Placer County Proposition 47 Cohort 2
FINAL LOCAL EVALUATION REPORT

Executive Summary

The Placer County ACTion Team Cohort 2 began delivering services in November 2019 and has achieved positive outcomes for individuals enrolled in the program. The ACTion Team is a multidisciplinary team that offers an array of services and resources, including substance use disorder (SUD) and mental health (MH) treatment services, to promote health and well-being and to reduce new convictions and criminal recidivism in justice-involved individuals, with histories of SUD and/or MH issues.

The ACTion Team is a collaboration between Granite Wellness Centers (GWC), Placer County Probation Department (PD), and Placer County Health and Human Services (HHS) which includes Behavioral Health. Services are available at GWC's sites in Roseville, Auburn, and a new location in Lincoln. Services are also provided in community settings, including the member's home. This approach has been extremely effective to deliver coordinated and collaborative services to this complex, high-risk population.

Referrals to the ACTion Team come from Probation, BH, organizational providers, and community partners. ACTion Team members received these coordinated and collaborative services and achieved positive outcomes, which included placement in and successful completion of residential SUD treatment; outpatient SUD and/or MH services; attaining or maintaining stable housing; obtaining education and/or employment; and reducing criminal recidivism.

The COVID-19 pandemic over the past three years presented new and unexpected challenges in the implementation of the Cohort 2 program. The ACTion Team quickly implemented new strategies and processes to be able to deliver services while ensuring the safety of everyone involved in the program. Extra precautions were taken when admitting new members as well as delivering services to our ongoing team members. This included, but not limited to, increased use of telehealth services, and expanded use of ride-share programs to support members to attend needed appointments. Probation also provided transportation to members, when needed.

Services were also enhanced to provide additional support for persons with increased SUD and/or MH symptoms as a result of extended isolation, prolonged shelter in place, and an inability to visit with family and friends. Management and staff continued to plan and implement new and revised strategies to modify services to ensure the safety, health, and welfare of both staff and members.

The success of this program is demonstrated by the outcomes achieved by the members served. At the end of Cohort 2, on February 15, 2023, a total of 249 unduplicated individuals were enrolled in the ACTion Team. Of those 249 members enrolled in the program, 178 members (71.5%) maintained or achieved stable housing and 159 members (63.9%) obtained or maintained employment. Of the 92 members (36.9%) placed into residential SUD treatment, 83

members (90.2%) were successfully discharged from residential SUD treatment. Only 59 of the 249 unduplicated members (23.7%) had new convictions.

Project Background

The Cohort 2 ACTion Team was modeled after the Placer County Proposition 47 Cohort 1 ACTion Team. The ACTion Team delivers strengths-based, individual- and family-driven, solution-focused wraparound-type services to address the substance use and mental health needs of young adults, ages 18-32.

The Cohort 2 ACTion Team utilized the same collaborative model that was successful with the Cohort 1 program and expanded services to all adults, ages 18 and older, as well as expanding services to diverse cultures. The ACTion Team offered an array of services and supports to engage members in services, delivered a broad array of services, and engaged family members in services, whenever possible, to achieve each member's goals.

ACTion Team services were individual and family driven, strengths based, and solution focused, with an overall goal to divert individuals and prevent recidivism. ACTion Team used a harm-reduction model that was trauma-informed, met the member's holistic needs, and delivered in the community. The Probation Officers support positive behavior change; expect and model accountability; and ensure compliance with court orders. The SUD and MH counselors delivered treatment, individually and in groups. Advocates provided case management and supportive services; provided transportation to appointments; worked with the families; and linked members to other services.

Advocates have lived experience and helped members see that it is possible to make positive changes and to succeed. The effectiveness of ACTion Team was found in the collaboration of the team, in working together to know each member, and engaging them to be active participants. SUD and MH counselors were embedded in the Probation Department, had access to the Probation's Caseload Explorer data management system, and shared timely assessments and diagnoses to make informed decisions about the member and their needs. This collaboration and integration of services worked at all levels to serve the member holistically, creating a safety net for the member, family, and AT, while holding each person accountable.

The ACTion Team was an integrated and collaborative multidisciplinary team that provided immediate, timely, and individualized case planning and services to meet the needs of each member, their families, and other support persons. Services were culturally responsive, trauma-informed, and tailored to the member's needs. Services were delivered to treat members' substance use disorder (SUD) and/or mental health (MH) issues and support members to achieve their goals by helping to secure housing, employment, and positive social connections. The development of these skills helped create a strong foundation to help deter members from activities that may cause recidivism. The ACTion Team model was effective in achieving the overall goals of diverting individuals from the criminal justice system, preventing recidivism, and promoting safe and healthy communities.

The ACTion Team utilized evidence-based practices and applies them in a creative, person-centered manner to engage individuals, families, and multiple agencies to support positive

outcomes. The multidisciplinary, integrated collaboration, daily communication, and team accountability have been essential in building trust and a consistent support network for members, which helps reduce SUD and MH symptoms, develop positive decision making, and reduce recidivism. The success of this project helps identify strategies that were effective with diverse populations and identify outcomes that make lasting behavior changes, as well as inform both policy and system changes across agencies. When obtaining feedback from current ACTion Team members, the overwhelming message was how ACTion Team created a safe and trusting environment, and that ACTion Team "never gave up on me, even when I had given up on myself." ACTion Team members also noted, "The Team knew what I needed, when I didn't know what I needed. But they also let me work on my goals at my own pace."

Goal 1: Transition individuals from jail, and deliver multidisciplinary, integrated ACTion Team services. Objectives: By the end of the grant period the ACTion Team will: a) Increase identification and assessment of culturally-diverse individuals who meet ACTion Team criteria; b) Increase the number of individuals and families who receive and complete ACTion Team services; c) Increase the number of individuals who avoid new criminal offenses and convictions; d) Deliver ACTion Team services to improve outcomes and increase diversion from jail; and e) Link individuals to needed services to achieve and sustain positive outcomes.

Goal 2: Reduce homelessness of ACTion Team members. Objectives: By the end of the grant period, the ACTion Team will: a) Increase the number and percent of individuals who are living in stable housing; b) Deliver housing-related assistance and support services to persons who are homeless or at risk of homelessness; c) Deliver ACTion Team advocacy services to build and sustain positive social connections.

Goal 3: Reduce recidivism of ACTion Team members. Objectives: By the end of the grant period, the ACTion Team will: a) Increase the number of individuals who complete vocational and educational activities; b) Increase the number of members who are employed, and help sustain their employment; c) Teach healthy communication skills; and d) Deliver services to family members to support reunification.

Evaluation Method and Design

A pre-post evaluation design was utilized to compare outcome indicators, during services, at discharge, and annually. Evaluation activities included gathering information from Probation, ACTion Team, Granite Wellness, and Health and Human Services-Behavioral Health. Evaluation activities included the state performance measurement requirements and expanded the data and analysis to inform the ACTion Team and partner agencies. Local evaluation activities were conducted throughout the grant period. Data was evaluated to identify differences in access, service utilization, and outcomes, to determine whether ACTion Team services were effective at promoting community safety and reducing recidivism. The ACTion Team adheres to the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Extensive data was collected on each member at referral and during admission, as well as throughout the program and at graduation and/or completion of services. Data for each member was analyzed and outcomes were calculated to determine the number of members who showed improvement and/or achieved each measure. Individuals could be referred to ACTion Team

through several sources. Probation reviewed each person's criminal history, and conducted the Correctional Assessment and Intervention System (CAIS) data to identify individuals who met the eligibility criteria. The ACTion Team worked directly with Probation, PREP, jail staff, courts, and BH to identify individuals who were appropriate for the AT. Community and cultural providers also referred individuals to AT for services. One of the priorities of this grant was to increase the number of referrals of racially- and culturally-diverse individuals. A bilingual, bicultural *promotore* also conducted outreach in the jail and community to identify persons who might benefit from referral.

Each person referred to the ACTion Team was screened and, if initial criteria were met, received a substance use disorder and mental health assessment. In addition, each individual participated in a Family Mapping meeting, which helped to document the individual's family life chronology and identify generational and cultural patterns in one's life, as well as identifying historical and current significant sources of support. From these activities, each member developed his or her goals and identifies activities to support them in accomplishing those goals. The multi-disciplinary ACTion Team worked closely with the member to develop a coordinated ACTion Team Plan.

Individuals were linked to the appropriate level of service, including residential treatment services for substance use disorders and community-based outpatient treatment for substance use and/or mental health treatment services. Housing assistance services were also offered to ensure the individual was able to live in a stable living situation in the community.

The ACTion Team met weekly to discuss new and ongoing members and identified immediate and longer-term needs. Services were coordinated to identify which team member could support the member to help them achieve their goals.

This comprehensive data provided the foundation for evaluating the services and outcomes of the ACTion Team to ensure quality and reliable data collection. When a new staff member joined the Cohort 2 ACTion Team, they were trained to collect data on the evaluation forms. This training provided guidance on how to use the SUD and/or MH assessment tools, document the target population criteria, and ensured timely access to the program. In addition, staff were trained in the identified Evidence-Based Practices (EBPs) to create core skills for delivering wellness, recovery, and strength-based services.

The ACTion Team delivered an array of multi-disciplinary services, including SUD, MH, case management, family supports, housing assistance, and linkage to services in the community. The ACTion Team coordinated each staff's schedule and the needs of each member to provide timely and individualized services. Members were also linked to other services in the community to meet their needs. This linkage included referrals to psychiatric MH services and medications; SUD Medication Assisted Treatment (MAT); SUD residential services; dental; collaboration with child welfare to promote reunification with a child; PREP and employment services; GED; community college, and other needed services. Diversion courts were utilized, when appropriate, to support the member and family to meet their goals.

ACTion Team advocates created a welcoming, recovery and strength-based environment to support positive choices and success. The ACTion Team helped each member navigate through the system to help them learn how to achieve their goals, such as to attain employment and/or enroll in the local community college or training program to gain skills to meet their goals.

Housing assistance was also available to help find an apartment, complete the required paperwork, and move into the living situation. A Housing First model was used to help members find housing and the ACTion Team provided support to help members stay housed. Some members were eligible for one of the limited number of housing vouchers. The goal was to provide support to the member to help them find stable and safe housing in the community and help them sustain it while receiving services. A vocational assistant linked members to employment opportunities, including the Placer Re-Entry Program (PREP). A representative from Sierra Community College served on our LAC, and served as a liaison to the collect to help support members to enroll and attend courses. Other training programs were also identified, based upon the member's identified goals.

ACTion Team staff were trained to deliver trauma-informed services to promote the development of resilience and positive relationships. The ACTion Team program was designed to have four Phases (1-4). Members moved through Phases (1-4) while enrolled in the program. Most members begin in the engagement stage at Phase 1, working closely with staff to create plans, identify goals, and utilize the resources available to them.

As members developed skills to manage their SUD and/or MH symptoms, find safe and stable housing, and secure employment and/or attend training or education as they moved up through the Phases. The ACTion Team met regularly to each discuss members' progress through the program to ensure members' successful progress towards their goals as well as to collaborate to address any new issues as a coordinated team.

Data was collected on an ongoing basis on all activities, services, and key outcome measures to provide the information needed to evaluate the goals of the program. Data was analyzed on the number of persons served, by demographics, services received, and outcomes achieved, over time.

Process variables included: a) Annual number of members (ages 18 and older) enrolled in the ACTion Team who met the target population criteria, with a priority to increase the number of racially- and culturally-diverse members; b) Number of outpatient SUD and/or MH service treatment hours delivered annually; c) Number of members who received SUD residential treatment annually and length of stay; d) Number of members who received housing assistance services; e) Number of members enrolled in vocational/educational activities annually; f) Number of members enrolled in Diversion Courts; g) Number of hours of transportation provided to members; h) Amount of flex funds used and the purpose for the purchase; i) Number of members who accessed legal services; j) Number of members who accessed Social Services; k) Number of members who received assistance with obtaining food; l) Number of members who received support for basic necessities (hygiene; socks; clothing; linens); m) Number of staff who attended cultural training annually; and j) Number of staff hired, by language and culture.

Data collection tools developed for Cohort 1 were also used for Cohort 2, with slight modifications to evaluate the success of the ACTion Team and to meet Cohort 2 reporting requirements. ACTion Team staff collected data daily, documenting member's enrollment and discharge information and the number of hours of service delivered each day, by date. HIPAA and 42 CFR standards were followed. Evaluation activities were designed, analyzed, and reported by the organization conducting Cohort 2 evaluation (IDEA Consulting).

The length of stay in the program was also analyzed to determine the number of months in the program. Data was also analyzed by age group; gender; race/ethnicity; and other demographics to determine if services were consistent across different cultural and age groups.

The ACTion Team data was collected by all ACTion Team staff including SUD and MH clinicians; Advocates; and Probation Officers. Data was recorded for each service delivered by staff, including date of service, type of service, and duration. In addition, key events for each member were recorded by date for each outcome. For example, admission and discharge from SUD residential treatment; date employment starts; date employment ends; reunification with children; changes in living situation (date homeless, date of move to new living situation, etc.). Data was entered into an Excel spreadsheet and analyzed at least monthly. Data was reviewed for quality and completeness; and staff were contacted if there were any discrepancies in the data or if there was missing data.

Data was analyzed and presented at the monthly meetings with the ACTion Team Leadership Committee to review and discuss the number of new admissions; total membership; demographics; and other key factors. Data was also shared and discussed at the quarterly Local Advisory Committee (LAC) meetings to obtain feedback from community members on the progress and implementation of the program. The committee members discussed any changes to the program, outcomes, and requests for additional analysis of the data. This ongoing collaboration helped to the program was implemented to fidelity.

The ACTion Team and the Evaluator continuously monitored service activities to ensure that the program and the evidence-based practices were implemented with fidelity to the model. A Quality Improvement process was used to modify programs or practices, as needed, to help achieve positive outcomes. In addition, periodic discussions with ACTion Team staff and members helped identify opportunities to strengthen services.

The Cohort 2 ACTion Team target population included individuals who were 18 years of age or older who have been arrested, charged with, or convicted of a nonviolent, non-serious criminal offense; and who have a history of SUD and/or MH problems that limit one or more of their life functions. Cohort 2 expanded the eligibility criteria to include persons who were ages 18 and older (Cohort 1 served only persons ages 18 to 32).

In addition, eligible members had at least one of the following risk factors: 1) Homeless or unstable living situation; 2) School drop-out; 3) History of trauma/abuse; 4) Out-of-home placement; and/or 5) Unstable family support system.

Cohort 2 was originally expected to serve approximately 150 persons per year, with a total of 350-400 people. With the reduction in services due to the pandemic, there were fewer persons

served. The total unduplicated number of persons served in Cohort 2 was 249. The program did not have a comparison group.

Data collected and analyzed on key outcome measures helped to continuously monitor and improve the quality and quantity of services to ensure that ACTion Team members achieved positive outcomes. Outcome data compared each member's baseline data on a number of different measures, and then collected data while in the program using the same measures across time. A comparison of each member's status on each data element from admission to graduation provides information on each member's outcomes. Data was analyzed and reported as Achieved/Obtained; Maintained; or Declined. For example, if a member was homeless at baseline and living in an independent living situation at graduation, the member would be reported as Achieved Stable Housing. If a member was living in an independent living situation at baseline and also living in an independent living situation at graduation, the member would be reported as Maintained Stable Housing.

Outcome data was used to inform participating entities and stakeholders about the success of the program, indicating that members were achieving their outcomes over time. Data on outcome measures was collected daily, which documented both services delivered and "key events" as they happened, by date. Outcomes included a) living in a stable living situation; b) employed; c) no new convictions; d) enrolled in training or education; and e) positive social supports.

Outcome data was entered into a database and analyzed quarterly and annually. Data from the Probation Department provided historical and current arrest data and conviction data.

The outcome measures for the Cohort 2 ACTion Team included number and percent of members who:

- Maintained or achieved stable housing;
- Maintained or achieved employment;
- Had no new convictions

The ACTion Team utilized a number of different EBPs to help individuals meet their goals. Staff were trained in Motivational Interviewing to help engage persons in services; Trauma-Focused Cognitive Behavioral Therapy to support health and wellness; and other EBPs, including Seeking Safety, Living in Balance, and a modified Matrix Model, to support recovery from substances.

The Wraparound Model was used to build support networks for individuals and their families, to ensure that the individual is actively involved and helps leads their treatment. Housing assistance services utilized a Housing First model to help members find housing and the ACTion Team and Housing Coordinator provided support to help members stay housed. A vocational assistant linked members to employment opportunities, including the Placer Re-Entry Program (PREP), as well as linked members to Sierra College or other educational settings to help them meet their goals. The Ready-to-Rent program was utilized, when appropriate.

The key data measurement tool was the Individual Services Tracking Sheet that each staff used to document all services delivered to members and all key events that happened in each

member's life. The Individual Services Tracking Sheet was modified periodically through conversations with the ACTion Team staff and the Evaluator, to ensure all essential information was consistently collected. Periodically, the staff would ask to add a few new variables to the tracking sheet to reflect the services they were delivering.

Members moved through the Phases (1-4) while enrolled in the project. Most members started in the engagement stage at Phase 1, in which they needed the most assistance from staff to create plans, identify goals, and learn to utilize the resources available to them. As members became stable in their SUD and/or MH symptoms, housing situation, and/or employment/education, they moved through the Phases. By the end of Phase 4, members needed minimal support from their advocates and other staff, had the confidence and skills they needed to set and work towards goals on their own, and were able to build a stable, healthy lifestyle.

The ACTion Team met weekly to discuss each member's progress through the program to ensure members' successful progress towards their goals. At each meeting, the ACTion Team discussed new referrals, ongoing members, and persons who were nearing graduation, to coordinate services, identify needs, and celebrate successes

This coordinated, multidisciplinary integration created a consistent safety net to help members meet their goals. This trust and consistency have been valuable in supporting members in their recovery. One ACTion Team member noted that the ACTion Team staff, especially the Probation Officer(s), served as a "pillar of accountability" in their lives.

Members were recommended for graduation (successful program completion) when they showed stability in SUD and/or MH symptoms, housing situation, met employment and education goals, and had a positive support network, including family involvement, whenever possible. Upon completion of the program, staff completed a Service Completion form for each member, which included questions regarding reasons for ending services, current housing situation and employment status, and current SUD and/or MH status.

Members attended a graduation where the ACTion Team staff and other persons supportive to the member came together to share their journey, recognize how the ACTion Team learned from the member, and how the member learned from the ACTion Team. This provided a powerful recognition of the positive changes achieved and a vision for their future.

Members who successfully completed the program were discharged and graduated from the AT when they met their goals and/or left the program. Some members left the program before completing all their goals because they found full time employment. Others may have been reunited with their children and moved out of the area to live with their families, while others may have been entering college or a training program, or had other life events happen. All of these examples were considered successes!

Data was collected on each member throughout the project through staff completion of data collection forms including the Individual Services Tracking Sheet. Members were recommended to the program upon review of the Probation CAIS data and a completed Referral Application form, which included questions regarding the potential member's demographic information,

including race/ethnicity and housing status, SUD and/or MH history, and reasons the potential member wanted to be admitted. If admitted to the program, staff complete an Admit Form for each member, which contains more detailed demographic questions and recommendations of which Phase was most appropriate for the member to begin the program. In addition, a clinical assessment was completed to help determine the level of SUD treatment and MH treatment needed to support the individual's goals.

Throughout services, staff completed an Individual Services Tracking form for each member, for each day of service. This form collected information on the date of service; types of services received; and key events (e.g., enrollment, discharge, successful completions, employment, educational activities, arrests, hospitalizations, and services received). The Individual Services Tracking form provided ongoing information on all services and events for each member and provided the foundation for the evaluation activities and outcomes.

Upon completion of the program, staff completed a Service Completion form for each member, which included questions regarding reason for ending services, key outcomes including current housing situation, employment status, and current SUD and/or MH status. ACTion Team staff compiled the data daily and submitted data collection materials monthly to the evaluation team (IDEA Consulting) for analysis and data quality checks. The evaluation team provided monthly feedback to staff to maintain quality of services and data collection.

As with all other aspects of the ACTion Team program, data collection was impacted by the COVID-19 pandemic. As staff transitioned to delivering services via telehealth, texting, emails, and/or by phone, changes to the data collection forms were needed to ensure that staff could continue to document their activities in a timely, accurate manner.

The Individual Services Tracking Sheets were updated so staff could report which mode of communication they used while delivering services (face-to-face, by phone or text, via telehealth, etc.) as well as the frequency of communicating between staff and the evaluation team to clarify how staff should report their new and adaptive types of service. For example, ACTion Team staff communicated with members via text several times per day. The ACTion Team staff worked with IDEA Consulting to ensure that texts and similar contacts with members were reported consistently by all staff.

Evaluation Results and Discussion

Placer County's Cohort 2 ACTion Team successfully implemented the goals of the grant. Cohort 2 members were enrolled into the program beginning in November 2019. By the end of the funding period, February 15, 2023, the ACTion Team had served 249 unduplicated members. The ACTion Team met weekly to discuss current members, identify needs of members, review data, and discuss coordination of services across agencies. The staff who met weekly included Probation staff, the SUD counselor(s), mental health staff, Clinical Supervisor, Advocates, and the Program Manager. The Evaluator met with the Team monthly, and as needed, to review data and continue refining the data collection process and providing data on outcomes.

Table 1 shows the 249 total members by age. There were 45 members (18.1%) who were ages 17-25 when they were enrolled in the program; 82 members (32.9%) were ages 26-32; 85

members (34.1%) were ages 33-45; 27 members (10.8%) were ages 46-55; nine (9) members (3.6%) were ages 56-65; and one (1) member (0.4%) was 66 or older.

Table 1
Number and Percent of Cohort 2 Members, by Age at Enrollment

	# of Members	% of Members
17 - 25 years	45	18.1%
26 - 32 years	82	32.9%
33 - 45 years	85	34.1%
46 - 55 years	27	10.8%
56 - 65 years	9	3.6%
66+ years	1	0.4%
Unduplicated Total Members	**249**	**100.0%**

Table 2 shows the 249 total members by gender. Of the 249 members who were enrolled in Cohort 2, 146 members (58.6%) identified as Male and 102 members (41.0%) identified as Female. One (1) member (0.4%) identified as another gender identity.

Table 2
Number and Percent of Cohort 2 Members, by Gender

	# of Members	% of Members
Male	146	58.6%
Female	102	41.0%
Another Gender Identity	1	0.4%
Unduplicated Total Members	**249**	**100.0%**

As of February 15, 2023, of the 249 total members, there were 69 members (27.7%) from racially diverse backgrounds (i.e., American Indian/Alaska Native, Asian, Hispanic), as seen in Table 3. Enrollment data shows that 42 members (16.9%) identified as Hispanic, Latino, or Spanish; 178 members (71.5%) identified their Race/Ethnicity as Caucasian/White; 7 members (2.8%) identified as Black or African American; 13 members (5.2%) identified as American Indian/Alaska Native; 4 members (1.6%) identified as Asian, two (2) members (0.8%) identified as Native Hawaiian/Other Pacific Islander, one (1) member (0.4%) identified as more than one race, and two (2) members (0.8%) Declined to State their Race/Ethnicity. Staff consistently worked to expand outreach efforts to increase the number of referrals to the ACTion Team from across the community.

Table 3
Number and Percent of Cohort 2 Members, by Race/Ethnicity

	# of Members	% of Members
Hispanic	42	16.9%
Caucasian/ White	178	71.5%
African American/ Black	7	2.8%
American Indian/ Alaska Native	13	5.2%
Asian	4	1.6%
Native Hawaiian/ Other Pacific Islander	2	0.8%
More than one race	1	0.4%
Prefer not to answer	2	0.8%
Unduplicated Total Members	**249**	**100.0%**

Table 4 shows the number and percent of Cohort 2 members by length of stay in the program. Some members were admitted to Cohort 2 and then transferred to Cohort 3 to continue receiving services. Other members were admitted and discharged while in the Cohort 2 program. This data shows the length of stay by the total number of days, to better understand the number of people with shorter and longer lengths of stay.

For the 40 persons who started in Cohort 2 and then transferred to Cohort 3 to continue receiving services, there were 9 members who were in Cohort 2 for 60 days or less (22.5%). There were 14 members who received Cohort 2 services for 61-180 days (35%) and 14 members who received Cohort 2 services for 181-364 days (35%). There were 3 members who received Cohort 2 services for 365 days or more (7.5%). For those members who were admitted and discharged from Cohort 2, there were 24 who received services for 60 days or less (11.5%). There were 64 members who were in the program from 61-180 days (30.6%) and 70 members who were in the program for 181-364 days (33.5%). There were 51 members who were in the program for 365 days or more (24.4%).

Table 4
Number and Percent of Cohort 2 Members, by Length of Stay by Number of Days

	Transferred from Cohort 2 to Cohort 3*		Discharged**		Total	
	# of Members	% of Members	# of Members	% of Members	# of Members	% of Members
60 days or less	9	22.5%	24	11.5%	33	13.3%
61 - 180 days	14	35.0%	64	30.6%	78	31.3%
181 - 364 days	14	35.0%	70	33.5%	84	33.7%
365+ days	3	7.5%	51	24.4%	54	21.7%
Unduplicated Total Members	**40**	**100.0%**	**209**	**100.0%**	**249**	**100.0%**

Table 5 shows that of the members who were admitted and discharged during Cohort 2, the average length of stay was 248 days, and the median number of days was 204. This data shows the importance of the members staying in the program for several months to achieve their goals.

Table 5
Average and Median Length of Stay for all Discharged Cohort 2 Members

Average LOS	248 days
Median LOS	204 days

Table 6 shows the number and percentage of members by type of services received. The ACTion Team delivered an extensive array of services to achieve the goals of the program. There were 226 members that received Family Mapping (90.8%); 249 who received Assessment and Treatment Planning (100%); all 249 members received Advocate and Support Services (100%); and 202 that received WRAP services (81.1%). For SUD services, 179 members received Outpatient SUD services (71.9%), 92 received Residential SUD Treatment (36.9%); and 83 successfully completed the SUD Residential services (33.3%). This data shows that 90.2% of members who were placed in SUD residential treatment were successfully discharged from SUD residential treatment (83 / 92). There were 86 members who lived in a Recovery Residence (34.5%). Of the 86 members that were placed in a recovery residence, 71 members (82.6%) were initially placed into SUD residential treatment.

There were 109 members who received outpatient Mental Health treatment services (43.8%). In addition, 45 members (18.1%) received Flex Funds to support Housing needs, and 182 members (73.1%) received Flex Funds to support other needs (e.g., transportation, food, education).

Some additional services were also available. A total of 132 members (53.0%) received housing-related assistance and services; 102 members (40.9%) received job-related services; 68 members (27.3%) received education-related services; 97 members (39.0%) received family support services; nine (9) members (3.6%) received dental work; and 24 members were referred to the PREP Center and enrolled in the program (9.6%).

Table 6
Number and Percent of Cohort 2 Members, by Services Received

	# of Members	% of Members
Family Mapping	226	90.8%
Assessment and Treatment Planning	249	100%
Advocate and Support Services	249	100%
WRAP Services	202	81.1%
Outpatient SUD Services	179	71.9%
Residential SUD Treatment	92	36.9%
Successfully Completed SUD Residential	83	33.3%
Recovery Residence	86	34.5%
Mental Health Outpatient Services	109	43.8%
Flex Funds - Housing (first and last; furnishing)	45	18.1%
Flex Funds - Other	182	73.1%
Unduplicated Total Members*	**249**	**100.0%**

** Individuals may have more than one (1) type of service received.*

Table 7 shows additional services and supports received by Cohort 2 members. There were 132 members that received housing assistance services (53.0%); 102 members received employment related services (40.9%); 24 members were referred to the PREP Center and enrolled in the program (9.6%); 68 members received education-related services (27.3%); and 97 members received strengthening family relationship services (39.0%).

Members were also linked to a number of community services. There were 116 members linked to legal services (46.6%); 57 members linked to social services for benefits and/or reunification with their children (22.9%); 124 received transportation services (49.8%); and nine members received dental work (3.6%) which helped transform their lives and gave them the confidence to make friends and find employment. There were 142 members who received assistance with food or were enrolled in the CalFRESH program (57%) and 125 were provided with basic necessities such hygiene supplies, clothing, socks, and linens (50.2%).

Table 7
Number and Percent of Cohort 2 Members, by Additional Services and Supports Received

	# of Members	% of Members
Housing assistance services (landlord, apartment search)	132	53.0%
Employment-Related Services	102	40.9%
PREP Services	24	9.6%
Education-Related Services	68	27.3%
Strengthening Family Relationships	97	39.0%
Legal Services	116	46.6%
Social Services	57	22.9%
Transportation Services	124	49.8%
Dental Work	9	3.6%
Assistance with Food and CalFresh	142	57.0%
Basic Necessities (hygiene; clothing; socks; linens)	125	50.2%
Unduplicated Total Members*	**249**	**100.0%**

** Individuals may have more than one (1) type of service received.*

Members were also referred to a number of community services (see Table 8). There were 64 members referred to Behavioral Health (BH) SUD services (25.7%); 80 members were referred to BH Specialty Mental Health Services (32.1%); 35 referred to medical health services (14.1%); 9 referred to dental services (3.6%); and 59 referred to other services (23.7%).

Table 8
Number and Percent of Cohort 2 Members, by Referrals

	# of Members	% of Members
Referrals to SUD Services	64	25.7%
Referrals to Specialty Mental Health Services	80	32.1%
Referrals to Medical Services	35	14.1%
Referrals to Dental Services	9	3.6%
Referrals to Other Services	59	23.7%
Unduplicated Total Members*	**249**	**100.0%**

** Individuals may have more than one (1) referral.*

- ***Progress towards Goal 1: Transition individuals from jail and deliver multidisciplinary, integrated ACTion Team services.***

Placer County's Cohort 2 ACTion Team made excellent progress toward implementing the goals of the grant. The total number of persons served in Cohort 1 was 100 members. Cohort 2 increased the number of individuals served to 249 members. In addition, as of February 15, 2023, 69 members of the 249 total members (27.7%) were from racially diverse backgrounds (e.g., American Indian/Alaska Native, Asian, Hispanic). This number was also an increase from Cohort 1. Throughout the implementation of the ACTion Team Program, staff have continued to expand outreach efforts to increase the number of referrals to the ACTion Team from across the community. In addition, Granite Wellness was successful in hiring a Spanish speaking Latina Advocate who is bilingual, bicultural and has been employed during Cohort 2. This new hire helped provide culturally sensitive services in a member's preferred language, and helped to achieve postive outcomes.

Cohort 2 also expanded services to persons of all ages. As Cohort 2 was implemented, the Program Manager commented that the members who are 32 years and older are much more involved and successful in the program. Many of these members have children and families and they are "ready" develop new skills and make new choices to be able to support their families.

The leadership team continued to discuss ways to increase the number of referrals and expand outreach to other programs. Each person referred to the ACTion Team was screened and, if initial criteria were met, received a substance use disorder and mental health assessment. In addition, each individual participated in a Family Mapping meeting, which helped to document the individual's family life chronology and identify generational and cultural patterns in one's

life, as well as identify historical and current sources of support. From these activities, each member developed his or her goals and identifies activities to support them in accomplishing those goals.

Individuals were linked to the appropriate level of service, including residential treatment services for substance use disorders and community-based outpatient services for substance use and/or mental health treatment services. Housing support services were also offered to ensure the individual could live in a stable living situation in the community and help them end homelessness. In addition, vocational support was offered to help develop the skills and resume to help the member find and keep employment.

With the ongoing COVID-19 pandemic, delivering services was more complex, but the team developed new strategies and processes to ensure the safety of the team and members. Extra precautions were taken for admitting new members, as well as delivering services to ongoing team members. These strategies included, but were not limited to, increased telehealth services, and the expanded use of ride-share programs, to support members to attend needed appointments. The expanded ride-share program helped provide transportation for members while minimizing the risk of exposure for both staff and members. Ride-share programs provided an excellent resource for helping transport members to keep health appointments. Probation was also available to provide transportation to member, when needed, to help keep appointments.

Management and staff continued to plan and implement new and revised strategies to modify services to ensure the safety, health, and welfare of both staff and members. A number of renovations to the Granite Wellness offices were made to comply with the COVID-19 distancing requirements. Modifications included changing office space to have workstations positioned at least six feet apart; purchasing additional modular walls to allow safe workspaces; locating hand sanitizers at all stations; and having signage at outside doors and bathrooms reminding of face coverings and use of hand sanitizers, etc. Staff also supported members to comply with COVID-19 safety rules, including providing face masks, supporting them to get tested, and providing essential needs including COVID-19 preventative materials for members who were unhoused.

Services were also enhanced to provide additional support for persons with increased symptoms as a result of extended isolation, prolonged shelter in place, and an inability to visit with family and friends. As a result, the ACTion Team offered more supportive psychoeducation with members to help address issues regarding isolation, sheltering in place, etc.

Staff were more flexible in offering services to members during non-traditional hours, when needed, to meet members' needs. Staff also expanded their capacity to deliver supportive SUD and / or mental health services through expanded use of telehealth, as well as delivering more frequent services, of shorter duration, to help reduce the feeling of isolation. For example, rather than a one-hour face-to-face meeting, staff would use telehealth services with a member 3-4 times a week for 15 minutes each time, to touch base with clients more frequently and meet their immediate needs and provide support.

Substance use treatment residential services were still available, when needed. However, there were fewer beds available because the treatment facilities needed to keep a few beds vacant in case a member needed to be isolated, while they were in treatment and positive for COVID-19. The ACTion Team continued to arrange transportation for members when they were being released from the jail and/or being discharged from a residential treatment facility. Transportation was provided by the ACTion Team, including Probation, and/or through purchasing a ride share voucher for the member, to transport the member to a safe location in the community. Ride share programs were also used to transport members to scheduled appointments, job interviews, applying for housing, etc.

Staff also increased the number of visits to the jail, to ensure that each person stayed in contact with the Team and feel less isolated while being temporarily detained. With so much isolation in the world, the ACTion Team strived to provide members with additional support and increased contact from the team.

Probation staff on the Team continued to provide transportation for members, with the majority of services delivered through electronic methods. Probation staff were also equipped to provide services via telehealth, texting, email, and phone calls in order to protect members and staff, while continuing to deliver needed services.

- ***Progress towards Goal 2: Reduce homelessness of ACTion Team members.***

Once each member completed the assessment and mapping process, the member and Team identified key goals. For members who were unhoused, or at risk of being unhoused, the Team provided housing support services to help the member find a safe and stable living situation and offered ongoing support to help the member successfully remain in the house or apartment. The Housing Coordinator, as well as all staff, helped find affordable housing, worked closely with property managers to quickly resolve any issues at the housing site, and supported the member to resolve any conflicts with roommates and/or family members.

The ACTion Team also helped the member to meet basic needs such as signing up for benefits, setting up the apartment (e.g., kitchen supplies, linens, basic furniture), as well as teaching them basic skills such as shopping, using public transportation, and budgeting. Several staff were trained in the Ready to Rent model, which has been effective in helping individuals find stable housing.

As of February 15, 2023, 132 of the 249 total members (53.0%) had received housing-related assistance and services. As a result of these services, 178 members of the 249 total members (71.5%) had maintained or achieved stable housing.

In addition to these housing-specific services, the ACTion Team offered supportive services to the family, when needed, to help stabilize the living situation and help resolve any issues in order to promote a healthy support system. The ACTion Team provided Strengthening Family Relationship services to 97 of the 249 total members (39.0%).

The biggest challenge regarding providing housing support was the lack of affordable apartments in the county. Placer County has a vacancy rate of less than 1%. This situation created a challenge for the ACTion members and Team to find a safe and affordable living situation. This housing challenge was especially difficult for persons who have felony convictions. COVID-19 added additional challenges to a very complex situation.

At the end of the program, several members lived in transitional housing, to give them the time to develop skills in managing their recovery and developing wellness skills. The ACTion Team strives to help members find independent living situations when the member is ready for independent living and a housing unit becomes available.

COVID-19 and the shelter-in-place order continued until March 2023, which was an ongoing complication provide housing support. Staff continued to deliver services via telehealth, text, emails, and phone calls, in order to support members to locate housing, whenever possible.

- ***Progress towards Goal 3: Reduce recidivism of ACTion Team members.***

The ACTion Team's multidisciplinary, collaborative service delivery model was extremely effective at keeping members in the community, while minimizing further criminal behavior.

As of February 15, 2023, 190 of the 249 members had no new convictions (76.3%). There were 59 of the 249 members that had new convictions (23.7%). This data clearly demonstrates the positive outcomes achieved by the ACTion team. Please see Table 9 in the next section regarding recidivism data.

The ACTion Team delivered services to complex members with multiple needs. Many of the individuals enrolled in the program had substance use disorders (SUD) and co-occurring mental health issues. Granite Wellness Centers were extremely proactive to identify the needs of these individuals and enroll a member in SUD residential and/or outpatient services as soon as the intake was completed. This model was highly effective at helping the members to begin developing the skills needed to reduce substance use and achieve recovery and wellness, starting from the beginning of the ACTion Team.

As of February 15, 2023, 92 of the 249 total members (36.9%) were placed into SUD residential treatment. Of those 92 members placed in SUD residential treatment, 83 were successfully discharged from SUD residential treatment (90.2%).

In addition, 86 of the 249 total members (34.5%) were placed in a recovery residence. Of the 86 members that were placed in a recovery residence, 71 members (82.6%) were initially placed into SUD residential treatment.

Once each member completed the Family Mapping meeting and had an assessment completed, the member and Team identify key goals. For members who had a goal of attending a vocational training program, obtaining their GED, and/or attending college, the ACTion Team helped coordinate the college or training admission process and helped find the appropriate educational setting to help them achieve their goals.

During the COVID-19 pandemic, staff implemented new measures to ensure the health and safety of both staff and members. Managers and staff immediately began planning how to modify services to be able to continue to admit new members. The intake process was changed by conducting additional mental health assessment services, having Advocates accompany the new intake into the office, while the assessment was completed via telehealth by the clinician and substance use disorder staff. Advocates were able to support the individual to set up the telehealth meeting, have paperwork completed and signed, while following all social distancing protocols. Small treatment groups of four persons were implemented, to help create opportunities for youth and adults to have some supportive social connections and treatment. This approach helped the Team identify ways to expedite the intake process while creating a warm, welcoming intake process that engaged the member and their family.

There were a number of programs in Placer County that were available as resources for ACTion Team members. For example, Probation offered the Placer Re-Entry Program (PREP) Center. The PREP Center provides individuals with one-on-one and group-level services to assist with their successful transition into the community, including educational and employment opportunities.

As of February 15, 2023, 102 of the 249 total members (40.9%) had received job-related services; 68 of the 249 total members (27.3%) had received education-related services; and 24 members of the 249 total members were referred to the PREP Center and enrolled in the program (9.6%). As of February 15, 2023, 159 of the 249 total members (63.9%), had obtained or maintained employment.

Table 9 shows that there were 190 members who had no new convictions (76.3%) and 59 who had a new conviction (23.7%).

Table 9
Number and Percent of Cohort 2 Members, by Recidivism

	# of Members	% of Members
No New Convictions (No Recidivism)	190	76.3%
New Convictions (Recidivism)	59	23.7%
Unduplicated Total Members	**249**	**100.0%**

As noted, the success of the integrated, collaborative services delivered by the ACTion Team is clearly illustrated by the low number of members who were convicted of a new conviction (59 out of 249), only 23.7% of the members. The coordinated, collaborative team with ongoing communication helped to achieve these positive results. The pandemic created additional barriers to the team and the ability to work closely together with the members. As the Team was able to work closely and in-person meetings with the member increased, outcomes improve. The definition of recidivism and new convictions used was consistent with the BSCC definition.

Table 10 shows the number and percent of Cohort 2 members by some additional outcomes achieved. Of the 249 members, 178 maintained or achieved stable housing (71.5%) and 159 maintained or obtained employment (63.9%). As of February 15, 2023, 202 of the 249 total members (81.1%) had or attained a high school diploma or an equivalent degree or higher. These are excellent outcomes for this high-risk, high-need population.

Table 10
Number and Percent of Cohort 2 Members, by Outcomes

	# of Members	% of Members
Maintained or Achieved Stable Housing	178	71.5%
Maintained or Obtained Employment	159	63.9%
Had or Attained High School Diploma	202	81.1%
Unduplicated Total Members*	**249**	**100.0%**

** Individuals may have more than one (1) outcome.*

Overall, the ACTion Team Cohort 2 had excellent outcomes. Cohort 1 served 100 total members. Cohort 2, with additional funding, had an increase in the number of persons served (249), additional staff hired, and an expansion of services delivered in additional locations (Granite Wellness opened a new clinic in Lincoln). The pandemic started at the same time that the Team was being expanded and new staff hired. As a public agency that served the public, Granite Wellness had to strictly follow all of the pandemic guidelines. Extra precautions were taken when admitting new members, as well as delivering services to our ongoing team members. As a result, services quickly changed from frequent face-to-face meetings, individual and group treatment, and meeting in the member's home or community to following the new distancing rules. Services were delivered remotely through telehealth meetings and phone check-ins and services. Transportation was provided through the expanded us of ride-share programs to support members to attend needed appointments. Probation also provided transportation to members, when needed.

The Granite Wellness SUD Residential program, which provided important services to over 35% of our members, also needed to reduce the total number of treatment beds available, in order to follow the distancing guidelines and ensure that there were beds available if a client tested positive after entering the program.

This change in service delivery created significant barriers and changes to how members were served. Members were isolated and had more difficulty in accessing services. Initially, many did not have the electronic capacity to participate online. Access to basic services such as CalFRESH and other benefits was also restricted.

As a result, the percentage of members who had new convictions increased from 10% in Cohort 1 to 23.7% for Cohort 2. As the Team is now able to meet in person and provide additional supportive services and group services, we anticipate that members will have reduced

convictions. The ACTion Team will continue to implement our successful model of coordination and collaboration to meet our member's needs.

Conclusions and Recommendations

This program is a true collaboration between agencies to improve coordination of services for each person enrolled in AT to reduce recidivism and ensure community safety.

Placer County has strong collaboration between Probation, Granite Wellness, Behavioral Health and HHSA and all were committed to timely implementation of this project, to helping members achieve positive outcomes, and to strengthening services to members and their families. All System of Care agencies worked collaboratively to meet the goals of the grant and identify resources for meeting the needs of the ACTion Team members. Members showed positive outcomes as a result of the ACTion Team services.

The multidisciplinary ACTion Team has been highly effective since the implementation of Cohort 2. This collaborative ACTion Team staff have been a coordinated group of individuals who meet weekly, and communicate daily, to support each member to meet their goals. The weekly meetings involved all of the ACTion Team staff, supervisors, additional Probation Officers, BH staff, the Evaluator, and other Granite Wellness staff. The discussion of each member's progress and challenges begins with an identification of which members have the most immediate need. This approach ensures that the Team can prioritize their time and be able to discuss and identify a strategy for each member with the highest needs. ACTion Team staff were willing to help resolve the member's need, depending upon who was available on any given day. For example, one member received ongoing medical treatment in San Francisco, but did not have transportation. Across the months, each ACTion Team staff was able to help provide transportation when their schedule allowed.

The success of the ACTion Team throughout Cohort 1 and Cohort 2 was based on the strong daily collaboration and communication; coordination of services; weekly discussions of members to systematically plan services to meet each person's needs; and the coordinated SUD, MH, and Probation services to achieve positive outcomes and build social support networks, including family involvement, to create lasting change.

Current Logic Model

Please see the next page for the Placer County Prop 47 Cohort 2 Logic Model.

Placer County Prop 47 Cohort 2– Logic Model

INPUTS	ACTIVITIES / OUTPUTS	GOALS / OUTCOMES		IMPACTS
• Granite Wellness (GW) contracts with HHS to implement the ACTion Team (AT) and utilize the principles of Assertive Community Treatment (ACT) and Wraparound; in collaboration and partnership with HHS, Behavioral Health, probation, education, housing, courts, jail, and community providers; peer and family advocates/ mentors; volunteer mentors; young adults and family members • Time • Leverage Funding: Grant dollars; AB 109 funds; MHSA; HUD; JAG; Veterans; Whole Person Care; in-kind contributions; SUD and/or MH Medi-Cal revenue • Local Community Partners • Research	• Deliver countywide coordinated, culturally competent evidence-based services in collaboration with Probation, Behavioral Health, and partner agencies • Conduct conducts comprehensive risk and needs assessment and develop a coordinated Case Plan • Deliver services using principles of restorative justice to reduce recidivism • Identify, refer, and enroll persons who have been arrested, charged, or convicted of an offense AND have SUD and/or MH issues. • Outreach into jail and the community to identify and refer persons from diverse cultures • Coordinate services which are client-centered and trauma-informed, including SUD and/or MH treatment, housing, employment, transportation, and flex funds • Utilize collaborative courts to support program goals • Utilize Peer Mentor and Family Advocates to support individuals and family members • Conduct weekly AT meetings • Gather data on service utilization and outcomes • Evaluate program through data analysis, share outcomes with AT and partners • Celebrate successes	<u>Outcomes</u> • Employed and/or in school • Reduced number of arrests and convictions • Reduced number of days in jail • Reduced recidivism • Reduced MH symptoms • Reduced SUD • Living in safe and stable housing • Involved in healthy social activities • Improved health, SUD and MH indicators • Long-term lasting support networks • Improved relationship with family, when appropriate	<u>System Outcomes</u> • Enhanced coordination and integration of probation, courts, jail, health, SUD and/or MH services, housing assistance, job skills and employment, civil legal services to reduce recidivism • Improved access for diverse cultures to AT through Promotor/a outreach and linkage • Implementation of culturally competent, trauma-informed wellness and recovery • Delivery of engagement activities, timely access to services; development of positive social community for individuals and family • Coordinated and individualized SUD and/or MH treatment; housing coordination; flex funds; employment; transportation • Evaluation of key health, SUD and MH indicators, arrests, and recidivism • Shared reports to improve services over time, including individual and family satisfaction with access, services, and outcomes	• Adults who have been arrested, charged with, or convicted of a criminal offense AND who have mental health and/or substance use issues; have increased access to intensive, coordinated, and individualized ACTion Team services to successfully redirect their lives, engage in a healthy social community, and achieve positive outcomes • A vibrant learning collaborative is maintained • Integrated services offer seamless, coordinated care • Evaluation and shared data across SUD and MH, Probation, and partner agencies to demonstrate improved quality and integration of care

Grantee Highlight

The Placer County ACTion Team Cohort 2 began delivering services in November 2019 and has achieved many positive outcomes for individuals enrolled in the program. The ACTion Team is a multidisciplinary team that offers an array of services and resources, including substance use disorder (SUD) and mental health (MH) treatment services, to promote health and well-being and to reduce criminal recidivism in justice-involved individuals, with histories of SUD and/or MH issues.

The ACTion Team is a collaboration between Granite Wellness Centers (GWC), Placer County Probation Department (PD), and Placer County Health and Human Services (HHS). Services were available at GWC's sites in Roseville, Auburn, and Lincoln, as well as in community settings including the member's home. This collaboration has proved to work well to deliver services to this complex, high-risk population. Staff regularly received referrals of potential new members to the program and members achieved positive outcomes, which included placement in and successful completion of residential SUD treatment; receiving outpatient SUD and MH services; maintaining stable housing; obtaining education and/or employment; and reducing criminal recidivism.

While the ongoing COVID-19 pandemic presented new and unexpected challenges in the implementation of the Cohort 2 program, the ACTion Team quickly adapted new strategies and processes to continue to deliver services while ensuring the safety of everyone involved in the program. Extra precautions were taken regarding admitting new members as well as delivering services to team members. These precautions included, but were not limited to, increased telehealth services, and expanding the use of ride-share programs, to support members to attend needed appointments.

Services were also enhanced to provide additional support for persons with increased symptoms as a result of extended isolation, prolonged shelter in place, and an inability to visit with family and friends. Management and staff planned and implemented new and revised strategies to modify services to ensure the safety, health, and welfare of both staff and members.

The success of this program is evident in the outcomes for its members. As of February 15, 2023, a total of 249 unduplicated individuals had been enrolled in the ACTion Team. Of those 249 members enrolled in the program, 178 members (71.5%) had maintained or achieved stable housing; 159 members (63.9%) had obtained or maintained employment; and 83 of the 92 members (90.2%) who entered SUD residential treatment successfully completed residential SUD treatment. Only 59 of the 249 unduplicated members (23.7%) have had new offenses or convictions.

The achievements of the ACTion Team are best illustrated with a member success story. One of our many success stories was a male who was 40 years of age. He started ACTion Team services during the summer of 2021. He had a history of substance use, lost custody of his two elementary age daughters, and was unemployed. During his time with the ACTion Team, he had two successful residential treatment episodes; lived in a recovery residence; graduated from Placer County Drug Court; and completed the requirements of his probation. From the ACTion Team he received outpatient substance use treatment and mental health therapy services, and vocational education services. He learned to develop healthy boundaries with family members.

Through all of his hard work, this member has been substance free since winter 2022. He is employed; living in a permanent independent home through Volunteers of America's Home Start Program; and has connected to a local 12-step community program where he gives back to others in recovery.

This member also participated in the Child Advocates of Placer County Parent Empowerment Group, which supports reunification and provides a peer support group for parents who are navigating the child welfare system. As a result of this important program, he has successfully reunified with his two daughters, and been awarded custody. As a part of the McKinney Vento program through the Placer County Office of Education, which supports homeless students and their families, this member has learned to be a strong advocate with the school district to ensure his daughters have the education they need.

As a result of his hard work with the ACTion Team, he has achieved many positive outcomes and is successful in this new chapter of life. He has a safe and stable place to live, is employed full-time, and has custody of his children. He is in recovery and is supporting others to also be successful in their recovery. We all celebrate his continued success!