Proposition 47 Grant Program

Cohort III

Local Evaluation Plan

Submitted March 01, 2023

Project Background

Over the last several years, Sonoma County has been building services aimed at reducing the numbers and length of incarceration for people with serious mental illness (SMI) and/or substance use disorders (SUDs). Currently, Sonoma County has an array of programs at various intercepts along the mental health & SUD /criminal justice continuum, including:

- a mental health pre-trial release program which provides community-based supports and services to individuals with SMI while they are awaiting trial,
- a mental health diversion program in which individuals charged with misdemeanors or felonies have an opportunity to accept community-based intensive services and, upon successful completion, have their charges dismissed,
- a forensic assertive community treatment team, in which individuals with SMI are sentenced to outpatient wrap-around treatment with an embedded probation officer in lieu of jail time, and
- An SUD program which provides intensive case management to individuals engaged in SUD treatment while in the jail or who express willingness to engage in treatment upon release.

There is a cohort of individuals in Sonoma County with high SMI and/or SUD needs who are repeatedly arrested and jailed and who are either unhoused or precariously housed who thus far have declined to accept available services and supports. The reasons individuals with behavioral health needs decline to engage in services are multiple and well known. They include stigma, fear and distrust of the behavioral health system, negative past experiences with behavioral healthcare including involuntary treatment and medications, programs offering services individuals do not want and not offering resources that they do want, and the individuals not feeling seen or understood by service providers.

Fortunately, strategies for engaging such individuals are also well known. They included repeated friendly, non-goal-oriented contacts to establish trust, being present, centering the individual's needs and goals, being reliable and consistent, offering needed and desired resources, and using active listening skills and motivational interviewing techniques. For these strategies to be effective, they require a great deal of unrushed face-to-face time and staff who understand the need to center the individual's agenda rather than their own.

This project is meant to provide staff who have the time and skills to do the intensive engagement needed with this population.

Scope

This project is narrow in scope. The purpose of this project is to use intensive engagement strategies to establish relationships with individuals who have serious mental health and/or substance use disorders, are unhoused or precariously housed and are repeatedly incarcerated. The scope of the project is to gain trust with these individuals while they are incarcerated and connect them with ongoing services, supports, and resources in the community. The program will serve up to 40 individuals at any given time.

Activities and Services

The primary activity will be repeated visits to these individuals while they are in custody and, if able, while out of custody to gain connectivity and trust. Staff will conduct needs and risk assessments with these individuals and connect them to Enhanced Care Management or ongoing behavioral

health treatment in the community via warm handoffs depending on their needs, wants, abilities, and willingness. Activities will have maximum flexibility to meet the individuals on their terms and ensure they are directed by the individuals themselves.

How the Activities and/or Services Will Address the Problem

By using the engagement activities described above, creating a trusting relationship, and centering the clients' goals, staff in the program will be able to reach individuals in need and connect them with desired programs and services.

Target Population

The target population is individuals with serious mental health and/or substance use disorders with two or more arrests in the previous year who are unhoused or precariously housed and have declined or are not currently engaged with services or treatment. There will be a specific focus on engaging underserved Latinx, Black, LGBTQ+, youth, and/or elder individuals. The individuals included in the project will be identified by custody staff, jail mental health staff, the pre-trial release and Diversion/FACT evaluators, and probation staff. The two project staff will maintain a caseload of 40 participants over three years, adding new participants as others complete or leave the program.

Goals and Objectives

The goals below pertain to participants who are enrolled and receive more than a one-time intervention service.

(1) Goal: Provide access to transition support services for individuals in the justice system with mental health and/or substance use disorders who have been precariously housed.				
Objectives:	1.A Provide transition support services for an ongoing caseload of 40 individuals; 1.B A minimum of 60% of participants receiving transition support services will be connected to Enhanced Care Management and/or a behavioral health treatment program			
Project activities that support the identified goal and objectives	Responsible staff/ partners	Timeline		
		Start Date	End Date	
-Convene Local Advisory Committee (LAC)	DHS-BHD Contract Mgr	09/01/22	06/30/26	
-Release RFP for NGO transition support service delivery	DHS-BHD Contract Mgr	10/01/22	11/01/22	
-Select NGO provider(s)	DHS-BHD Contract Mgr	12/01/22	2/28/26	
-NGOs offer transition support services	NGO Peer Support Staff and Clinician	12/01/22	2/21/26	

(2) Goal: Decrease participant engagement in criminal activity	
Objectives:	2.Assess all participants for criminogenic risk and needs during the engagement process using an evidence-based tool; 2.B Reduce individual re-arrest rate for participants by 30% from the period one year prior to participation in program services

Project activities that support the identified goal and objectives	Responsible staff/ partners	Timeline	
		Start Date	End Date
-Inform Public Defender, DA, Court, Probation, Stepping UP partnership regarding grant award	DHS-BHD Contract Mgr	9/01/22	10/1/22
-Develop referral strategies, particularly for underserved populations	Contract Mgr, Sheriff, Well Path, Probation	10/01/22	2/28/26
-Participants access comprehensive services	NGO & public partners	12/01/22	2/28/26

(3) Goal: Increase the number of participants who access community resources to maintain stable residence in the community	
Objectives:	3. 65% of participants will access entitlements, including Drug Medi-Cal Treatment, MHSA, HUD funded housing supports, VA Supportive Services for Veteran Families, CalWorks, GA, SNAP, and SSI; 3.B 15% of participants will access permanent, transitional and/or supported housing; 3.C 25% participate in civil legal services, including expungement, fair housing; 3.D 15% participate in job skills training

Project activities that support the identified goal and objectives	Responsible staff/ partners	Timeline	
		Start Date	End Date
-NGO provider(s) selected	DHS-BHD Contract Mgr	12/01/22	1/1/23
-NGO provides intensive engagement, trust building and needs assessment	NGO Peer Support Staff and Clinician	12/01/22	2/28/26
-NGO staff accompany participants to community and local government services via warm handoff	NGO Peer Support Staff and Clinician	12/01/22	2/28/26

Logic Model

Inputs	Activities	Outputs	Outcomes	Impacts
• BSCC Prop 47 grant funding • Leveraged funds • Local Advisory Committee • 1 licensed or certified staff & 1 peer provider • Training in motivational interviewing, intensive outreach and engagement strategies, trauma-informed interventions, gender-specific treatment, restorative justice principles, and	• Motivational interviewing • Trauma-informed contacts to establish trust • Provision of needs and criminogenic risk assessments • Warm hand-offs to community-based supports and services	• Number of participants enrolled in program • Number of participants connected to community-based services • Number of participants assessed • Decreased percentage of participants rearrested • Number of participants connected to entitlements	• Participants in the justice system with mental health and/or substance use disorders who have been precariously housed will have access to transition support services. • Decreased number of participants engaged in criminal activity • Increased number of participants who access community resources to	• Reduced recidivism rates for unhoused or precariously housed adults with mental health and/or substance use disorders • Increased participation in mental health and substance use disorder services • Reduction in homelessness

cultural responsiveness		• Number of participants accessing housing • Number of participants participating in civil legal services • Number of participants enrolled in job skills training	maintain stable residence in the community	

Process Evaluation Method and Design

• What is the research design for the process evaluation?

Our process evaluation design will involve the monitoring of administrative records. We will focus on documenting program implementation activities and services to determine if our program is implemented as originally intended, and if not, how circumstances/barriers resulted in the modification of intended activities. The program staff will be trained in data entry and documentation to ensure the accuracy of information collected and this data will be regularly reviewed to assess fidelity of implementation, to assess and troubleshoot barriers, and to engage in program quality improvement.

The participants in this project will be enrolled as a cohort in Sonoma County's Accessing Coordinated Care and Empowering Self Sufficiency (ACCESS) Sonoma initiative. ACCESS Sonoma focuses on the critical needs of county residents who are experiencing physical and mental health challenges, economic uncertainty, housing instability, substance use disorders, criminal justice engagement and social inequity.

ACCESS Sonoma has a four-pronged approach; an Interdepartmental Multidisciplinary Team staffed by representatives from all of the Safety Net Departments, an Integrated Data Hub/Watson Care Manager developed in partnership with IBM, a system of governance led by the County's Safety Net Collaborative, and partnerships with community-based organizations and academic institutions. The result is coordinated care from across our Safety Net Departments for our most vulnerable residents. Care that is informed and supported by an innovative information and care management system, with strategic direction from the Safety Net Collaborative.

Inputs, activities, and outputs that will be assessed:

Inputs	Activities	Outputs
• # of NGO staff hired • # of service hours provided • # of hours of training for NGO staff • # of meetings of LAC	• # of contacts made with participants • # of motivational interviewing sessions with participants • # of participants assessed using needs assessment and risk tools • # of warm hand-offs to community providers	• # of participants served • # and % of participants connected to ECM or treatment • # of participants who complete treatment • # of participants who received relapse prevention education • # of participants assessed • % percentage of participants rearrested • # of participants connected to entitlements

		• # of participants who access housing • # of participants participating in civil legal services • # Number of participants enrolled in job skills training

Data for the activities and outputs will be entered directly into the Watson Care Manager Integrated Data Hub by project staff in data fields specifically designed for the project. Staff will make entries daily to capture the activities and outputs accomplished. This data will be regularly downloaded into the quarterly reporting spreadsheet to assess completeness and accuracy of information and program progress as it compares to intended implementation.

Successful program completion is defined as completing enrollment and engaging in activities in a community-based service or treatment organization. Project successes and barriers will be documented by the program evaluator with input from the LAC. Project activities will be adjusted as needed if early interventions do not lead to expected outcome, with permission from the grantor.

Outcome Evaluation Method and Design

• What is the research design for the outcome evaluation?

A causal-comparative/quasi-experimental pre/post research design will be employed to demonstrate the impacts of the service on the target population. Specifically, the intention is to demonstrate that the program activities and interventions increase participation in services, reduce recidivism rates, and increase the numbers of housed individuals in the target population.

• What are the outcomes that you will be assessing?

- Participation in services
- Pre-post arrest rate
- Recidivism rates
- #/% of participants housed

• What is your definition of the outcomes?

- **Participation in services:** Participation in services is defined as enrollment and at least one appointment with the Enhanced Care Management team, or county or community based mental health or SUD treatment. Data will be obtained from the electronic health records used by each organization.

- **Arrest rates:** Participants' arrests in the year prior to enrollment will by compared to arrests in the year after enrollment. The pre/post arrest rates will be calculated by dividing the number of participant arrests by the number of participants and multiplying by 100,000.

- **Recidivism rates:** For "recidivism", the project will use the BSCC definition, which is "conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal

conviction". Data for recidivism rates will be obtained through the criminal justice database and supplied by the Sheriff's Office and/or Probation Department.

- **#/% of participants housed:** "Housed" is defined as living in transitional or permanent housing, whether in a congregate or individual living situation, such as a transitional housing program, residential treatment program, residential care facility, room and board, or independent apartment or house. Shelters or "couch surfing" do not qualify. Housing data will be entered into Watson Care Manager Integrated Data Hub.

• How often will the data be collected?

Implementation/service/activity data will be collected daily or as needed: The two program staff will enter participant data in Watson Care Manager during intake and as needed to record all visits, events, and service activities.

Data quality management and review will occur quarterly, or more frequently: Watson Care Manager participant data will be downloaded into a reporting spreadsheet and reviewed for accuracy and to assess trends in service participation, arrests, and housing for continuous program quality improvement.

Justice data will be requested mid-way through implementation: We will collect pre/post arrest data for participants enrolled at least one year to assess pre/post arrest rates

At project conclusion, we will examine the outcomes for all project participants across years including participation in services, pre/post arrest rates, pre/post recidivism rates, and #/% housed

• How will you know that the change was due to the project, and are there any limitations to your approach?

For each project goal, we will assess program impact in the following ways:
- **Goal: Provide access to transition support services for individuals in the justice system with mental health and/or substance use disorders who have been precariously housed.** The target population has historically had difficulty engaging in services previously. If more than half (at least 60% of participants) successfully connect to services after intensive intervention, we will conclude that this outcome was due to program staff engagement efforts, and not likely due to chance or other circumstances.
- **Goal: Decrease participant engagement in criminal activity** To assess program impacts on this outcome, we will use a pre-post comparison in arrest activity among participants who received more than a one-time intervention service. We will conclude that the program was successful in reducing arrests if the rearrest rate in the year after program enrollment is at least 30% lower than the year prior to enrollment. The pre/post arrest rates will be calculated by dividing the number of participant arrests by the number of program participants and multiplying by 100,000.

Data to be assessed	
*Records from **one year prior** to arrest for misdemeanor or felony that led to program participation among participants who received more than a one-time intervention service*	*Records from **one year after** for misdemeanor or felony arrest that led to program participation among participants who received more than a one-time intervention service*

• # of prior arrests • #/% of participants with prior arrests one year period before program participation	• # of subsequent arrests • #/% of participants with subsequent arrests during one year period after program participation

At project conclusion, recidivism rates will be examined in a similar pre-post methodology to assess impact, but looking three years prior to enrollment and up to three years after enrollment for any prior or subsequent misdemeanor or felony convictions.

- **Goal: Increase the number of participants who access community resources to maintain stable residence in the community**
- Changes in the percent of participants housed and/or engaged in different types of community resources to support this goal will be tracked over time by program staff in Watson Care Manager and the quarterly excel reporting sheet. Quarterly, annually, mid-implementation and at project conclusion, we will assess the proportion of participants enrolled in different types of services. Our goal is that:
    - At least 15% of participants will access permanent, transitional and/or supported housing
    - At least 65% of participants will access entitlements for which they are eligible, including Drug Medi-Cal Treatment, MHSA, HUD funded housing supports, VA Supportive Services for Veteran Families, CalWorks, GA, SNAP, and SSI
    - At least 25% of participants will participate in civil legal services, including expungement, fair housing;
    - At least 15% of participants will participate in job skills training

If we are not meeting these benchmarks on a quarterly or annual basis, we will reassess our strategies and approach and work on increasing these percentages.

Limitations in our ability to assess project impact include that we are working with a hard to reach, high risk, vulnerable population with multiple mental health, substance use, housing and legal system challenges. These individuals have many factors occurring in their lives in addition to program participation that will influence their outcomes. That said, if participants do engage and link to services in the midst of these significant challenges, we feel confident in concluding that program participation and relationship building efforts will have played a role in this success.

• How will you determine whether recidivism was lower at the end of the project relative to before the project began?

For "recidivism", the project will use the BSCC definition, which is "conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction". Data for recidivism rates will be obtained through the criminal justice database and supplied by the Sheriff's Office and/or Probation Department.

At project conclusion will assess the proportion of unduplicated participants (receiving more than a one-time service) who experienced recidivism in the three years prior to the misdemeanor/felony event that led to program participation as compared to the time passed after enrollment.

• How will you analyze data, if relevant? Will you simply compare over time? Do you have staff capability or expertise that would allow for any more sophisticated statistical analysis?

We plan to contract with an outside evaluator to assist with data management and reporting. The evaluators will be tasked with:

- Working with project staff to assess data completeness and accuracy quarterly.
- Developing quarterly summaries and reports.
- Annually, providing a brief descriptive summary of service participation, arrest, and housing outcomes for unduplicated participants that year.
- Mid-implementation, conducting a full analysis of the outcomes of unduplicated participants enrolled at least one year to assess the % enrolled in services, pre/post arrest rates as compared to the year prior to participation.
- At project end, conducting a full analysis of the outcomes of unduplicated participants of the course of the project to assess the % enrolled in services, pre/post arrest rates, pre/post recidivism rates and #/% housed. This summary will include descriptive analyses comparing participants with no recidivism compared to participants who re-offend in terms of their challenges (mental health and/or substance use), average # of program staff encounters, and services with which they were connected.