other community agencies.

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 with a criminal justice history. These findings suggest that the Homeward Bound Initiative may represent an important step towards addressing a significant gap in the San Joaquin County Behavioral Health System-of-Care, delivering services in a manner that is successfully engaging historically underserved groups, improving outcomes, and providing services with a very high degree of consumer satisfaction.
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Project Description

The Homeward Bound Initiative represents a significant expansion of community-based behavioral health services, designed to improve population-level behavioral health outcomes for the residents of San Joaquin County. The overarching goal of the Homeward Bound Initiative was to improve access to substance use and mental health services for county residents with mild-to-moderate behavioral health concerns by expanding services and increasing low-barrier pathways to care. The program emphasizes supporting vulnerable and underserved populations, including 1) non-serious, non-violent offenders with trauma or other mental health concerns, 2) high-risk individuals with substance use disorders (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 focused 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 service referrals via community partners (e.g., Stockton Shelter for the Homeless, St. Marys’ Dining Room, etc.), emergency services, San Joaquin County Behavioral Health Services (SJC BHS), law enforcement, the county court system, CMC primary care, and self-referral. If the individual accesses CMC services while intoxicated, they are offered sobering services, which consists of sobering beds available on the premises. Once sober, or if they access services when not intoxicated, they are offered a brief screening assessment to identify treatment needs, in addition to access to respite services to address any immediate basic needs (e.g., thirst, hunger, hygiene). In the event of a positive screen, or based on the clinician’s clinical judgment, the individual is offered a full behavioral health assessment, followed by services that 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 are also 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 SJC BHS. Figure 2 depicts how ARC services fit within the broader context of available care delivered under the Homeward Bound Initiative. When an individual with a severe mental health condition engages with services at CMC, they receive an expedited referral to SJC BHS including a “warm hand-off,” with details from the CMC assessment passed on to SJC BHS to minimize any duplication in assessments or procedures. In cases where a screening or full assessment at SJC BHS takes place and the individual is deemed to be experiencing a mild-to-moderate behavioral health concern, the individual is referred directly to CMC with a “warm hand-off”. The goal of this pathway is to minimize barriers to appropriate care and improve access and engagement to appropriate treatment, which in turn should improve outcomes.
Figure 2: The Homeward Bound Initiative Full System of Care

Development of the “Hub and Spoke” System of Care to Expand Homeward Bound Services Across San Joaquin County

Key to the county-wide expansion of Homeward Bound services is the implementation of a “hub and spoke” model of service delivery. A visual representation of this model is presented in Figure 3. Under this proposal, the implementation of the Homeward Bound Initiative was designed to follow three discrete stages. First, CMC develops the primary “hub” site for Homeward Bound services situated in the county capital, Stockton. This site is co-located with the CMC Waterloo Road primary care site. Once established, the next phase of the plan involved expanding services to satellite CMC clinics across San Joaquin County (the “spokes”). These spokes include the provision of clinical services in large towns spanning the geography of San Joaquin County: Lodi, Tracy, and Manteca. Under this model, consumers could either be initially seen at the hub site and then referred out to one of the satellite clinics at the convenience of the consumer, or else they could be referred into the system of care at the spoke site directly. The spoke site typically utilizes the technical expertise and additional resources of the hub to best respond to the needs of the consumers’ treatment. In the third and final stage of the proposal, CMC aim to develop a larger, stand-alone site in Stockton that...
can provide additional specialty services such as short-term residential care. The implementation of this final phase is currently ongoing.

Figure 3: Visual Representation of the “Hub and Spoke” Model of Homeward Bound Service Delivery Across San Joaquin County

Legend: ⭐️ = Hub Site, ⭐️⭐️ = Spoke Site.

Defining Mild-to-Moderate and Severe Mental Health Concerns

One component of the Homeward Bound Initiative involves a direct referral pathway between CMC and SJC BHS to ensure each consumer receives the appropriate level of care for their behavioral health concern promptly. Individuals determined to have a 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 SJC 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 six 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.

Reducing Convictions amongst Consumers with a Criminal Justice History
In addition to improving care access and the range of services available, one of the key aims of the project is to reduce recidivism amongst individuals with behavioral health disorders. For this study, recidivism has been defined in multiple ways. Consistent with the requirements of the California Board of State and Community Corrections (BSCC) Proposition-47 grant, in the first part of the analysis recidivism has been defined as follows:

“The 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.

Due to the inconsistent period between consumers’ release from custody or placement on supervision and their initiation of their Homeward Bound treatment, in a secondary analysis recidivism was defined as follows:

The conviction of a new felony or misdemeanor committed within a specified period after the initiation of Homeward Bound treatment, as defined by the baseline assessment date.

Goals and Objectives

The Homeward Bound Initiative combines project goals as stated in the “Project Evaluation Plan” section of the Proposition 47 grant proposal, submitted to the BSCC 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 SUDs.
- 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 SUD 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 SUD treatment services, ensuring that providers are trained in effective treatment practices, and are assigned to deliver services.
• To provide effective SUD 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 SUD; 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 SUD and reduce the rate of recidivism in this population.

Logic Model
The logic model for the formative and summative evaluation of the Homeward Bound Initiative is detailed in Figure 4. The figure details the original aims of the project, the proposed activities designed to meet those aims, a measure of how successful the project was at producing those activities ("outputs"), and the impact of the activities delivered (the "outcomes"). The "beneficial impacts" column lists the wider, system-level changes one may hope or expect to see based on the success of the previous components of the logic model as outlined.
Figure 4: Logic Model of the Homeward Bound Initiative

<table>
<thead>
<tr>
<th>1. PROJECT AIMS</th>
<th>2. ACTIVITIES</th>
<th>3. OUTPUTS</th>
<th>4. OUTCOMES</th>
<th>5. BENEFICIAL IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Reduce systemic gaps which lead to the under-utilization of mental health services.</td>
<td>2.1. Implement community-based Assessment and Respite Center (ARC).</td>
<td>3.1. Number of service users screened, assessed and treated for mental health concerns and substance use disorders, including with MAT management, MAT, case management, and/or behavioral health treatments.</td>
<td>4.1. Significantly increase exceptional engagement in behavioral healthcare.</td>
<td>5.1. Reduce readmissions/discharge from services.</td>
</tr>
<tr>
<td>1.2. Improve access to mental health services for underserved groups.</td>
<td>2.2. Develop policies, practices, and protocols to deliver treatments for individuals with mild-to-moderate mental health concerns and/or substance use disorders.</td>
<td>3.2. Availability of services—hours open, number of providers, waiting times and services available.</td>
<td>4.2. Significantly reduce disparities in behavioral healthcare utilization.</td>
<td>5.2. Reduce the number of individuals with untreated mental illness.</td>
</tr>
<tr>
<td>1.3. Reduce gaps in the substance use disorder continuum of care.</td>
<td>2.3. Add community providers to implement practices for substance use disorder treatments, including with MAT management and MAT.</td>
<td>3.3. Total resources generated from behavioral health community services.</td>
<td>4.3. Significantly reduce booking, conviction and readmission rates.</td>
<td>5.3. Reduce the number of individuals with untreated mental illness.</td>
</tr>
<tr>
<td>1.4. Reduce recidivism rates and risk of individuals with mental health disorders.</td>
<td>2.4. Create direct referral pathways between CMC, BHS and community providers.</td>
<td>3.4. Number of service users referred between CMC and BHS, and stipend subsequently engaged in treatment.</td>
<td>4.4. Provide services to high levels of service satisfaction.</td>
<td>5.4. Reduce number of violations, bookings, new charges filed against individuals, non-violent offenders with behavioral health concerns.</td>
</tr>
<tr>
<td>1.5. Develop respite, case management and housing supports for target groups.</td>
<td>2.5. Develop respite, case management and housing supports for target groups.</td>
<td>3.5. Significantly improve functioning in those who receive comprehensive services.</td>
<td>4.5.</td>
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Key: ARC, Assessment and Respite Center; BHS, Behavioral Health Service; CMC, Community Medical Centers; MAT, Medication-Assisted Treatment.

Modifications to the Delivery of Homeward Bound Services because of the COVID-19 Pandemic

At the beginning of the coronavirus disease – 2019 (COVID-19) pandemic, states began to implement shelter-in-place orders to reduce the rate of transmission. By mid-March 2020, CMC had implemented a significant restructuring of its services to safeguard the health of providers and consumers, and to comply with shelter-in-place mandates. To understand the scope of these amendments, and their impact on the evaluation, members of the evaluation team interviewed the CMC project lead on two separate occasions. The first took place on April 21, 2020, not long after the protocol changes had been implemented. In this meeting the focus was on understanding the immediate changes that had taken place, and the potential short-term impact of the pandemic on the project. The second interview took place on October 1, 2020, to better understand the medium-to-long term impacts of the pandemic and the service changes, including the period from July to August 2020, when COVID-19 reported cases were at their first peak in San Joaquin County. The findings of these interviews are detailed in the results section below.
Methods/Data Collection

Study Design
This report represents a formative and summative evaluation of the Homeward Bound Initiative. The outcomes evaluated in this report follow directly from the goals outlined in the Goals and Objectives section of this document and were outlined in detail in Section 4 of the San Joaquin County Homeward Bound Initiative Evaluation Plan, beginning on page 25. Those outcomes are listed below:

1) Improvements in Access and Engagement in Care
2) Reducing Disparities in Behavioral Healthcare Services Utilization
3) Reducing Criminal Justice Bookings, Convictions, and Recidivism
4) Delivering High Levels of Consumer and Provider Satisfaction with New Models of Care
5) Functional Improvements Following Treatment

Target Population
Eligible participants included all adults who accessed services delivered through the Homeward Bound Initiative who reported having a criminal justice history. In the current report, the analysis included all service data collected from the point when the Homeward Bound program’s data was incorporated into the CMC electronic medical record (EMR), from 08/01/2018 until 7/31/2021. This includes all eligible individuals who were either referred or self-referred to one of the Homeward Bound program’s hub or spoke sites to receive care, or utilized the sobering facilities during a period of intoxication.

Data Collection Procedures
If at the point of initial contact with Homeward Bound services the consumer did not have an EMR within CMC’s system, one was 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 completed the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Scale (GAD-7). During this, or any subsequent appointments consumers with a past or current SUD were encouraged to complete the Treatment Needs Questionnaire (TNQ). If this screening form identified any intravenous drug use, prior receipt of MAT, use of cocaine or benzodiazepines, or alcohol misuse, then the consumer was referred to complete a full behavioral health assessment. During that assessment, the consumer was 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 reported a history of alcohol problems. The individual was then 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 completed the Office-Based Opioid Treatment Stability Index (OBOT) at the initiation of treatment, and then at monthly intervals to review patient stability and recovery outcomes. As part of ongoing care, all consumers completed the PHQ-9 at the start of each appointment. When consumers reported experiencing anxiety, they were instructed to complete the GAD-7, based on clinical need. These data were used to both inform care, and track symptom progression over time. All the data was stored within the CMC EMR, and at each reporting stage, this data was extracted by CMC analysts and provided to the evaluation team for analysis.

Data Collection Procedures for Recidivism Data
In the original proposal, convictions data was due to be sourced through the State of California Department of Justice records. However, due state policy changes, Health Insurance Portability and Accountability Act (HIPAA) requirements, to and significant barriers concerning release of information requests this approach was not considered feasible for this project. Consequently, in January 2019 CMC and the evaluation team modified their data collection practices in the following ways. First, as part of the intake assessment in addition to asking consumers whether they had a criminal history they were also asked for the most recent date of release from prison or placement on supervision. This data was then later extracted from the intake assessment form and added to a dedicated excel sheet used to track convictions data. This approach was considered feasible, given the evidence supporting the validity of self-reported arrest data (i.e., Daylor et al., 2019).

To track subsequent convictions, CMC staff manually checked the Superior Court of San Joaquin County public court records for consumers every 12 months post the baseline assessment. These records were available at the following address: https://cms.sjcourts.org/fullcourtweb/mainMenu.do?&PageSize=0&Index=0. In cases where the consumer was convicted of a new felony or misdemeanor post assessment, this information was added to the convictions data excel sheet. This check was completed three times over three years for each consumer, and then again at the end of the project.

To link both the recidivism and EMR datasets, an analyst based at CMC assigned all consumers with a unique identification (ID) number. These datasets were then both submitted to the evaluation team separately via the secure, HIPAA-compliant MyResearch system, hosted by the University of California, San Francisco. Once the evaluation team received the datasets, they were merged via the anonymized unique identifiers.

Measures
In the current evaluation the analysis will focus on the data from the following sources:
**Patient Health Questionnaire (PHQ-9)**

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) is a brief, nine-item instrument designed to diagnose depression and measure depression severity. Items concern different features of depression such as anhedonia, depressed mood, and loss of appetite, and depression is diagnosed by a PHQ-9 score of 10 or greater. As a severity measure, the scale ranges from 0-27, with a higher score indicating more severe depression. A score of 0-4 is considered to indicate no depression, 5-9 mild, 10-14 moderate, and 15-19 moderate-severe and 20-27 severe depression. In this evaluation, all consumers will complete the PHQ-9 at the point of assessment, and then at each appointment until the point of discharge from Homeward Bound Services.

**Generalized Anxiety Disorder Scale (GAD-7)**

The Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006) is a seven-item questionnaire designed to both diagnose and measure the severity of anxiety the responder has experienced over the past two weeks. Items relate to symptoms such as uncontrollable worrying, irritability, and restlessness. Each item is rated on a scale of 0 (“not at all” bothered) to 3 (“bothered “nearly every day”). A score of 1-4 is considered to indicate minimal anxiety, 5-9 mild, 10-14 moderate, and 15-21 severe. The authors suggest a score of 10 or higher as a reasonable cut-off point for identifying cases of GAD. The scale will be administered by all consumers at the point of assessment amongst those who present with anxiety, as determined by the assessing clinician.

**The Drug Abuse Screening Test (DAST)**

The Drug Abuse Screening Test (DAST; Skinner 1982) is a 20-item self-report questionnaire designed to measure the degree of problems the consumer experiences as a consequence of their drug use. Each item requires a dichotomous yes/no response and includes items relating to interpersonal conflicts, occupational problems, criminal activities, side effects, guilt, addiction, and treatment-related to drug use. American Society of Addiction Medicine (ASAM) placement criteria suggest that a score ≤ 5 indicates a low-level impact of drug abuse, 6-10 indicates moderate, 11-15 indicates substantial, and ≥ 16 indicates a severe impact, with the individual likely requiring intensive treatment services. Consumers will complete the DAST at CMC at the intake assessment.

**The CAGE Substance Abuse Screening Tool**

The CAGE Substance Abuse Screening Tool (Ewing, 1984) is a four-item questionnaire used to identify responders who may potentially be misusing alcohol. Each item requires a dichotomous yes/no response and asks the responder whether they have ever felt that they should cut down on their drinking, if they get annoyed because people criticize their drinking, if they have felt guilty regarding drinking, or if they have ever had a drink first thing in the morning to alleviate symptoms of alcohol addiction or a hangover. The typical cutoff used for the CAGE is two positive answers. Consumers will complete the CAGE in CMC at the intake assessment.
Client Satisfaction Questionnaire (CSQ-8)
Consumers’ satisfaction will be assessed using the CSQ-8 (Larsen et al., 1979). The CSQ is an eight-item Likert questionnaire where responders rate each item from 1-4, with a higher score representing greater satisfaction with treatment. The CSQ-8 has been extensively used in various healthcare settings and has been validated for use in SUD populations (Wilde and Henriks, 2005). Consumers receiving services at SJCBHS will complete the CSQ-8 during their full assessment. Consumers receiving care at CMC will complete the CSQ-8 at the point of assessment.

Services Delivered by the Homeward Bound Initiative
Components delivered as part of the Homeward Bound Initiative included MAT, withdrawal management, sobering, case management, respite services, mental health treatment, and SUD counseling from a recovery counselor. The services delivered were 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 were 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 administered 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 is an effective intervention in the 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 on a one-to-one basis. Both treatment formats are delivered by qualified recovery counselors, and the focus of these treatments is to support the individual in their recovery from SUD. If either during the assessment or ongoing SUD treatment the consumer is identified as having additional mental health needs, then they are referred to a CMC behavioral health clinician where they can receive additional services.

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

In addition to mental health and SUD treatment, the Homeward Bound Initiative provided a range of additional supportive services delivered as part of case management and respite care. This included 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 were delivered by ARC providers or referred out to community partners.

Addressing immediate needs and engaging consumers in SUD treatment was considered critical to facilitate engagement with mental health services also delivered by CMC. For consumers who meet criteria for the receipt of behavioral health services but were not yet ready to fully engage in treatment at that time, case management services were provided by CMC providers to build rapport, engage the consumer, address basic needs, and provide an additional pathway to treatment for SUD and/or mental health treatment.

**Analysis Plan**

The analysis detailed in the current report comprised of two discrete sections, which include the formative and the outcomes evaluation. The formative evaluation focused on the following areas: summarizing the impact of COVID-19 on program implementation, detailing the number of and types of services delivered over time, and summarizing the sociodemographic and clinical presentation of the sample to ensure the program has been successful at engaging the intended target population.

The impact of COVID-19 on program delivery was explored utilizing semi-structured qualitative interviews with program leadership in a longitudinal design to capture both the short- and longer-term impacts. The interviews were recorded, with the main findings described in brief narrative summary. Next, a review of the implementation and expansion of Homeward Bound services was conducted. This included utilizing basic summary statistics to detail the number of consumers enrolling into different components of care over time, and the expansion of services across the hub and spoke sites. Additionally, summary statistics detailing consumer engagement in different Homeward Bound services and 6-month retention rates were examined, with retention calculated as the difference between the month of their first appointment, and the last appointment date recorded for that specific intervention in the consumers EMR.

The sociodemographic details of the sample, including consumer age, race and ethnicity (combined as single variable), gender, and housing status, were examined utilizing simple summary statistics, based on consumers’ self-report at the baseline assessment stage. Finally, the clinical presentation of the sample at the baseline stage was examined using the PHQ-9 to capture depressive symptoms, the GAD-7 to measure symptoms of anxiety, the DAST to record the degree of problems experienced related to drug use, and the CAGE to record the degree of problems related to alcohol use.

The outcomes evaluation focused on the following areas: improve behavioral healthcare utilization amongst underserved groups, summarize the recidivism and reconviction rates.
Homeward Bound consumers, provide services to a high degree of consumer satisfaction, and improve clinical outcomes amongst Homeward Bound consumers over time.

In the first part of the summative evaluation, referral, and engagement rates of consumers from historically underserved groups were compared to the total population. In the context of this evaluation, historically underserved groups included homeless individuals, Black and Latinx individuals. 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 and ethnicity, this was compared to population rate and the service utilization rate at SJCBHS, 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.

Analysis of behavioral healthcare service utilization among underserved populations was accomplished by examining the demographics of the consumer population, including the share of consumers in mental health treatment and SUD counseling for at least six months. We assessed the utilization of services by underserved groups by comparing the Homeward Bound Initiative’s service utilization by race and ethnicity to their respective rates within the general population.

In the analysis of consumer recidivism, this was explored in multiple ways. First, the recidivism rate was calculated based on the BSCC’s definition as a date of the offense that leads to a conviction of a new felony or misdemeanor committed within three years of release from custody or placement on supervision for a previous criminal conviction. Additionally, the reconviction rate amongst consumers both at 12- and 24-months post-enrollment was conducted, to minimize the potential impact of the variation between the point of release from custody or placement on supervision and their initiation of Homeward Bound treatment. Finally, to explore the possible impact of Homeward Bound services on recidivism rates a series of logistic regressions were performed with the number of behavioral health visits, SUD counseling visits, and MAT visits included as the independent variables, and reconviction as the dichotomous independent variable.

In the evaluation of consumer satisfaction, simple summary statistics were utilized to explore the degree of satisfaction consumers had with services, as measured using the CSQ-8. In this analysis satisfaction scores were analyzed as a single summary score, in addition to item-level analysis. Additionally, the proportion of consumers that scored at least a mean score of ‘3’ on the CSQ-8, indicating moderately high levels of satisfaction was reported.
In the final part of the summative evaluation, the analysis of functional improvements in consumers with mild-to-moderate behavioral health concerns was limited to consumers with mild-to-moderate depression. Consumers with mild-to-moderate depression were identified using the PHQ-9 questionnaire administered during the consumer’s initial assessment; we define this initial PHQ-9 as the consumer’s baseline PHQ-9 score. We assess the share of consumers receiving the PHQ-9 questionnaire in each month since their baseline month, where a consumer’s baseline PHQ-9 is indexed as month one. We also estimate the mean month-to-month change in subsequent PHQ-9 scores relative to the mean baseline PHQ-9 score using fixed-effects panel regression to control for unobserved consumer characteristics that are constant in time and correlated with PHQ-9 scores.

**Formative Evaluation - Results**

**Impact of COVID-19 on Homeward Bound Program Implementation**

In order to detail both the short- and longer-term impact of COVID-19 on the implementation of the Homeward Bound Initiative two rounds of semi-structured qualitative interviews with CMC Leadership were conducted. The first took place on April 21\textsuperscript{st}, 2020, while the second took place on October 1\textsuperscript{st}, 2020. A summary of the findings from these interviews is detailed blow.

**April 21, 2020, Meeting Between the CMC Program Lead and the Evaluation Team**

By the middle of March 2020, to minimize potential COVID-19 exposure to consumers and providers inside the ARC, CMC implemented an outdoor triaging service where consumers were screened before coming in for their appointments or assessments. In addition, many appointments that were previously conducted in-person, either on-site or in the community, were changed to be delivered over the phone. At the time, the program director suggested that this shift to telemedicine had been received well by consumers with minimal impact on service engagement.

Regarding services that were either reduced or canceled, CMC was no longer able to offer the “Shower of Love” service, which entails making showers available every Wednesday with the provision of fresh clothing. To minimize the impact of this, they started to provide “Health Kits” that included sanitary products and hand sanitizer as an alternative. Sobering services were restricted to one patient per room, which significantly reduced the service capacity. Additionally, the hours of operation were shortened from 24 hours a day to running from 8 a.m. to 5 p.m.

The CMC program lead reported a significant shift in the population served, and the reported needs of the consumers. This change was attributed primarily to four factors: 1) the reduced
hours of operation, 2) the closure of local liquor stores, 3) the change in referral pathways, and 4) the shift in need toward housing and nutritional support due to increased unemployment/lack of work, the need to be off the streets during a pandemic, and other agencies either closing or reducing services.

As stated previously, due to staffing and sanitation needs, CMC changed the hours of operation of the ARCH from 24 hours to 8 a.m. to 5 p.m. Anecdotally, the experience of the program lead was that these new hours limited access for people who normally scheduled evening appointments, or did walk-ins after 5 p.m. This was considered to represent a particular barrier to those employed during standard work hours, albeit with the impact mitigated to some extent through the expansion of telehealth services.

Additionally, CMC noticed a rise in the number of consumers seeking help with their alcohol use disorder, and greater consistency in appointment attendance amongst those who had previously been inconsistent. Some of the factors that were attributed to this included the closure of local liquor stores reducing the accessibility of alcohol, the greater flexibility afforded by the availability of telemedicine, and a decline in other competing ways consumers were able to spend their time. In response, an additional provider was brought into the MAT program to manage the increased demand. CMC were also in the process of hiring more SUD counselors to respond to the increased need.

The typical referral pathway into the Homeward Bound program experienced a significant shift because of the pandemic. The main changes included a greater number of referrals coming from emergency departments (ED), and the absence of consumers being referred from the county law courts after their closure in March. Regarding the changes in ED referrals, part of this change was attributed to the significant outreach that CMC had been conducting with local hospitals immediately prior to the start of the pandemic. However, another factor was ED personnel more actively referring housing-insecure consumers to Homeward Bound services who were either exposed to COVID-19 or were experiencing non-serious COVID-related symptoms to facilitate isolation. This was considered an important factor in the shift towards an increase in demand for housing services, relative to prior to the pandemic. Regarding the county court closures, not only did this mean a previous referral source was unavailable to the project, but it is also anticipated to reduce the proportion of the treated population that report having a criminal history, particularly those who are released from custody/placed on supervision within three years of treatment initiation. This is likely to lead to a reduction of BSCC Proposition 47-eligible consumers during this period, and the total number of consumers that could potentially meet the recidivism definition mandated by the Proposition 47 grant, as the primary outcome for the study.

One of the biggest changes was the shift from referrals for SUD needs to housing-related needs. Because CMC was one of the few programs still providing services to the community at the time, there was a higher demand for respite services and housing. Through the help of
Proposition 47 and Mental Health Services Act (MHSA) Innovation grant, the county allowed them to use hotel vouchers to house consumers. CMC has also been purchasing food, providing laundry vouchers and soap, and providing pet food—which has increased costs—and expanded the scope of CMC’s services.

**October 1, 2020, Meeting Between the CMC Program Lead and the Evaluation Team**

The evaluation team reached out to CMC again in late 2020 to get updates on how the pandemic continued to affect services and implementation. Notably, costs increased due to the need to buy equipment for staff to work from home long-term, such as laptops and cell phones. Referral pathways had also changed. The courts opened in May, resulting in a flux of court referrals beginning in September. In September, police began to refer individuals again now that more knowledge about COVID-19 and preventative measures had been disseminated. Heightened police referrals led to an increase in sobering utilization.

CMC hired more staff, all of whom specialize in addiction. Even with the additional staff, there had been staffing shortages, and an increase in staff anxiety and burnout as the pandemic continues. Many staff have children and are balancing family responsibilities with children at home full-time, and remote working. CMC offered time off to help with burnout, but many staff declined the offer because there are no travel opportunities during the pandemic. Those who did take time off did so for family obligations, and therefore were not resting, leading to further burnout. CMC opted to allow some staff to come back into the office, while maintaining distance to alleviate the double burden of working while aiding in childcare.

Consumers were initially excited to have the service remain open, but as time goes on it was noted that consumers found the situation increasingly challenging, resulting in a higher rate of relapse and increased demands upon staff. SUD patients that previously had consistent, regular appointments adjusted well to remote sessions. However, newer consumers had trouble engaging via phone. Moreover, there was an influx of consumers who were predominantly seeking housing, not treatment. Once assessments and treatment started, many of these consumers opted to leave, increasing dropout rates.

Staff has also needed to educate consumers on confidentiality and finding a safe space to engage in remote sessions. Consumers sometimes call into sessions in public or near family, compromising the confidentiality of sessions. Staff encourage consumers to find private locations, but when not available, staff document the circumstances of the session (i.e., family in earshot, etc.). Another issue with remote sessions has been making sure consumers have enough minutes on their cell phones to last a full session.

For consumers who are now going into CMC, there have been issues surrounding transportation. CMC used to utilize Lyft for consumer transportation, however in the pandemic
there has been a shortage of Lyft drivers. Furthermore, busses are limiting how many individuals can ride at a time, furthering transportation limitations.

**Impact of COVID-19 on Homeward Bound Implementation – Summary**

The service-level changes implemented at CMC due to the pandemic are anticipated to have a significant impact on the evaluation overall. First, the experiences reported by the Program Lead over both interviews indicate that a significant change in the case-mix of new consumers may be evident. In the early stages of the pandemic, it was suggested that a larger proportion of consumers who were entering into the system had significantly more housing needs—and a greater focus on addressing their housing situation—as opposed to substance use disorder needs, relative to pre-COVID consumers. In addition, a greater number of referrals were coming from EDs, but none from the county court system. These changes in the case-mix could potentially lead to significant changes in the data in terms of how consumers engage in treatment, modify treatment response trajectories, reduce the proportion of Proposition 47-eligible referrals, and impact recidivism outcomes which are of particular importance to the BSCC. In the October 2020 interview, the prolonged experience of working and living through a pandemic, and the subsequent shelter-in-place mandates, were found to lead to significant burnout among providers and increased frustration among consumers. In both cases, this could again negatively impact staff turnover, treatment engagement, and subsequent treatment outcomes. In addition, it is also important to consider the changes in services delivered both by Homeward Bound and community partners on the evaluation itself. For example, the switch from in-person appointments to telehealth may represent barriers to consumers who do not have phones, have limited minutes on their pre-paid phone plans, or frequently lose access to their phones. In addition, CMC reported that while existing consumers have managed to remain engaged in treatment, engaging new referrals via telemedicine was more challenging, suggesting that higher dropout rates during this period for new consumers might be expected. Social distancing requirements have led to a significant reduction in the availability of sobering beds, which is likely to significantly reduce the number of consumers who both receive these services, and other services, as a consequence of coming in via this pathway. The closure and restriction of services delivered by other community agencies is also likely to result in fewer needs of the consumers being met. Overall, consistent with the changes in the case-mix of consumers, these changes all have the potential to negatively impact the number of consumers who receive multiple services, unmet consumer needs, treatment engagement, and treatment outcomes. These different factors will be explored in the dataset, and, where necessary, will either be adjusted for in the analysis plan, or incorporated into the interpretation of the findings.
**Service Delivery and Expansion over Time**

Between August 1, 2018 – July 31, 2021, 994 unique Proposition 47 eligible individuals were enrolled in the Homeward Bound Initiative. The number of individuals enrolled over time during this period can be found in Figure 5. The Homeward Bound Initiative treated roughly 27.6 unique Proposition 47 eligible consumers per month. During the period depicted, there was a steady increase in the rate of enrollment over time until the start of 2021, at which point enrollment began to drop slightly. It is unclear how the backdrop of the COVID-19 pandemic has affected enrollment. The slight decrease in enrollment in 2021 could be due to people going back to work after the shelter-in-place mandate lifted, resulting in individuals having less flexible availability for treatment. Moreover, it could be a settling period after the rapid growth of Homeward Bound services in 2020 during the implementation of the hub and spoke model.

*Figure 5: Number of New Proposition 47 eligible Consumers Enrolled into the Homeward Bound Initiative over Time*

In total, 572 Proposition 47 Homeward Bound consumers enrolled in SUD counseling provided by a Homeward Bound Initiative provider. The rate of enrollment over time is presented in Figure 6. There is a gradual increase in enrollment with spikes in March 2019 and March 2020, before enrollment decreases in February 2021. As expected, this pattern mirrors enrollement in the Homeward Bound Initiative.
Finally, the mean duration of time between attending the Homeward Bound Initiative intake assessment and the start of SUD treatment by month is presented in Figure 7. The data indicate that between August 2018 – December 2018 there was a notable delay between the intake assessment and the initiation of treatment. In December 2018, SUD counseling took on average over five months to initiate from the point of assessment. However, since January 2019 this delay is notably not evident. All months have a delay of fewer than two months, with the majority having delays less than one month. The delays at the start of the project are likely to be attributable to the hiring challenges the program experienced during the initial implementation period. Once the providers were in their position and treatment capacity could be expanded, the data indicates that the Homeward Bound Initiative has been highly successful at progressing consumers into SUD care quickly from the point of assessment.
Development of the “Hub and Spoke” Model of Homeward Bound Service Delivery

A review of the development of the “hub and spoke” model to Homeward Bound care delivery is presented in Table 1. While the first consumer to be entered into the updated EMR took place on August 1, 2018, the first Homeward Bound Initiative consumer was seen in January 2018 at the Waterloo Road hub site. Since then, services were first delivered at the Lodi site in August 2018 before the broader expansion in March 2019. At the Manteca site, the first Homeward Bound consumer was served in December 2018, and in Tracy, the first consumer received services in September 2019. In January 2020, consumers from out-of-county who were originally seen at the Stockton hub site were referred to CMC sites in neighboring counties, including the cities Dixon and Vacaville in Solano County. Despite these additional sites, it is notable that almost all consumers involved in the program were served at the Hub Waterloo Road site.
Table 1: Expansion of the Homeward Bound Initiative Across Hub and Spoke Sites

<table>
<thead>
<tr>
<th>CMC Clinic Site</th>
<th>N=994</th>
<th>%</th>
<th>First Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub Site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stockton</td>
<td>916</td>
<td>92.15%</td>
<td>Jan-2018</td>
</tr>
<tr>
<td>San Joaquin Spoke Site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodi</td>
<td>8</td>
<td>0.80%</td>
<td>Aug-2018</td>
</tr>
<tr>
<td>Tracy</td>
<td>66</td>
<td>6.64%</td>
<td>Sep-2019</td>
</tr>
<tr>
<td>Other Locations</td>
<td>4</td>
<td>0.40%</td>
<td></td>
</tr>
</tbody>
</table>

Services Delivered by Community Medical Centers (CMC) to Homeward Bound Consumers

The number of different types of health appointments completed by Proposition 47 eligible Homeward Bound consumers is presented in Table 2. Overall, 976 (98.19%) consumers completed at least one behavioral health visit, 569 (57.24%) completed one SUD appointment, and 322 (32.29%) completed at least one session of MAT. Of those that received these services, consumers on average attended at least two (inter-quartile range (IQR) = 1 - 5) behavioral health visits, two (IQR = 1 - 5) SUD counseling visits, and three (IQR = 1 - 8) sessions of MAT.

In addition to the various behavioral health appointments Proposition 47 eligible Homeward Bound consumers attended, 777 (78.17%) also attended primary care visits. Individuals that attended primary care visits on average attended 5 (IQR = 2 - 11) appointments each. Due to the nature of the data, we are unable to determine what proportion of consumers were existing CMC primary care consumers, and what proportion are new consumers that were enrolled into CMC primary care via the ARC. Regardless, engagement in CMC care via either pathway should be considered important. If the Homeward Bound Initiative is leading to new consumers engaging in primary care via the ARC, then the subsequent increase in billable primary care services represents a component of the sustainability plan for the ARC. If the Homeward Bound Initiative is serving existing CMC consumers, then given the previous gaps in SUD continuum of care across San Joaquin County, this is likely to be addressing an important previously unmet need amongst CMC consumers.
Table 2: Number of Health Appointments

<table>
<thead>
<tr>
<th>Variable</th>
<th>N of Consumers</th>
<th>% of Consumers</th>
<th>Median (IQR)</th>
<th>Range</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Visits</td>
<td>976</td>
<td>98.19%</td>
<td>2 (IQR = 1 – 5)</td>
<td></td>
<td>1</td>
<td>61</td>
</tr>
<tr>
<td>SUD Counseling Visits</td>
<td>569</td>
<td>57.24%</td>
<td>2 (IQR = 1 – 5)</td>
<td></td>
<td>1</td>
<td>72</td>
</tr>
<tr>
<td>MAT Appointments</td>
<td>322</td>
<td>32.39%</td>
<td>3 (IQR = 1 – 8)</td>
<td></td>
<td>1</td>
<td>55</td>
</tr>
<tr>
<td>Primary Care Appointments</td>
<td>777</td>
<td>78.17%</td>
<td>5 (IQR = 2 - 11)</td>
<td></td>
<td>1</td>
<td>88</td>
</tr>
</tbody>
</table>

The six-month retention rates of consumers served between August 2018 and January 2021 across different intervention types are presented in Figure 8. Of the 632 consumers who received behavioral health services, 217 (34.34%) were still receiving services at least six months later. Of the 509 individuals who received SUD treatment, 146 (28.68%) were still receiving services at least six months later. Lastly, of the 237 individuals who received MAT services, 105 (44.49%) were still receiving services six months later. Notably, retention was higher before the start of the COVID-19 pandemic (i.e., 8/2018 – 2/2020) relative to during (i.e., 3/2020 – 01/2021). Before the pandemic, the six-month retention rate for Behavioral Health services was 43.91%, 43.62% for SUD services and 55.56% for MAT. After the start of the pandemic, the six-month retention rate dropped to 27.15% for behavioral health services, 10.13% for SUD, and 35.16% for MAT.
Service Delivery and Expansion of Services over Time Summary
Throughout the Homeward Bound Initiative, a substantial increase in the number of unique consumers entering the program each month was evident up until the end of 2020, after which a slight drop was experienced. The increase over much of the duration of the project is likely to be attributable to the expansion of service availability, the successful implementation of the ‘hub and spoke’ model expanding program outreach, and the extension outreach and engagement efforts implemented by staff at CMC. Notably, the increase in enrollment throughout 2020 shows that services were not substantially impacted by the COVID-19 pandemic as the program quickly adapted to the associated challenges. Moreover, many other
services in the area were shut down during the shelter-in-place mandate, likely increasing engagement in Homeward Bound during this period. The slight decrease in enrollment and service engagement in 2021 may be due to enrollment leveling out after the major expansion of services. It could also signify more local services re-opening, increasing competition, or people returning to work, limiting their availability to attend services.

Notably, once the program got through the initial development stage, the wait times for services between the initial assessment and the start of SUD treatment were minimal. These findings indicate that the pathways through care within the Homeward Bound Initiative were efficient and that the program had sufficient capacity to meet the needs of the population referred. Importantly, these transitions into care did not appear to have been substantially impacted by COVID-19, or the subsequent shift to telehealth as a consequence of the shelter-in-place mandates.

With only 26.68% of consumers who start substance use disorder counseling still in services 6-months later dropout from the program was relatively high relative to estimates presented in the literature (i.e., Lappan et al., 2019). However, at least part of this appears to be related to the impact of the pandemic. Prior to March 2020 the 6-month retention rate was 43.62%, dropping substantially to 10.13% during COVID. Based on the data collected during the qualitative interview with the CMC program lead, this is likely to be attributable to a multitude of factors, including the challenge of engaging new consumers via telehealth, the shift in the case-mix of consumers seen during the pandemic, and the fact a much greater proportion of new consumers who came into the program during this period were looking primarily for housing support, as opposed to SUD treatment. Assuming the changes in treatment retention area were predominantly attributable to these factors, one could assume that treatment retention rates should return to pre-March 2020 levels once the impact of COVID-19 eventually subsides.

More positively, 44.49% of consumers who started MAT remained engaged in treatment 6-months, which compares relatively positively with the literature which has shown a high degree of variability in treatment retention (Timko et al., 2016). Additionally, while treatment retention was found to drop to 35.16% during the pandemic, this is not nearly as substantial a drop as that seen in substance use disorder counseling. This finding suggests that CMC has been relatively successful at identifying and engaging consumers in MAT at the appropriate stage in their recovery. Anecdotally, the extensive array of Homeward Bound services available including case management, housing support, and respite care was also considered to be an important factor in MAT treatment retention based on provider experiences.

**Sociodemographic Breakdown of Homeward Bound Consumers**
The sociodemographic details of all Proposition 47 eligible individuals that received Homeward Bound services are presented in Table 3. The mean age of the sample was 40.99 years old
(SD=12.23). Across race and ethnicity, 39.54% of individuals identified as White non-Hispanic, 22.35% as Hispanic/Latinx, 11.47% as Black/African American, 3.62% identified as Asian, 2.62% as Alaskan Native or Native American, 0.90% identified as Native Hawaiian or Pacific Islander, and 4.83% as having more than one race. In total, 65.59% of consumers identified as male. At the point of the assessment 21.88% identified as homeless, defined as individuals either living on the street or a place not for habitation, in temporary shelters, or in other transitional housing.

<p>| Table 3: Sociodemographic Details of all Consumers Enrolled in the Homeward Bound Program |</p>
<table>
<thead>
<tr>
<th>Variable</th>
<th>Sex (n, %)</th>
<th>Age (M, SD)</th>
<th>Race/Ethnicity (n, %)</th>
<th>Homeless (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male 652</td>
<td>40.99 ± 12.23</td>
<td>White 393 39.54</td>
<td>Yes* 210 21.88%</td>
</tr>
<tr>
<td></td>
<td>Female 342</td>
<td></td>
<td>Hispanic/Latinx 239</td>
<td>No 705 73.44%</td>
</tr>
<tr>
<td></td>
<td>Other 0</td>
<td></td>
<td>Black/African American 114</td>
<td>Unknown/missing 45 4.69%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Asian 36 3.62</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Native American/Alaskan Native 26</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Native Hawaiian/Pacific Islander 9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>More than 1 Race 48</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Missing/Declined 129</td>
<td></td>
</tr>
</tbody>
</table>

Key: ETOH = alcohol; n = number; M = mean; SD = standard deviation
* Includes individuals reported living on the street, in shelters, and in transitional housing

Clinical Presentation of the Homeward Bound Initiative Sample

Depressive Symptoms
In total, the PHQ-9 was administered 5,863 times to a total of 881 Proposition 47 eligible Homeward Bound consumers, with consumers completing the scale a mean of 6.7 times each (SD = 7.5). At the baseline stage, consumers reported a mean depression score of 10.5 (SD=7.7). The proportion of consumers that report mild, moderate, or severe levels of depression is presented in Figure 9. In total, 50.74% of the sample reported at least moderate levels of depression at baseline, a level considered sufficient to meet the Diagnostic and Statistical
Manual of Mental Disorders (DSM-5) criteria for a depressive disorder. These findings highlight the high prevalence of depression in the population treated by the Homeward Bound Initiative, indicating its critical importance as a treatment target.

Figure 9: Proportion of Consumers with Mild, Moderate, or Severe Depression at the Baseline Assessment Stage

![Bar Chart

Anxiety Symptoms
At the baseline assessment stage, when consumers exhibited suspected symptoms of anxiety, they were asked to complete the GAD-7. The proportion of Proposition 47 eligible Homeward Bound consumers that report mild, moderate, or severe levels of anxiety is presented in Figure 10. This process led to a total of 144 consumers completing the GAD-7, representing 14.5% of the total sample. Of these, 56.25% (81 consumers) reported experiencing at least moderate levels of anxiety, which is considered sufficient to meet DSM criteria for Generalized Anxiety Disorder. This represents 8.15% of the total Proposition 47 eligible Homeward Bound sample. Notably, of these, 35.42% of consumers reported anxiety symptoms in the severe range. Overall, given the low prevalence of GAD-7 completions, it is difficult to determine the prevalence of anxiety in the Homeward Bound sample. However, amongst those that were assessed, a substantial proportion was found to report prominent anxiety symptoms, and of these many reported such symptoms in the severe range.
Complete DAST data was available for 558 Proposition 47 eligible Homeward Bound consumers, who include all individuals suspected of experiencing problems due to their substance use. At the baseline stage, consumers reported a mean DAST-20 score of 8.9 (SD=5.9). The proportion of consumers that report mild, moderate, or severe levels of depression is presented in Figure 11. In total, 64.5% of consumers met scored at least a six on the DAST-20, indicating at least intermediate considered likely to meet DSM-5 criteria for a SUD, and meet ASAM placement criteria of Level I or II. Additionally, 28.4% of consumers reported substantial interference, likely meeting ASAM criteria II or III, and 16.9% reported severe interference, likely meeting ASAM criteria III or IV. Overall, these figures indicate that a large proportion of Homeward Bound consumers experience significant interference in their daily living activities caused by substance use, in many cases rising to a level of substantial impairment.
Figure 11: Proportion of Consumers Experiencing Low, Intermediate, Substantial, and Severe Interference in Daily Functioning Caused by Drug Use

Degree of Problems Related to Alcohol Use

In total, 566 Proposition 47 eligible Homeward Bound consumers completed the CAGE at the baseline assessment stage (56.9% of the total sample). Of these, 53.89% (305 consumers) reported a score of intermediate or higher, which is a level considered to be clinically significant. The proportion of consumers experiencing low, intermediate, substantial, or severe problems due to alcohol use is presented in Figure 12. Notably, of those that completed the CAGE, a substantial proportion of consumers reported the impact in the severe range (28.1%).
Summary of the Clinical Presentation of the Homeward Bound Sample

The assessment battery that Proposition-47 eligible Homeward Bound consumers completed at the baseline stage indicates that many consumers are experiencing significant and impairing symptoms of depression and anxiety, as well as significant impairments in daily functioning due to either alcohol or drug use. Alongside the relatively high degree of homelessness indicated in Table 3, these findings highlight the importance of the comprehensive integrated approach to care that the Homeward Bound Initiative delivers, incorporating case management, housing services, mental healthcare, and SUD counseling.

Across the different assessment tools, it is notable that over 96% of consumers completed at least one PHQ-9 screen, and consumers on average each completed 6.7 screens over the duration of their care. Given the availability of the data, allied with the high proportion of consumers experiencing symptoms at a level that would be considered to meet DSM criteria, tracking depressive symptoms over time may represent the most feasible method to evaluate the impact of Homeward Bound Initiative on outcomes.
Outcomes Evaluation – Results

Improving Access and Engagement in Historically Underserved Populations

One of the main aims of the Homeward Bound project was to increase access and engagement to community behavioral health services in San Joaquin County amongst historically underserved groups, namely Black and Latinx communities. Figure 13 below compares the racial and ethnic makeup of San Joaquin County with that of Homeward Bound consumers. It is important to note that conclusions based on analysis of race and ethnicity data are challenging, since race is a social construct, and given that assessments of race (including how people self-identify versus how race is assigned to people) are ambiguous and imprecise.

The population of San Joaquin County was 752,660 in 2018 according to the American Community Survey (U.S. Census Bureau, 2019), of which 41.9% identified as of Hispanic/Latinx ethnicity, 7% identified themselves as Black, 31% as White, 15.7% as Asian, while 4.4% identify as a member of another minority group. As compared to the racial and ethnic breakdown of the census data, Non-Hispanic Whites were overrepresented in the Homeward Bound treatment sample by 8.54%, and Black/African American individuals were overrepresented by 4.47%. Hispanic/Latinx individuals across all races were found to be underrepresented by 16.86%, and Asian underrepresented by 12.08%. Given the lack of data regarding treatment need by racial and ethnic groups within the San Joaquin County region, firm conclusions cannot be drawn from these findings. However, the figures overall suggest that the Initiative has been successful at engaging Black/African American individuals in community behavioral healthcare, but continues to experience challenges in engaging Hispanic/Latinx individuals. Additionally, the findings appear to indicate that residents who identify as Asian are also significantly underrepresented.
Across different racial and ethnic groups, over 98% of consumers who engaged in Homeward Bound services attended at least one behavioral health appointment and 57.24% of consumers attended one SUD counseling session. The proportion of consumers that attended SUD counseling by race and ethnicity is presented in Figure 14. Overall, Black/African American consumers reported the highest attendance rates amongst substance use disorder counseling (63.7%), while Asian consumers reported the lowest (52.8%). However, these differences across race/ethnicity were not found to be significant (p=.695). Black/African American consumers were significantly less likely to initiate treatment with MAT. This finding is consistent with the literature that has found that Black/African American individuals are significantly less likely to be offered MAT due to structural and provider-level biases (i.e., Hansen et al., 2013).
Figure 14: Proportion of Consumers who receive Substance Use Disorder Counseling and MAT, by Race/Ethnicity

14.1 Engagement in substance use disorder Counselling

14.2 Engagement in MAT

Figure 15 below depicts treatment retention in mental health and SUD counseling at the six-month follow-up stage across race and ethnicity amongst all consumers until November 2020. Across both mental health treatment and SUD counseling, Black/African American consumers were most likely to remain engaged in services for at least six months, relative to other racial and ethnic groups (43.2% and 38.1% treatment retention respectively). Asian participants were least likely to remain in mental health treatment at 6-months follow-up (26.9%), while White non-Hispanic consumers were least likely to remain in substance use disorder treatment after the same period (26.5%). The variation in treatment retention in both mental health treatment and SUD counseling was not found to be significant ($\chi^2 = 6.8654$, $p=.231$) while we do not have sufficient data to determine whether there is a clear statistical relationship between SUD counseling and race/ethnicity ($\chi^2 = 10.5553$, $p=.061$). Regardless, treatment and retention in services amongst Black and Hispanic/Latinx consumers appear to be at least equivalent to White non-Hispanic consumers, meaning the project appears to be successfully delivering services to these historically underserved populations once connected with care.
Figure 15: Proportion of Proposition 47 eligible Consumers that remain in Mental Health and Substance Use Disorder Treatment at Six Month Follow up stage, across Race/Ethnicity

<table>
<thead>
<tr>
<th>15.1 Mental Health Treatment Retention</th>
<th>15.2 Substance Use Disorder Treatment Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>35.1</td>
<td>43.2</td>
</tr>
</tbody>
</table>

Access and retention in Community Behavioral Health Treatment across Individuals that Identify as Homeless

Individuals who identify as homeless are another group historically underserved and target in the Homeward Bound Initiative. As indicated in Table 3, 21.88% of the total sample identified as homeless. Amongst those that went on to receive behavioral health treatment, 21.94% identified as homeless, while 24.28% of individuals that received SUD counseling identified as homeless. This indicates that homeless individuals were found to initially engage in these services at a comparable level to those not homeless. With regards to treatment retention, $33.17\%$ of homeless individuals and $39.94\%$ of not homeless individuals were found to be still in behavioral health treatment six months later. With regards to SUD counseling specifically, $29.85\%$ of homeless individuals remained in treatment six months later, relative to $23.28\%$ of non-homeless individuals. In both cases, these differences were not found to be significant ($\chi^2=3.10, p=.078$ and $\chi^2=2.22, p=.136$). These findings suggest that homeless individuals are remaining in care at comparable levels to those not homeless, despite the additional barriers they may face.

Improving Access and Retention Amongst Historically Underserved Groups Summary

The findings indicate that the Homeward Bound Initiative to date has been successful in engaging Black/African American individuals in community care, but there is still progress to be made in engaging individuals from the Hispanic/Latinx community. These findings are consistent with the findings from the previous annual reports. The lack of increased access to care amongst Hispanic/Latinx individuals could be considered somewhat expected, given the
outreach activities and collaborations with other community agencies that would be necessary to address such barriers to access have been significantly hampered from March 2020 onwards due to COVID-19 and the subsequent shelter-in-place mandates.

Once consumers enter into the Homeward Bound system of care Hispanic/Latinx and Black/African American consumers were found to be at least as likely to engage in mental health and SUD treatment and remain in care six months later, relative to other racial and ethnic groups. However, the data also indicates that Black/African American individuals are significantly less likely to start MAT. This a finding that is consistent with the literature (Hansen et al., 2013), and has been attributed to provider-related biases concerning who is identified as an appropriate candidate for MAT treatment. With regards to Homeward Bound specifically, part of this discrepancy may also be attributable to differences in how individuals enter the Homeward Bound system of care across race and ethnicity. Notably, there are fewer barriers to MAT initiation when clients are referred via ED departments and have already started MAT, relative to those who initiate MAT following engagement in Homeward Bound delivered SUD counseling. While the data is unavailable to explore this empirically, anecdotally, the program manager reported that ED referrals where the consumer had already initiated MAT in the ED were disproportionately White. Overall, these findings suggest that while Homeward Bound Initiative has been successful at addressing some of the barriers to engagement and retention in care amongst Hispanic/Latinx and Black/African American individuals, regarding MAT in particular, further work to address structural barriers and provider bias may be necessary.
In the 2019 San Joaquin Point-in-Time Survey, 2,629 homeless individuals were identified as living in San Joaquin County, representing 0.3% of the county population. As this is a measure of point prevalence, as opposed to incidence, direct comparisons with the number of homeless individuals engaged in Homeward Bound care cannot be made. However, with 210 consumers identifying as homeless (21.88% of total sample), this suggests the program has been very successful at engaging this chronically underserved, high-need group. Additionally, once in care, homeless individuals were found to be equally likely to remain in mental health and SUD treatment at six-months follow-up, despite the substantial additional barriers to care this population may face. The reasons for this higher rate of retention are unclear but may relate to the volume of additional services the Homeward Bound program can provide, including respite care, case management, and housing services. If so, these findings highlighted the importance of providing wrap-around care that programs such as the Homeward Bound Initiative can provide to individuals with significant unmet needs.

Reducing Criminal Justice Convictions

Proportion of Consumers who receive Homeward Bound Services that Report having a Criminal Justice History

One of the primary aims of the Homeward Bound Initiative is to reduce incarceration and recidivism amongst San Joaquin County residents who have a mild-to-moderate behavioral health concern and SUD. Of the 1,419 consumers that received Homeward Bound services, between August 2018 – July 2021, 994 (70.05%) reported having a criminal justice history. Figure 16 below presents the proportion of new Homeward Bound consumers who reported having a criminal justice history during their intake interview. From March 2020 forward, there is a notable increase in the proportion of individuals with a criminal justice history. Prior to March 2020, 349 consumers (61.01%) of consumers self-reported having a criminal justice history at the intake assessment, while from March 2020 onwards this figure increased to 76.15% (645 consumers). This is notable, given the San Joaquin Superior County court was closed for all non-essential services between March 18th, 2020 – May 28th, 2020, meaning referrals from the court system were unavailable during this period. This is likely to have reduced the proportion of consumers with a criminal justice history referred into Homeward Bound during this period.

Figure 16: Proportion of New Consumers that Report a Criminal Justice History During the Intake Assessment over Time
Exploration of Recidivism Outcomes

Follow up conviction data was sought for consumers between August 2018 – December 2020. Data was also not collected from consumers that enrolled after December 2020 to allow for a sufficient period from the initiation of treatment for a subsequent offense and conviction to occur. Additionally, the most recent date of release from prison/placement on supervision prior to treatment initiation was only collected from consumers who initiated treatment on January 1, 2019, or later, which was when it became evident that justice data that could be linked to their Homeward Bound treatment would not be available from the State Department of Justice records. Overall, the most recent release from prison/placement on supervision data and subsequent conviction data were available for 32.7% of all Proposition-47 consumers (325 in total).

Of the 325 consumers with release from prison/placement on supervision and follow-up conviction data, 132 consumers (40.6%) reported that their most recent release from prison/placement on supervision occurred over 36 months ago or longer from the point of enrollment into the Homeward Bound program. Given the primary outcome specified by the BSCC is for the 36-month recidivism rate from the point of most recent release from prison/placement on supervision, those with a release from prison/placement on supervision date longer than 36-months than their Homeward Bound assessment date were also excluded from the analysis, given it would not be possible for them to recidivate over that timeframe. Therefore, the 36-month recidivism rate from the point of release from prison/placement to
the date of a new offense that led to a conviction was examined in 193 consumers (19.4% of
the entire Proposition-47 eligible sample). Of those 193 consumers, the 36-month recidivism
rate as defined by the BSQCC was 4.66%. This may be considered incredibly low given the recent
3-year reconviction rate in California has been reported to be 46.5% (California Department of
Corrections and Rehabilitation, 2020), and in the broader literature is typically over 50%
amongst those with SUD (Zgoba et al., 2020). However, it is important to note that the median
time between release from prison/placement on supervision and initiation of treatment
amongst the sample examined was 9 months (IQR 3-17 months), meaning comparison with the
literature is challenging given a substantial proportion of reconvictions typically occur within
the first 12 months (California Department of Corrections and Rehabilitation, 2020).
Additionally, due to the limited length of the study many consumers could not be followed up
for the full 36-months, meaning this figure may increase as time goes on.

To address the limitations of both an inconsistent period between release from
prison/placement of supervision and initiation of treatment, and the fact that many consumers
could not be followed up for the full 36-month period, in a secondary analysis the 12-month
and 24-month reconviction rates from the point of Homeward Bound treatment initiation were
explored. In this analysis, the 12-month reconviction rate of all Proposition-47 eligible
consumers who initiated Homeward Bound treatment between August 2018 and July 2020 was
available for 457 consumers. Amongst this sample, the 12-month reconviction rate was found
to be 8.1%. The 24-month reconviction rate of all Proposition-47 eligible consumers who
initiated Homeward Bound treatment between August 2018 and July 2019 was available for
162 consumers. Of these, the 24-month reconviction rate was found to be 15.4%. While much
higher than the figure reported calculated utilizing the BSQCC definition, this figure should still be
considered very low relative to the 2019 California recidivism published (California Department
of Corrections and Rehabilitation, 2020), and amongst consumers who are released from prison
with a SUD (Zgoba et al., 2020). However, consistent with the recidivism analysis utilizing the
BSQCC definition, due to differences in the case-mix of individuals, and the period of time
between release from prison/placement on supervision and treatment initiation direct
comparisons between these figures cannot be drawn.
**Impact of Treatment Engagement on Recidivism Outcomes**

To examine the impact of engagement in Homeward Bound treatment, whether or not consumers who initiated behavioral health treatment, SUD counseling, or MAT engaged in this care for at least 6 months was examined as a predictor of recidivism over 24 months. The findings are presented in Table 4. Overall, the effect of being in either behavioral health treatment or substance use disorder counseling for at least six months was not found to significantly impact the likelihood of reconviction. However, attending MAT for at least six months was found to decrease the probability of a conviction over 24 months by 39.4%. While this finding appears to suggest a positive association between MAT engagement and lower recidivism outcomes, it is important to note both the small sample size (n=30), and the fact people who are incarcerated within the first six months of treatment would also stop treatment, which would lead to the impact of MAT engagement being inflated. Regardless, these findings do appear to indicate that engagement in MAT delivered by Homeward Bound may have some mitigating effect on recidivism.

**Table 4. Services Utilized as a Predictor of Subsequent Conviction:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Std Err</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended Behavioral Health Treatment ≥6months</td>
<td>-5.8%</td>
<td>6.6% -18.8% 7.2%</td>
</tr>
<tr>
<td>Attended Substance Use Disorder Counseling ≥6months</td>
<td>1.7%</td>
<td>7.4% -12.8% 16.2%</td>
</tr>
<tr>
<td>Attended Medication Assisted Treatment ≥6months</td>
<td>-39.4%</td>
<td>14.4% -67.6% -11.1%</td>
</tr>
</tbody>
</table>

Estimated by logistic regression of a 24-month reconviction indicator on the above indicators, separately. 95% CIs are estimated using the sandwich variance estimator.

**Reducing Criminal Justice Convictions Summary**

In total, 70.5% of the consumers who received Homeward Bound services reported having a criminal justice history prior to the initiation of services. This high proportion indicates the success of the project at engaging individuals with a criminal justice history. Notably, the proportion of consumers served that reported a criminal justice history was found to increase over time, and escalated during the COVID-19 pandemic. The reasons for this are unclear but are likely to be attributable to the significant change in the case-mix of consumers served during the pandemic, and improved collaboration with local law enforcement during this period as detailed in the qualitative interview summary with the CMC program lead.

The 36-month recidivism rate (per BSCC definitions) was found to be 4.66%. The 12-month and 24-month recidivism rate from the point of initiation of Homeward Bound treatment was found to be 8.1% and 15.4%. These figures are very low relative to both statewide recidivism calculations and those published in the literature (California Department of Corrections and...
Rehabilitation, 2020; Zgoba et al., 2020). However, as detailed in the findings these results come with a series of caveats, limiting the ability to make direct comparisons.

In the final part of the analysis, the degree of engagement in services as a predictor of subsequent convictions was explored. Overall, engaging in behavioral health treatment and/or SUD counseling for at least six months was not found to be associated with a lower or high likelihood of a subsequent conviction up to 24 months later. However, when consumers attended at least six months of MAT, this decreased the probability of observing 24-month recidivism by almost 40%. While this finding should be interpreted cautiously due to the small sample size and methodological limitations, it does provide some tentative support for delivering MAT within the context of a broad package of services such as those delivered by Homeward Bound as a possible method to reduce recidivism amongst individuals. Interestingly, while being randomized to receive MAT in clinical trials have not typically been found to impact recidivism outcomes (Robertson et al., 2018), there is some evidence to suggest that individuals who continue their MAT treatment may have lower recidivism outcomes than those who terminate such care early (i.e, Farrell-MacDonald et al., 2014). Overall, these and other findings may highlight the importance of ongoing MAT care.

**Consumer Satisfaction with Homeward Bound Services**

In total, 337 Proposition 47 eligible Homeward Bound consumers completed the CSQ-8 between October 2019 and May 2021. Overall, almost all consumers who received services reported being highly satisfied with the level of care they received. In total, 76.26% of consumers reported the highest level of satisfaction possible (i.e., a score of four out of four on all eight items). Additionally, 92.57% of consumers reported a mean score of three or higher, indicating at least moderately high levels of satisfaction with services. Notably, no consumers reported a mean satisfaction score below two, which would indicate any degree of dissatisfaction with services. The item-level CSQ-8 scores are presented in Figure 18. Across the eight different items, consumers reported a mean satisfaction range of 3.83 (SD = 0.43) for Item 6 (“Have the services you received helped you to deal more effectively with your problems?”) to 3.97 (SD=0.29) for Item 3 (“To what extent has our program met your needs?”), indicating very high levels of satisfaction with care across all domains assessed.
Changes in Outcomes amongst Homeward Bound Consumers over time

The longitudinal course of depressive symptoms amongst individuals that received Homeward Bound services is presented in Figure 19. After one month of receiving Homeward Bound services, consumers reported PHQ-9 scores on average nearly four points lower compared to their baseline score. This reduction in PHQ-9 scores was found to continue the longer the consumer remained in Homeward Bound services up until the 21-month point, where consumers reported PHQ-9 scores on average six points lower than their baseline values. Over this period, the reductions in PHQ-9 scores were all found to be statistically different. From 24 months onwards, the lower number of PHQ-9 completions appeared to result in substantial variability between timepoints and much larger confidence intervals, suggesting firm conclusions cannot be drawn on this data.
Figure 19: Mean Rate of Change of Depressive Symptoms over Time
Discussion

The Homeward Bound Initiative was designed to improve access and engagement in behavioral healthcare across San Joaquin County, reduce disparities in utilization amongst underserved groups, reduce convictions and recidivism, and improve outcomes, all while delivering services with a high degree of consumer satisfaction. Across these different aims, the project has made significant advances, despite the significant challenges to implementation that came with the pandemic and the subsequent shelter-in-place mandate detailed in the qualitative interviews with program leadership.

With regards to increasing access and engagement in behavioral healthcare, 994 Proposition 47 eligible consumers have received Homeward Bound services, including 976 receiving behavioral health services, 569 SUD counseling, and 322 receiving MAT. Notably, 777 Homeward Bound consumers also received primary care serves at a median of 5 appointments each, suggesting the Homeward Bound Initiative may be an important facilitator to increased physical health utilization, in addition to behavioral healthcare. The high degree of engagement in care is likely attributable to the extensive outreach and engagement Homeward Bound leadership have conducted prior to the pandemic that is not detailed in this deliverable, alongside the successful implementation of the “hub and spoke” model, enabling a greater geographic spread across San Joaquin County.

Consistent with earlier findings, the Homeward Bound Initiative appears to be successful at engaging individuals who identify as homeless, and Black/African American people in care. However, the under-representation of Asian and Hispanic/Latinx individuals engaging in care is a concern. The fact that the under-representation in care amongst Hispanic/Latinx and Asian residents has not significantly changed from earlier annual reports is unsurprising, given the methods most likely used to address these discrepancies (i.e., extensive community outreach and engagement) have been seriously curtailed by the pandemic since March 2020. As shelter-in-place mandates reduce and community engagement becomes more feasible, the plan is for such outreach efforts to increase. One recent example of this is the recent collaboration with local advocacy groups Little Manilla (https://www.littlemanila.org) and Asian Pacific Self-Development and Residential Association (APSARA, https://apsaraonline.org/) to address barriers to behavioral health services engagement amongst individuals from the local South Asian community.

Once consumers enter into the Homeward Bound system of care, Hispanic/Latinx and Black/African American consumers were at least as likely to engage in mental health and SUD treatment and remain in care six months later, relative to other racial and ethnic groups. However, Black/African American individuals were significantly less likely to initiate MAT. This finding is consistent with the literature that has found that Black/African American individuals
are significantly less likely to be offered MAT due to structural and provider-level biases (i.e., Hansen et al., 2013). Consequently, efforts to address inequities in MAT access across race/ethnicity are merited. More positively, homeless individuals were found to be at least as likely to remain in behavioral health and substance use disorder care, relative to those reportedly not homeless. While there is progress to be made in some areas, overall, these findings are highly positive and point to the Homeward Bound Initiative being successful at engaging and retaining historically underserved groups in care.

Recidivism rates calculated both from the most recent release from prison/placement on supervision and from the initiation of Homeward Bound treatment were found to be very low. Interpretation of recidivism outcomes are challenging due to multiple reasons. These include variability in the period of time between the release from prison/placement on supervision and Homeward Bound treatment initiation, the likely non-representative sample of consumers who elect to receive community treatment for SUD and mild-to-moderate behavioral health concerns relative to the whole population of individuals released from prison/placed on supervision, the issue that not all consumers could be followed-up for the whole 36-month duration due to the limited length of the project, and the fact that the county superior court was closed between March 2020 – May 2020 potentially impacting amount of consumers seen at court. Regardless, that the different recidivism rates were found to be so low should be considered promising and support the whole-person care model adopted by the Homeward Bound initiative.

One notable finding is the remarkably high degree of consumer satisfaction that consumers report regarding the care they have received from Homeward Bound services. Over two-thirds of consumers reported the highest level of satisfaction possible on the CSQ-8, and over 90% reported a mean score of 3 or higher, indicating the vast majority of those surveyed experienced at least moderately high levels of satisfaction with services. While these findings are encouraging, it is important to note that they come with one important caveat. During the study period when the CSQ-8 was available, only 32.9% of all consumers completed the scale. As a result, it is unclear if these satisfaction values are representative of the whole sample. For example, it is unclear if a substantial proportion of the missing consumers were missed due to random error, or if individuals who were less satisfied with care may have refused to complete the scale or dropped out leading to fewer opportunities to complete the questionnaire. However, it is also possible that consumers who are less satisfied with services could be more likely to complete the questionnaire as a mechanism by which to be able to communicate their dissatisfaction with care. Regardless, the findings indicate that amongst those who were surveyed, satisfaction with Homeward Bound services is very high.

With regards to the final project aim – an exploration of the impact of Homeward Bound services on outcomes – the longitudinal course of depressive symptoms amongst those enrolled in care were explored. Due to the absence of a control group, the lack of data amongst
those who do not continue to receive services, and the likelihood of regression to the mean, one should be highly cautious when interpreting the data. However, following engagement in care with the Homeward Bound Initiative, consumers reported a mean drop in the PHQ-9 scores by approximately four points by the first month, and consumer scores continued to trend downward to a six-point drop at the 21-month post-baseline stage. Notably, a drop of five points on the PHQ-9 is considered clinically significant (Kroenke et al., 2012), indicating that at the sample level, the consumers who received care experienced a clinically meaningful reduction in depressive symptoms.

**Conclusion**

Over the course of the implementation of the Homeward Bound Initiative, there have been some notable successes despite operating against the backdrop of the pandemic. There has been a significant expansion of mental health and SUD services for residents across San Joaquin County. While Asian and Hispanic/Latinx residents continue to be underserved, engagement in care amongst Black/African American and homeless residents is high. Furthermore, once these historically underserved individuals engage in care, retention in services is relatively high. It is difficult to determine the impact of Homeward Bound services on recidivism outcomes, however the very low rates of reconviction amongst consumers appears promising, in addition to the lower 24-months recidivism rates amongst individuals who remain in MAT. Over time, consumers report significant and clinically meaningful reductions in depressive symptoms. Finally, amongst those who responded, Homeward Bound consumers report a very high level of satisfaction in the services that they have received.
References


