

I. Executive Summary

The Homeward Bound Initiative is an innovative, comprehensive array of behavioral health services designed to improve population health outcomes for residents of San Joaquin County. Substance use disorders, mental health disorders, homelessness, unemployment, and justice system interactions are prevalent among certain populations of San Joaquin County, and these populations often have limited access to and utilization of available behavioral health treatment services. In conjunction with community partners and stakeholders, San Joaquin County's Behavioral Health Services developed the Homeward Bound Initiative to address these issues that are impeding the health of the San Joaquin County communities.

The overarching goal of the Homeward Bound Initiative is to improve access to behavioral health care services for all residents of San Joaquin County by increasing pathways to care, with an emphasis on 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, who are homeless, and/or who have frequent contacts with law enforcement, and 3) African American and Latino individuals who are underserved through traditional, existing behavioral health services.

Significant activities that the Homeward Bound Initiative will accomplish include *service expansion* through the creation of an Assessment and Respite Center with co-located withdrawal management services, *system strengthening* by developing shared data use agreements, referral pathways, and bidirectional assessment protocols between provider groups, and *service enhancement* by creating wrap-around housing and case management services for those individuals that require intensive services to achieve recovery from behavioral health conditions.

If successfully implemented, expected outcomes include:

1. Improvements in the access, pathways, and engagement in care
2. Reduction of racial/ethnic disparities in behavioral healthcare service provision
3. Reduction of rates of recidivism
4. Improvements in functioning following receipt of intensive support services
5. High levels of client and provider satisfaction with new models of care

The evaluation team of the University of California, Davis Behavioral Health Center of Excellence will conduct a comprehensive evaluation of the Homeward Bound Initiative. The evaluation plan will involve ongoing representation and input from community stakeholders. The evaluation will assess capacity-building, client and provider satisfaction, and provision of services using a range of available data from multidisciplinary sources. Evaluation activities will occur over a five-year project period, with the final evaluation plan due in April 2018, and evaluation reports due at yearly intervals.

II. Project Background

San Joaquin County, located in California's Central Valley, is a vibrant community of just over 700,000 individuals, with a diverse population. San Joaquin County has the highest unemployment rate of any large county in California (*CA Employment Development Department*), and a high rate of homelessness. In addition, the county has the second highest crime rate of all counties in California.

In a recent survey (San Joaquin County Continuum of Care, March 2017) 31% of unsheltered homeless individuals in the Stockton area self-identified having a mental health concern and 45% reported having a problem with alcohol, illegal substances, or both. With regards to the prevalence of mental illness in the San Joaquin jail system, the County Sheriff estimates that approximately 40% of the individuals detained in the jail annually have some behavioral health concern. In light of these statistics, in 2016, the Mental Health Services Act (MHSA) - Planning Stakeholder Steering Committee charged San Joaquin's Behavioral Health Service (BHS) to conduct a planning process that focused on addressing the needs and concerns of adults with mental health disorders that have co-occurring substance use disorders, are homeless or at risk for homelessness, or have frequent justice encounters associated with untreated behavioral health concerns. In response, the BHS, in conjunction with various stakeholders, developed the San Joaquin County Homeward Bound Initiative.

San Joaquin County's Homeward Bound Initiative is a five-year program designed to develop and implement a comprehensive package of care for non-serious, non-violent offenders with mild to moderate behavioral health concerns, with the aim of reducing recidivism. This goal will be achieved by expanding the care continuum and reducing systemic barriers between mental health and substance use disorder treatment services. By increasing the variety and coordination of different behavioral health services, the Homeward Bound Initiative aims to reduce systemic gaps that result in untreated behavioral health concerns amongst high-risk populations.

Project efforts seek to improve access to behavioral health care services (mental health and substance use disorder treatment services) for all residents of San Joaquin County by creating more pathways to care. However, the target populations addressed through the Homeward Bound Initiative are vulnerable, high-risk populations that are currently underutilizing the behavioral healthcare system. These include:

- Non-serious, non-violent offenders with trauma, or other mental health concerns, that impede rehabilitation.
- High-risk individuals with substance use disorders, which are homeless and/or have frequent law enforcement contacts associated with a behavioral health concern.

In addition, the Homeward Bound initiative aims to increase the number and proportion of African-American and Latino individuals who utilize community behavioral health services, given that they are a traditionally underserved population in this setting.

The lead partners in this initiative, San Joaquin County BHS and Community Medical Centers (CMC), anticipate that full implementation of the Homeward Bound Initiative will lead to significant improvements in the behavioral health system of care and have the following beneficial impacts for the high-risk individuals identified as target initiative recipients:

- Reductions in the number of individuals with untreated mental illness.
- Reductions in the number of individuals with untreated substance use disorders.
- Reductions in racial/ethnic disparities in the delivery of behavioral health services.
- Reductions in the number of violations, bookings, or new charges filed amongst non-serious, non-violent offenders with behavioral health concerns.

Project funding for the Homeward Bound Initiative includes \$6 million through a grant from the California Board of State and Community Corrections. Over three years, the project will start-up withdrawal management services and pilot the provision of housing and case management services for program participants who are non-serious, non-violent offenders and that do not meet criteria for specialty mental health services. Additional funding (over \$7.5 million through San Joaquin County's MHSAs and other resources) is also allocated over five years to pilot and start-up a community-based Assessment and Respite Center. The pilot project will serve as an opportunity to develop and test joint protocols for screening, assessments, and referrals and practice communication and coordination between the two systems of care.

Project Activities

The Homeward Bound Initiative seeks to expand the behavioral health service delivery system by introducing new substance use disorder treatment services and expanding access to mental health services for individuals with mild to moderate mental health concerns. The Initiative also seeks to strengthen the behavioral health continuum of care by reducing barriers to entry and creating seamless pathways between public and community-based service providers. Finally, the Initiative will enhance services by offering a "full spectrum" of services to support individuals with complex needs. When necessary, the Homeward Bound Initiative will offer housing and case management services to help stabilize individuals, encourage treatment adherence, and support functional improvements.

- **Service Expansion:** Create an Assessment and Respite Center (ARC) with co-located withdrawal management services.
- **System Strengthening:** Create bi-directional assessment protocols, referral pathways, and information sharing agreements between BHS and CMC for coordinated and aligned behavioral health services (both mental health and substance use disorder treatment services). Ensure that project activities are designed to leverage all available federal and state funds including those available through the Organized Delivery System to support long term project sustainability.
- **Service Enhancement:** Create wrap-around housing and case management services for vulnerable adults with behavioral health concerns that would not otherwise meet qualifications for either full-services partnership programming or specialty mental health services.

The ARC and co-located withdrawal management services will be developed in three phases. The first phase (currently underway) is the development of the behavioral health treatment protocols and pathways for assessment and withdrawal management services. Under the first phase, CMC is training prescribers in medication-assisted treatment (MAT) protocols, hiring new program staff, and working with BHS and other community partners to develop referral and coordination pathways. Examples of activities currently underway include the development of documentation work instructions for patients to receive comprehensive primary and behavioral health services while still remaining in compliance with the Code of Federal Regulations (CFR, #42), hiring new program staff, and conducting trainings in new treatment protocols.

The second phase of the project (anticipated start summer 2018) is to pilot operations of an Assessment and Respite Center with co-located withdrawal management services at an existing clinic location. During this phase CMC will expand withdrawal management services to include brief withdrawal management and respite services. BHS and CMC will begin practicing the use of shared assessment protocols, bi-directional referrals and psychiatric consultations. Additional funding will be leveraged and CMC will negotiate the lease and improvements of a new Assessment and Respite Facility designed to serve 20-30 individuals on a walk-in basis daily. CMC and community partners will refine design and service considerations, including the provision of 24/7 response protocols and additional withdrawal management services. BHS and CMC will work jointly to align new substance use disorder withdrawal management and recovery treatment services within the Organized Delivery System that will be made available in San Joaquin County through Drug Medi-Cal. Phase 2 will also see the roll-out of enhanced services for non-serious, non-violent offenders (housing and case management) made available through Proposition 47 grant funds. Protocols and practices for other leveraged services (such as outreach and engagement to homeless individuals through the Homeless Outreach Team and precontemplation housing for individuals with acute substance-use disorders) will also be developed and refined during this period.

During the final phase of the project (Years 3-5), CMC will open and operate a standalone Assessment and Respite Center with a co-located Withdrawal Management Unit that offers a range of substance use disorder treatment services to aid in withdrawal and recovery processes, including MAT. Full operations are anticipated to begin in 2019. During the fourth and fifth years of the project, additional funds, leveraged through federal financial reimbursements, will be drawn down to create a full spectrum of services that are sustainable over the long term.

The program evaluation will test the efficacy of program services in meeting the overarching desired goals of the project and will determine the impact of case management and housing support services have on client stabilization, treatment compliance, and overall changes in functioning for high-risk participants that engage in services at an intensive level.

Project Utilization and Dosage

Project utilization will increase annually. During the first six months of project start-up (January 2018-June 2018) CMC anticipates offering withdrawal management services to approximately 40-50 patients as it begins piloting treatment protocols. During the second phase of the project (which will pilot full project operations) CMC anticipates serving an estimated 8-10 individuals per day, with the capacity for up to two individuals at a time receiving intensive brief withdrawal management. By the end of the project period, the Assessment and Respite Center with a co-located Withdrawal Management Unit will have the capacity to serve 20-30 individuals per day. Additionally, five CMC clinic sites will also have the capacity to provide MAT for withdrawal management and recovery and offer integrated substance use and mental health treatment services for clients who prefer to receive treatment interventions in a traditional health care setting. Over the five-year program period BHS and CMC anticipate services will be offered to over 1,000 individuals with an untreated behavioral health concerns who are non-serious, non-violent offenders and/or who are homeless or at risk of homelessness.

Project Goals

The Homeward Bound Initiative combines project goals as stated in the ‘Project Evaluation Plan’ section of the Proposition 47 grant proposal, submitted to the California Board of State and Community Corrections (see page 17) in February 2017 *and* the goals and objectives stated in the ‘Purpose of the Innovation’ section of the Assessment and Respite Center MHS Innovation Plan Document, submitted to the California Mental Health Oversight and Accountability Commission (see page 16) in November 2017. Where goals and objectives are closely related or overlap each other they have been combined and synthesized for clarity. Anticipated project outputs, and long and short-term outcomes, are further described in the project logic model.

Purpose Statements and Goals

I. Reduce systemic gaps which lead to the underutilization of mental health services.

Goal 1: Address structural limitations of the current model of care that leads to the under-utilization of appropriate services in people with mental illnesses and co-morbid substance use disorders.

Goal 2: Provide stabilization services, respite care, withdrawal management, housing, and case management, when necessary, to facilitate client engagement in mental health treatments

II. Improve access to mental health services for underserved groups.

Goal 1: To provide mental health services to non-serious, non-violent offenders with trauma or other mental health concerns.

Goal 2: To provide mental health services to high-risk individuals with substance use disorders who are homeless, and/or have frequent law-enforcement contact associated with their behavioral health concerns.

Goal 3: To increase the number and proportion of African-American and Latino individuals who utilize community behavioral health services.

III. Reduce gaps in the substance use disorder continuum of care.

Goal 1: Provide effective substance use treatment services, ensuring that providers are trained in effective treatment practices, and are assigned to deliver services.

Goal 2: Provide effective substance use treatment services, allowing former offenders to receive diversion programming and/or direct their own recovery efforts.

IV. Reduce conviction rates and recidivism of individuals with mental health disorders.

Goal 1: Improve the quality of life for non-serious, non-violent service users with prior convictions; individuals with substance use disorders; and/or 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.

Goal 2: Reduce the number of incarcerations among non-serious, non-violent offenders with untreated mental health and/or substance use disorders, and reduce the proportion that recidivate.

III. Methodology

Study design

Given the complexity of the proposed Homeward Bound Initiative, the investigation will adopt a mixed-methods design. Qualitative interviews will be used to evaluate the experiences of service users and providers utilizing both the previous and proposed system model. An evaluation of the new system of care will consist of a cross-sectional study, with some outcomes compared to historical control groups. A longitudinal design will be used to measure outcomes related to recidivism, functioning, and to assess the proportion of those that remain in stable housing following treatment.

Institutional Review

Prior to conducting any aspect of the program evaluation, the protocol and procedures will be approved by the UC Davis Institutional Review Board (IRB).

Target population

Adults with possible mental health and co-morbid substance abuse disorders in the Stockton area will be considered appropriate for services delivered under the Homeward Bound Initiative. The program aims to implement a “No Wrong Door” approach to maximize the chance of engaging potential service users in the program. Individuals may come into contact with Homeward Bound Initiative services via self-referral, either presenting to the ARC or via the telephone; the Whole Person Care (WPC) assertive outreach workers; their primary care physician; or through Stockton Police Mental Health liaison services.

Of particular focus will be adults who have been booked, charged, or convicted of non-serious, non-violent offenses and have substance use disorders. Sub-populations that will receive focused outreach and engagement include individuals arrested for drug-related non-violent crimes, individuals with

multiple contacts with law enforcement for disorderly conduct, and homeless individuals with current or prior justice contact. In order to address current treatment utilization disparities, recruiting potential service users who identify as either African-American or Latino will also be of particular focus to the program.

Project oversight and management

The Local Advisory Committee and Homeward Bound Leadership Team

Project oversight will be conducted by the Local Advisory Committee (LAC), which will meet on a quarterly basis to review program implementation activities, track project performance over time, and produce recommendations based on these evaluations. The LAC will comprise of senior members from the CMC, BHS, Health Care Services Agency (HCSA), service user and caregiver representatives, law enforcement representatives, and other community organization stakeholders. Monthly Homeward Bound Leadership Team (HBLT) meetings will be held to approve project work plans and timetables, and provide ongoing management relating to the implementation and evaluation of the program. The Leadership team will comprise of representatives from the CMC, BHS, and the program evaluation team.

In addition to the above committees, the formulation of the following sub-committees are proposed to aid implementation efforts:

Clinical Services Committee (CSC)

The CSC will comprise primarily of CMC and BHS staff, with input from the program evaluation team where necessary, and will address issues relating to tool selection, clinical protocols, staff training, and co-ordination of services.

Interagency Agreements and Training Committee (IATC)

The IATC will comprise of BHS, CMC, HCSA, program evaluation staff, and Law Enforcement Partners with the aim of developing interagency referral and data sharing protocols, agreements regarding communication and coordination, training, referrals, transports, and protection of confidential health information.

Evaluation and Data Collection Committee (EDCC)

The EDCC will comprise of law enforcement partners, CMC, BHS and program evaluation staff with the aim of coordinating and harmonizing data collection practices, and to ensure the necessary data are being collected in order to fulfill the program evaluation aims and objectives.

Measures

The proposed evaluation is likely to include, but may not necessary be limited to, the following measurement tools. Possible additional measures will be reviewed by the HBLT, CSC and EDCC, and any changes will be finalized prior to the final evaluation plan, due June 2018.

Substance use disorder screening tool

The selection of a brief, validated, self-report substance use screening tool to complete the screening component of Screening, Brief Intervention, and Referral to Treatment (SBIRT) will be conducted by the CSC and the program evaluation team, following a thorough review of all appropriate options.

Adult Needs and Strengths Assessment (ANSA)

Any changes in functioning following the provision of Homeward Bound Initiative services will be conducted using the ANSA (Lyons & Walton; 2013). The ANSA is a validated assessment tool in substance use disorder populations (Allen and Olson, 2015), and will be completed both at the initiation of treatment, and at a point determined as clinically relevant by the CSC. This timepoint will be determined prior to the submission of the final evaluation plan (due June 2018).

Client Satisfaction Questionnaire (CSQ-8)

At the end of each episode of care, service users' satisfaction with service provision will be assessed using the CSQ-8 (Larsen et al., 1979). The CSQ-8 is an 8-item Likert questionnaire that has been extensively used in various healthcare settings, and has been validated for use in substance use disorder populations (Wilde and Henriks, 2005). In addition to recording service satisfaction, basic demographic information will also be recorded in order to assess satisfaction across different racial and ethnic groups.

Survey of provider self-reported confidence in delivering substance use disorder treatment

A brief, self-rated questionnaire to assess healthcare provider self-confidence in delivering behavioral health services to will be developed by the program evaluation team, and approved by the CSC and LAC prior to submission to the UC Davis IRB for final approval. The questionnaire will be completed by all providers pre- and post- training sessions delivered as part of the Homeward Bound Initiative.

Client and provider qualitative interview guides

The qualitative interview guides for both the client and provider interviews will be developed by the program evaluation team in conjunction in various stakeholders, including the CSC, service user, and caregiver representatives, and will be approved by the LAC prior to submission to the UC Davis IRB for final approval.

Data Sharing Procedures

In order to successfully implement the Homeward Bound Initiative, it will be necessary for Protected Health Information (PHI) to be shared between different stakeholders, including the BHS, CMC, HCSA and law enforcement partners. As a result, prior to the initiation of the project, data sharing agreements between the relevant partners will be produced. Stakeholders will work with the HCSA to create a memorandum of understanding (MOU) regarding data sharing that will be based on the County's current electronic health record and data sharing agreements. The process by which these agreements will be drafted and finalized will fall under the purview of the IATC. Discussions regarding the structure of the data sharing agreements are currently at the preliminary stage and are ongoing, and will be

finalized with signed data use agreements in place prior to the submission of the final evaluation proposal in June 2018.

In addition to data sharing agreements being required between different service providers involved in implementing the Homeward Bound Initiative, data sharing agreements will also need to be drafted between the relevant stakeholders and the program evaluation team for the duration of the program evaluation. The nature of the data required will be contingent on the finalized analysis plan contained within the final evaluation proposal, due to be submitted in June 2018. All data will be transferred via Health Insurance Portability and Accountability Act (HIPAA) compliant, secure, encrypted transfer systems. All data will be stored on a secure server, consistent with UC Davis IRB protocols. At no time will study personnel store any data on personal laptops. All data transfer and storage procedures will be reviewed and approved by the UC Davis IRB prior to any data transfer to the program evaluation team.

Process Evaluation

The main component of the process evaluation will be to record the capacity-building developments necessary to deliver the different aspects of care incorporated under the Homeward Bound Initiative. This will include (but not necessarily be limited to): determining the capacity to deliver screening, assessment, withdrawal management treatments (including brief withdrawal management), trauma-focused counseling, respite care, case management, and housing support. The process evaluation will also analyze the number of providers trained to deliver the different interventions, either via the recruitment of new providers and/or training of existing staff. In addition, the process evaluation will examine service utilization of these different components of care, and how successful established linkage and referral systems are in directing service users to the appropriate providers. Service use and provider satisfaction will also be evaluated, utilizing both quantitative and qualitative methods. These data will be used to address any identified barriers to successful implementation and help refine the program to ensure the Homeward Bound Initiative achieves its stated goals and objectives.

The findings of the process evaluation will be presented to the Board of State and Community Corrections (BSCC) as part of the two-year preliminary evaluation report, due in August 2019.

Outcome Evaluation

The main evaluation outcomes are linked to the stated primary goals: 1) to significantly increase behavioral healthcare utilization relative to historical controls; 2) to significantly reduce racial and ethnic disparities in behavioral healthcare utilization; 3) to significantly reduce bookings, convictions and recidivism in those that receive services; and 4) to address the strengths and needs of those that receive comprehensive behavioral health services and support. Successful achievement of these outcomes could lead to lasting changes in San Joaquin County; reducing racial and ethnic health disparities, reducing the number of individuals with untreated mental health and substance use disorders, and reducing long term recidivism.

Inputs from Program Partners

Outreach and Engagement: Homeless Outreach Teams, The Stockton Shelter for the Homeless, St. Mary's Dining Room, community-based organizations, inpatient and crisis residential programs, local law enforcement, and others community stakeholders will identify potential program participants and link them to a service navigator.

Screening and Assessment: CMC Assessment and Respite Center, BHS Crisis Unit, and local mental health clinic providers which will conduct mental health assessments to determine eligibility for the program and to establish a baseline assessment of health status.

Treatment and Recovery Services: BHS Mental Health Services, the Wellness Center, the Martin Gipson Socialization Center, outpatient recovery groups, 12-Step programs and recovery support groups, and various community-based organizations will provide ongoing mental health treatment services, recovery services, therapeutic groups, social and emotional support services, case management, and advocacy.

Re-entry and Community Support Services: San Joaquin County Probation Department, the Superior Court of San Joaquin County, the Office of the Public Defender, the District Attorney's Office, and various local law enforcement agencies will partner together to support diversion opportunities and to offer evidence-based programming that has been demonstrated to reduce criminogenic risk, including anger management and a range of trauma-informed cognitive behavioral interventions. Also, various community-based organizations will provide life skills classes, mentoring, and vocational training opportunities.

Activities

1. Implement the Assessment and Respite Center: As part of the Homeward Bound Initiative an Assessment and Respite Center (ARC) will be developed, where assessment, substance use disorder treatment, case management and housing support, and mental health treatment for mild to moderate mental health disorders will be integrated and delivered in a community setting. These services will be delivered by CMC, in conjunction with other community partners. CMC has an established track record of delivering comprehensive primary and preventive care services to vulnerable and under-served populations, and runs eight Federally Qualified Health Centers (FQHCs) across the city of Stockton. The ARC will be fully-integrated into primary care, and potential services users will be provided "warm handoffs" to facilitate engagement in behavioral health treatment services.

It is anticipated that services will be utilized by clients at three levels of care, resulting in different service experiences and anticipated impacts.

- *(Light – Level 1) SBIRT Level of Services:* Individuals are referred to the ARC, and are provided with respite, screening, a brief intervention to facilitate engagement, followed by possible

referrals for additional services. Service users may receive brief withdrawal management services during periods of acute intoxication. Clients may or may not complete a full psychosocial assessment, depending on their specific needs and desires at the point of intervention. Clients' immediate health and behavioral health treatment needs are met, but they typically do not receive additional services at this time.

- *(Medium – Level 2) Behavioral Health Level of Services:* Individuals referred to the ARC, receiving a screening and brief intervention, complete an assessment, and are referred for further behavioral health treatment services that may include mental health counseling, withdrawal management services, or engagement in behavioral health services and supports (such as groups or classes).
- *(Intensive – Level 3) Comprehensive and Integrated Services and Supports:* Appropriate individuals (i.e. non-violent, non-serious offenders and/or homeless individuals or those at risk for homelessness) are offered a combination of mental health treatments, substance use disorder withdrawal management and recovery treatment services, case management, and housing support and stabilization services, where appropriate. A period of 30-90 days will be used to make a full assessment and determine program needs. Program participants may stay engaged in services for 9-18 months in order to achieve recovery goals, and to support re-entry and rehabilitation efforts.

2. Recruit, train, and assign community providers to provide treatment services for individuals with mild/moderate mental health concerns and co-morbid substance use disorders: In order to deliver the services outlined above, it will be necessary to train various community providers. This includes training physicians and nurse practitioners to deliver MAT; social workers and case managers to deliver SBIRT; and physicians to qualify for physician waivers to prescribe and dispense buprenorphine.

3. Create direct referral pathways between CMC, BHS, and community providers: In order to deliver the full range of services associated with the ARC as proposed by the Homeward Bound Initiative, it will be necessary to create referral pathways to stabilization services such as: respite care, case management, housing support and trauma-focused counseling for high-risk risk clients. Such services may be delivered either by CMC, or other community partners. In addition, the Homeward Bound Initiative will establish a direct referral pathway between the ARC and BHS for situations where ARC service users are identified as having severe mental health needs that require more intensive support.

4. Develop respite, case management and housing support for at-risk groups: In addition to mental health and substance use treatment, the Homeward Bound Initiative will aim to provide a range of additional supportive services, depending upon the requirements of the individual. This may extend to addressing immediate needs (i.e. providing food, basic hygiene support, etc.) to providing long-term case management and housing support. Depending upon the nature of the support required, these services will be provided as part of ARC, or referred to other community partners.

Outputs

The outputs evaluated under each domain are as follows:

1. Capacity Building:

- 1a. Clinical capacity to deliver mental health treatments under the auspices of the Homeward Bound Initiative over time.
- 1b. Clinical capacity to deliver withdrawal management treatment under the auspices of the Homeward Initiative over time.
- 1c. Clinical capacity to deliver brief withdrawal management under the auspices of the Homeward Initiative over time.
- 1d. Proportion/number of physicians and nurse practitioners qualified to deliver MAT in CMC community services.
- 1e. Proportion/number of licensed clinical social workers (LCSWs) and case managers qualified to deliver SBIRT in CMC community services.
- 1f. Proportion/number of physicians with physician waivers to prescribe and dispense buprenorphine in CMC community services.
- 1g. Self-reported confidence/competence among CMC community providers to deliver appropriate services for individuals with co-occurring substance use disorders and mild to moderate mental health problems following training

2. Engagement with Behavioral Health Services

- 2a. Number/proportion of individuals screened for substance use disorders at ARC using a standardized assessment tool (*Level 1 services*).
- 2b. Number of clients utilizing ARC brief withdrawal management services (*Level 1 services*).
- 2c. Number/proportion of appropriate clients engaging* with MAT for substance use disorder treatment, consistent with American Society of Addiction Medicine (ASAM) National Guidelines (*Level 2 services*).
- 2d. Number/proportion of individuals receiving ongoing MAT for substance abuse, consistent with ASAM National Guidelines (*Level 2 services*).
- 2e. Number/proportion of appropriate clients engaging with trauma-informed counselling services (*Level 2 services*).
- 2f. Number/proportion of clients that engage in the intensive services (when appropriate), including mental health and withdrawal management treatment, respite care, case management, housing support and stabilization services (*Level 3 services*).

Outcomes

The outcomes evaluated under each domain are as follows:

1. Improvements in the Access, Pathways and Engagement in Care

* For the purposes of the evaluation, engagement is defined as completing the first appointment.

- 1a. Reduce the number/proportion of referrals to BHS for mild/moderate mental health and co-occurring substance use disorders, relative to historical controls.
- 1b. Increase the number of referrals to BHS with serious behavioral health concerns, relative to historical controls.
- 1c. Significantly increase the number of individuals assessed for treatment for mild/moderate behavioral health concerns at ARC, relative to historical controls of those assessed with mild/moderate behavioral health concerns assessed at BHS.
- 1d. Significantly increase the number of people referred to receive substance use disorders treatment at ARC, relative to historical controls.
- 1e. Significantly increase the number of individuals engaged in treatment for substance use disorders, relative to historical controls across all services.
- 1f. Significantly increase the number of individuals that are in recovery^{*} for a substance use disorder following treatment, relative to historical controls across all services.
- 1g. Significantly increase the number of individuals with mild/moderate behavioral health concerns referred to receive mental health treatment, relative to historical controls across all services.
- 1h. Significantly increase the number of individuals with a mild/moderate behavioral health concerns engaged in mental health treatment, relative to historical controls across all services.
- 1i. Significantly increase the number of individuals with a mild/moderate behavioral health concerns that continue to receive behavioral health treatment 6-months from baseline, relative to historical controls across all services.
- 1j. Across CMC and BHS services, significantly increase the total number of individuals that complete a full behavioral health assessment, relative to historical controls.
- 1k. Across CMC and BHS, increase the total number of individuals receiving behavioral health treatment for mental health and co-occurring substance use disorders, relative to historical controls.
- 1l. Significantly increase the proportion of individuals that are referred to substance use treatment that are in recovery, relative to historical controls.
- 1m. Increase the number/proportion of individuals that receive SBIRT following receipt of ARC brief withdrawal management services.
- 1n. Significantly increase the number/proportion of individuals that are referred to behavioral health services following an episode of brief withdrawal management relative to historical controls.
- 1o. Significantly increase the number/proportion of individuals that engage in behavioral health treatment following an episode of brief withdrawal management relative to historical controls.

2. Reducing Racial/Ethnic Disparities in Behavioral Healthcare Services Provision

- 2a. Increase the number/proportion of clients from under-represented groups referred to substance use disorders treatment, relative to historical controls.

^{*} The criteria by which recovery will be defined will be determined by the CSC, prior to the submission of the final evaluation plan

- 2b. Increase the number/proportion of clients from under-represented groups that engage in substance use disorders treatment, relative to historical controls.
- 2c. Increase the number/proportion of clients from under-represented groups in recovery from substance use disorders, relative to historical controls.
- 2d. Increase the number/proportion of clients from under-represented groups referred to mental health treatment at ARC, relative to historical controls.
- 2e. Increase the number/proportion of clients from under-represented groups that engage in mental health treatment at ARC, relative to historical controls.
- 2f. Increase the number/proportion of clients from under-represented groups that either remain in CMC services after 6 months, or complete treatment, relative to historical controls.

3. Reducing criminal justice bookings, convictions and recidivism

- 3a. Reduce the number/proportion of those that are booked, charged, or convicted of a new felony or misdemeanor within 30 days following engagement in substance use disorder treatment services delivered as part of the Homeward Bound Initiative.
- 3b. Reduce the number/proportion of those that are booked, charged, or convicted of a new felony or misdemeanor within 30 days following engagement in mental health treatment, delivered as part of the Homeward Bound Initiative.
- 3c. Reduce the number/proportion of those that are booked, charged, or convicted of a new felony or misdemeanor within 90 days following engagement in substance use disorder treatment services delivered as part of the Homeward Bound Initiative.
- 3d. Reduce the number/proportion of those that are booked, charged, or convicted of a new felony or misdemeanor within 90 days following engagement in mental health treatment services delivered as part of the Homeward Bound Initiative.
- 3e. Reduce the number of individuals cited for public intoxication (within a to-be- determined designated target area), relative to historical control.

4. Delivering High Levels of Client and Provider Satisfaction with New Models of Care

- 4a. Measure high levels of client-reported satisfaction with treatment at ARC for each episode of care.
- 4b. Measure at least equivalent client-reported satisfaction in treatment with those that self-identify as African-American or Latino, relative to other racial/ethnic groups.
- 4c. Explore clients' experiences of receiving care.
- 4d. Explore providers experiences delivering care under the Homeward Bound Initiative.

5. Functional Improvements Following Receipt of Intensive Support Services

- 5a. Significantly improve functioning as determined by the ANSA following a sufficient period of engagement in treatment* or recovery, relative to baseline.

* "Sufficient period of engagement in treatment" will be determined by the CSC, based on their preliminary experiences of delivering case management and trauma-focused counseling in accordance with the Homeward Bound Initiative.

5b. Assess the number/proportion of clients that are either employed or are enrolled in a job training program following a sufficient period of engagement in treatment or recovery.

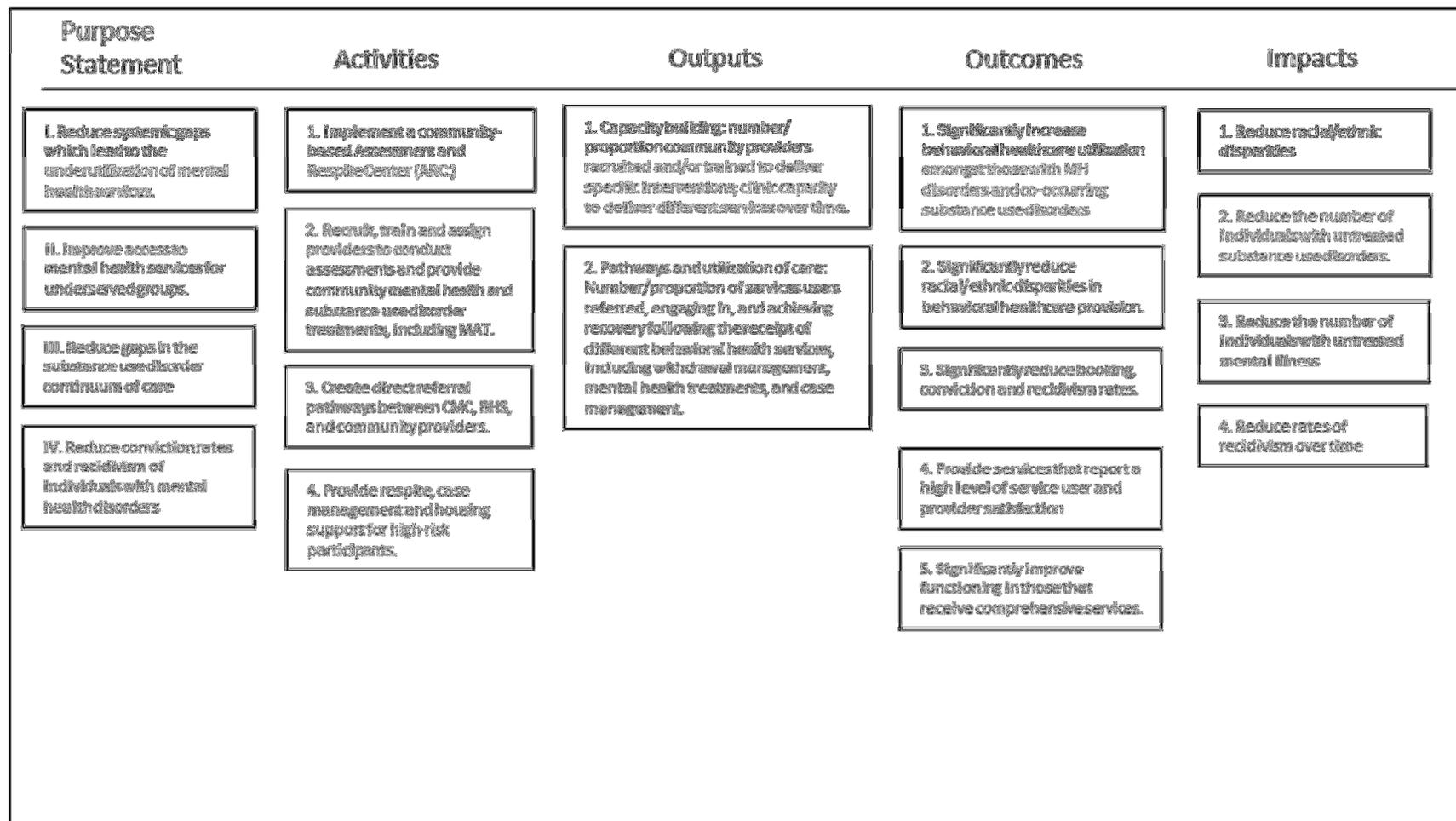
5c. Assess the number/proportion of individuals that remain in stable housing three months following a sufficient period of engagement in treatment or recovery.

Impacts

Contingent on meeting the stated objectives, we would expect the following long-term systemic consequences of the Homeward Bound Initiative to include:

1. A reduction in racial/ethnic health disparities among African American and Latino populations.
2. A reduction in the number of individuals with untreated substance use disorders.
3. A reduction in the number of individuals with untreated mental illnesses.
4. A reduction in recidivism over time.

Figure 2: Logic model of the Homeward Bound Initiative



Data collection plan

In order to evaluate the program in accordance with the stated goals and objectives it will be necessary to collect a range of data from different sources. Each stakeholder involved in the data process will be represented on the EDCC. Prior to the submission of the full evaluation plan, the evaluation team will assess and determine how the data will be feasibly recorded, the existing and available data, the format of the data, and the necessary data sharing agreements that will need to be implemented. Before new data collection procedures are implemented, or data shared with the program evaluation team all procedures will be reviewed and approved by the UC Davis IRB.

To evaluate the capacity-building component of the Homeward Bound Initiative over time the program evaluation team will keep a log of all incidences of clinic openings/expansions, all providers recruited to deliver Homeward Bound-related services, and all relevant trainings and qualifications obtained. In order to assess the impact of training on provider self-reported confidence and competency in delivering the interventions, providers will complete a brief self-report survey pre- and post- training sessions. To assess changes to the access, pathways, and engagement in care, CMC and BHS will make a record of each time a client is referred to a particular service, each time the client successfully engages in a service, and each time a client successfully completes an encounter of care. Demographic information will also be collected in order to evaluate outcomes related to racial/ethnic disparities in behavioral healthcare provision. To determine whether these changes have led to a significant increase in the utilization of behavioral health services, the reported figures will be compared to historical data, obtained from existing BHS records.

In order to assess client and provider satisfaction with services, qualitative and quantitative data will be collected. Quantitative data will be collected via the CSQ-8, which will be given to clients after each episode of care. Each survey will include basic demographic information in order to assess satisfaction across racial/ethnic and other distinct population groups. Qualitative data will be collected in the form of semi-structured interviews, both with clients and providers, in order to explore individuals' experiences of care, and to identify any possible barriers to treatment. These data will be used to refine services as part of the process evaluation.

In order to evaluate whether the provision of behavioral health services leads to functional improvements over time, all clients that engage in a comprehensive package of care (defined as Level 3 services) will complete the ANSA as part of their intake assessment, and again at an appropriate endpoint that will be determined by the CSC prior to the full proposal submission date. To evaluate whether the Homeward Bound Initiative is effective in reducing the number of bookings, charges, and rates of recidivism of those enrolled in Homeward Bound Initiative services, data collected by the County Sheriff will be used.

IV. Capacity of the Local Evaluator

Ruth S. Shim, M.D., M.P.H., Principal Investigator

Ruth S. Shim is the Luke & Grace Kim Professor of Cultural Psychiatry. Before joining the Department at UC Davis, she was Vice Chair of Education and Faculty Development at the Department of Psychiatry at Lenox Hill

Hospital, part of the Northwell Health in New York, and was previously Associate Professor in the Department of Psychiatry and Behavioral Sciences and Associate Director of Behavioral Health at the National Center for Primary Care (NCPC), both at Morehouse School of Medicine in Atlanta. Dr. Shim has specific expertise in the social determinants of mental health and disparities in access to mental health services. As Principal Investigator, Dr. Shim will be involved in the daily operations of the evaluation, being ultimately responsible for all aspects of the evaluation design, data analysis, and dissemination of findings.

Amanda Berry, B.S., Project Manager

Amanda Berry is the project manager for the Behavioral Health Center of Excellence and oversees collaborative activities and evaluation projects with external organizations and California counties. Amanda holds a bachelor's degree in biopsychology and is experienced in communication and marketing. As project manager, Amanda will work closely with the evaluation team and the San Joaquin County team to coordinate successful completion of pertinent deadlines and organizational aspects of the project.

Mark Savill, Ph.D., Co-Investigator

Mark Savill is a Postdoctoral Fellow on the T-32 Clifford Attkisson Services Research Training program at UC San Francisco. Dr. Savill specializes in services research, with experience of evaluating complex interventions for individuals with severe mental health disorders in the community. As a co-investigator, Dr. Savill will assist in the evaluation design, data collection and analysis, and dissemination of the findings.

Rachel Loewy, Ph.D., Co-Investigator

Dr. Loewy is an Associate Professor of Psychiatry at the University of California, San Francisco and a clinical psychologist with extensive research and clinical training regarding serious mental illness. She has served as PI for several individual county evaluation contracts in California for programs supported by MHSA Prevention and Early Intervention funds, and collaborated with Drs. Carter, Niendam, Melnikow and Savill on a statewide MHSA evaluation project. She will provide expertise related to county-level program evaluation and supervise Dr. Savill.

Joy Melnikow, M.D., M.P.H., Key Personnel

Joy Melnikow is the Director of the Center for Healthcare Policy and Research and Professor of Family and Community Medicine at UC Davis. Dr. Melnikow will provide expertise related to cost effectiveness evaluation. She will assist the project team in developing elements of the evaluation plan including specific methods for tracking program costs, potential savings in areas outside of the program, and defining measurable, specific outcomes feasible for use in an economic analysis of the program effects.

V. Evaluation Timeline

Evaluation activities will occur over a five-year project period. Major activities are described in the chart below. The dates for reports due to the BSCC are fixed and are indicated in red font. The Year Two and Year Three Evaluation Reports will include all required content for the "preliminary" and "final" evaluation reports, as requested by BSCC.

Evaluation Activities and Deliverables

September 2017	Identify Local Evaluator
November 2017	(Preliminary) Local Evaluation Plan (11/15/2017)
April 2018	Submit Evaluation Plan for IRB Review
June 2018	(Final) Local Evaluation Plan
August 2019	Year Two Evaluation Report (8/15/2019)
September 2019	Presentation of Preliminary Findings to Project Stakeholders
September 2020	Year Three Evaluation Report (9/30/2020)
November 2020	Lessons Learned and Recommendations for Program Improvement, and (Revised) Local Evaluation Plan
September 2021	Year Four Evaluation Report
September 2022	Final Outcome and Process Evaluation Report
December 2022	Presentation of Findings to Project Stakeholders, and Dissemination of Research/Lessons Learned

References

Allen, R. S., & Olson, B. D., 2015. Validity of the Adult Needs and Strengths Assessment with Substance Abuse Populations. *Journal of Addition Research and Therapy*, 6(3), 235. DOI: 10.4172/2155-6105.1000235.

De Wilde, E. F., & Hendriks, V. M. (2005). The Client Satisfaction Questionnaire: psychometric properties in a Dutch addict population. *European addiction research*, 11(4), 157-162.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: development of a general scale. *Evaluation and program planning*, 2(3), 197-207.

Lyons, J. S., & Walton, B. A. (2013). Adult Needs and Strengths Assessment (ANSA): an information integration tool for adults with behavioral health challenges. *Chicago, IL: Buddin Praed Foundation*.

San Joaquin County Continuum of Care, March 2017. *The 2017 Point-in-Time Count*. Retrieved November 15, 2017, from <http://blogs.esanjoaquin.com/stockton-city-hall-blog/files/2017/04/Point-in-Time-Report-overall-FINAL-4-4-17.pdf>.