Alameda County Proposition 47

COHORT II FINAL EVALUATION REPORT

RDA CONSULTING

COUNTY OF ALAMEDA CALIFORNIA

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Cohort II Final Evaluation Report

This report was developed by RDA Consulting under contract with the Alameda County Health Care Services Agency.

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alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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Executive Summary

Alameda County's $6 million Proposition (Prop) 47 Cohort II grant supported four distinct program areas that provided services to justice-involved individuals[1] with behavioral health needs: (1) Multidisciplinary Reentry Treatment Teams (RTTs) that offered comprehensive case management and mental health treatment; (2) recovery residences that provided stable, sober housing for individuals participating in outpatient substance use treatment; (3) a housing assistance program that provided clients with up to $5,000 for eligible expenditure; and (4) a mental health misdemeanor diversion program that redirected individuals who have committed low-level offenses into mental health and/or substance use treatment and away from incarceration and the criminal justice system.

The California Board of State and Community Corrections awarded Alameda County the Cohort II Prop 47 grant in 2019 to expand on the successful implementation of the Cohort I grant by augmenting existing services and creating a new diversion program. The County subcontracted $4.51 million of the award (75%) to community-based organizations to deliver programs.

Program Accomplishments

In Cohort II, Alameda County provided mental health, substance use, housing, and diversion services to 2,837 justice-involved individuals.[2] Overall, Prop 47 funded programs worked as intended as demonstrated by enrollment numbers, services provided, and recidivism rates across programs.

Mental Health Reentry Treatment Teams (RTTs)[3]

112
clients served

933
services provided

84%
did not recidivate

Alameda County's Prop 47 Reentry Treatment Teams (RTTs) administered mental health services to 112 clients through February 15, 2023, including intensive care coordination/case management; connection to community resources; and linkages to mental health, substance use, legal, and life

[1] Justice-involved includes individuals with any justice system contact, including arrest.

[2] The total client count may not be unduplicated as clients may have been enrolled in more than one Prop 47 program.

[3] Data reporting period: April 1, 2021 - February 15, 2023.

skills services. The multidisciplinary teams and individualized services are strengths of the RTTs, although staff capacity, client engagement, and service misalignment has been a challenge.

Substance Use Disorder (SUD) Services[4]

1,695
individuals called the hotline

171
clients served in recovery residences (RRs)

74%
of RR clients reached or partially reached their treatment goals

86%
of RR clients did not recidivate

Alameda County's Prop 47 Center Point hotline screened 1,695 individuals for SUD. Recovery residences (RRs) provided 171 clients with stable housing, food, and substance use support through June 30, 2022. Clients valued peer staff members and the combination of an independent living environment with sufficient structure to keep them working toward their goals. However, recovery residences struggle with high demand for beds and individuals seeking services who have more intensive service needs than they offer.

Housing Assistance[5]

$1.9m
distributed

540
clients served

97%
did not recidivate

Alameda County's Prop 47 housing program provided housing-related financial assistance to 540 clients through February 15, 2023, averaging $3,529 per client. Among them, 61% had a mental health diagnosis, 55% had a substance use diagnosis, and 20% had a co-occurring mental health and substance use disorder. Sixty-seven percent of clients were experiencing homelessness or at the risk of homelessness. Flexible funding allows staff to support clients' individual needs to help them maintain short-term stability. Long-term stability, however, continues to be a challenge, given that the maximum payout of $5,000 in housing assistance does not last long in the Bay Area.

[4] Data reporting period: July 1, 2020 – June 30, 2022 (Unlike the other program areas, the SUD programs served clients in Cohort II from July 1, 2020, through June 30, 2022; see Table 2).

[5] Data reporting period: August 1, 2019 – February 15, 2023.

Diversion[6]

319
individuals referred to diversion

159
individuals deflected from the justice system

82%
received referrals to external agencies

93%
did not recidivate

Alameda County's Prop 47 diversion program, the Community Assessment, Referral, and Engagement Services (CARES) Navigation Center, received 319 unique individuals and served 159 clients, 82% of which were referred to 41 different agencies. In addition to diverting clients away from the criminal justice system, the program provides them with food, clothing, and other basic necessities. This facilitates de-escalation while they are assessed by CARES staff and await details about their diversion plan, which is put together by the CARES team and the DA. One strength of CARES is the peer staff as shown by their teamwork and dedication to their clients. They make clients feel welcome and connect them with appropriate services the client may not have been aware of otherwise. CARES continues to struggle with low rates of referrals from law enforcement and, in general, public awareness of the program.

Cross-Cutting Findings & Recommendations

1. Services are **high quality** and clients are overall **satisfied** with the services they receive. Prop 47 should continue to **support increased program capacity**, so staff can keep providing high quality services.
2. Prop 47-funded programs are associated with a **reduction in recidivism**. However, **inconsistent data collection practices** across providers make it difficult to effectively communicate this impact. Prop 47 should more **closely monitor data collection activities**, set **standards** across programs when possible, and provide **technical assistance** and funding to build or improve data infrastructure.
3. Service providers appreciated **coordination** across Prop 47 service providers as an efficient way to help clients address a variety of needs. Prop 47 should encourage **direct communication** between providers to streamline this process.
4. Clients and providers all highlighted increased **housing assistance and stability** as a critical need that has implications on other areas of an individual's life. Prop 47 should continue to **invest in housing assistance** by seeking additional funding, strengthening existing partnerships, and exploring new ones with landlords and other housing providers.
5. Both staff and clients highlighted the **benefits of having peer staff** available across programs. Prop 47 should continue **investing** in their peer staff and utilizing funding to hire more staff with lived experience.

[6] Data reporting period: February 1, 2021 - Jan 15, 2023.

6. **Client engagement** was commonly cited by staff as a challenge to service delivery. In the future, Prop 47 should focus on **building up** client engagement strategies across program areas and at different engagement points.
7. Many of these challenges have **persisted** since Cohort I. Prop 47 funds should include opportunities for service providers and clients to **actively participate** in the design of future cohorts.

Introduction and Project Description

Approved by California voters in November 2014, Proposition 47 (Prop 47) reclassified certain nonviolent, non-serious drug and property crimes from felonies to misdemeanors and generated millions of dollars in state savings from the reduction of the state prison population, state hospital commitments, and court caseloads. Prop 47 requires these savings to be placed in the Safe Neighborhoods and Schools Fund and mandates the Board of State and Community Corrections (BSCC) to allocate 65% of the funds for mental health (MH) and substance use disorder (SUD) treatment aimed at reducing recidivism, 25% for crime prevention and support programs in schools, and 10% for trauma recovery services for crime victims. Funds are allocated to local agencies through a competitive grant process administered by the BSCC to provide services to justice-involved individuals with behavioral health needs.

The Alameda County Health Care Services Agency (HCSA), in partnership with the Alameda County Probation Department, Bay Area Community Services, La Familia Counseling Services, Canales Unidos Reformando Adictos (CURA), Center Point Inc., Second Chance Inc., and Roots Community Health Center, obtained a $6 million grant from the BSCC through the first and second cohorts of Prop 47 funding to provide targeted mental health treatment, SUD treatment, diversion, and housing support services to justice-involved adults in the County with behavioral health needs.[7] Figure 1 summarizes these program areas.

Figure 1. Alameda County Prop 47 Program Areas

Mental Health
Reentry treatment teams

Housing Assistance
Community housing grants

Substance Use Disorder
Telephone hotline & recovery residences

Diversion
Referrals to mental health or SUD services

[7] To determine Prop 47 eligibility, justice-involved includes individuals with any justice system contact, including arrest.

Alameda County directed Prop 47 Cohort II funds across multiple program areas to its existing mental health, housing assistance, and SUD services, and established a new diversion program. Specifically, Alameda County used Prop 47 funds to:

1. Implement multidisciplinary **Reentry Treatment Teams (RTTs)** led by community-based organizations (CBOs) to provide services for justice-involved individuals with serious mental illness (SMI). RTTs provide psychiatric treatment, case management, housing, and employment support, as well as linkages to community resources, other behavioral health treatment, legal services, life skills, and education services. Alameda County allocated **$1.7 million** of Prop 47 funds to RTTs.[8] Cohort II RTTs operated from April 1, 2021, through February 15th, 2023.

2. Utilize partnerships with CBOs already providing **SUD services** to fund treatment services for justice-involved individuals. The Prop 47 Cohort II grant funded eleven beds at community-based **recovery residences (RRs)** that provide sober living environments for individuals participating in outpatient SUD treatment. Prop 47 also partially funded a **telephone hotline** that screens clients for SUDs and makes referrals to the appropriate level of care. Alameda County allocated **$600,000** of Prop 47 funds to SUD programs.

3. Establish a **housing assistance program** to increase the number and capacity of CBOs that provide housing support to justice-involved individuals with behavioral health needs. CBOs provide assistance with rent, security deposits, utilities, credit repair, and other resources to establish suitable housing. Alameda County allocated **$1.6 million** of Prop 47 funds to the housing assistance program.

4. Establish funding to support a mental health **misdemeanor diversion program** that redirects individuals who have committed low-level offenses into mental health and/or substance use treatment and away from incarceration and the criminal justice system. Alameda County allocated **$1.5 million** of Cohort II Prop 47 funds to the diversion program.[9]

Alameda County's Prop 47 programs are overseen by the Local Advisory Committee (LAC), a group of County agency representatives and community stakeholders with knowledge and experience related to Prop 47 programs and services. The LAC is co-chaired by Alameda County's Behavioral Health Services Agency Director and Chief Probation Officer and includes representatives from agencies such as the District Attorney, Public Defender, Sheriff, and Courts, as well as community representatives who are formerly incarcerated and/or systems-impacted (see full list of LAC members in Appendix A). The LAC was established during Cohort I, provided ongoing support for Prop 47 Cohort II implementation, and will continue to do so for Cohort III.

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[8] Alameda County originally planned to dedicate $2.1 million to RTTs, but later shifted $800,000 from RTTs to the housing assistance program. In addition to the $1.3 in Prop 47 funding, the program also leveraged $6.4 million from other funding sources.

[9] Diversion program funding includes $900,000 for County agencies (i.e., District Attorneys' Office and Probation Department) and $600,000 for a community-based organization.

Evaluation and Report Overview

RDA Consulting (RDA) was contracted by Alameda County as the external evaluator of the County's Prop 47 programs to report the County's progress in a preliminary and a final program evaluation report. This final report provides a review of Cohort II program implementation and client outcomes. The purpose of the final evaluation is to assess whether Alameda County accomplished the goals and objectives described in its Prop 47 proposal. The goals and objectives established by the County for its Prop 47 grant funded activities are detailed in Table 1. These goals and objectives are further contextualized in the program logic model found in Appendix B. A detailed explanation of progress toward each of these goals is presented in Appendix C.

Table 1. Prop 47 Goals and Objectives in Alameda County

Goals	Objectives
Formerly incarcerated individuals with SMI are stabilized through community-based MH treatment and services and do not reoffend.	65% of clients who enroll in RTT have 2+ treatment sessions within 60 days of admission.
	Upon program completion, 50% of RTT clients show a decrease in functional impairment as measured by repeated Adult Needs and Strengths Assessment.
	75% of RTT clients maintain engagement in MH treatment and services or successfully complete treatment during the 12 to 24-month treatment period.
	75% of disabled clients without supplemental security income (SSI) are successfully connected with an SSI Advocate.
	80% of RTT clients do not recidivate during the treatment period.
Formerly incarcerated individuals with substance use disorders are stabilized through community-based treatment and services and do not reoffend.	60% of Prop 47 clients referred to SUD programs enroll in Alameda County Behavioral Health (ACBH) SUD programs.
	80% of Prop 47 recovery residence clients enroll in SUD outpatient treatment and services.
	50% of recovery residence clients exit recovery residences with successful progress.
	50% of recovery residence clients reduce admission to detox programs.

	80% of SUD clients do not recidivate during the treatment period.
Justice-involved individuals with any mental illness who have contact with law enforcement and/or have engaged in misdemeanor criminal conduct are stabilized through community-based services to avoid incarceration.	50% of individuals deflected from the criminal justice system do not recidivate.
	65% of individuals deferred from the criminal justice system are not charged.
	65% of individuals diverted from the criminal justice system are not convicted.
	50% of individuals on the behavioral health/diversion probation caseload complete probation without a violation or new conviction.

Research Design

To complete this report, RDA conducted a mixed-method process and outcome evaluation. The mixed-method approach incorporates quantitative and qualitative data collection and analysis to provide a comprehensive assessment of grant-funded efforts. This research design was selected to maximize validity and provides different perspectives on complex, multi-dimensional issues. The quantitative data analysis includes individual- and system-level measures to examine service referral and receipt as well as outcomes of treatment and impacts on recidivism. Qualitative data analysis explores experiences with implementation from clients, service providers, and management to identify successes, challenges, and areas for improvement. The descriptive study consists of two key components, a process evaluation and an outcome evaluation, to measure program implementation and effectiveness. See Appendix D for specific outcome and process measures.

Qualitative Data Collection Methodology

RDA conducted primary data collection with a diverse group of Prop 47 stakeholders to obtain insights about their experiences with Prop 47 activities. These qualitative data are used with quantitative data to assess Prop 47 implementation and outcomes and provide recommendations to increase program impact. This section describes data collection techniques used and limitations encountered during the data collection process.

Instrument Development. RDA developed qualitative protocols for interviews and focus groups. These protocols were designed to be appropriate for diverse participants that come from a range of cultural, linguistic, and educational backgrounds. Protocols originally written for the previous preliminary and annual evaluations were utilized and updated.

Key Informant Interviews. RDA conducted a total of twenty individual and group virtual interviews with Prop 47 program leadership, supervisors, managers, and LAC members to assess stakeholder

experiences with program implementation and outcomes of Prop 47 activities. RDA asked participants about interagency collaboration, experiences with program implementation, and perceptions of outcomes. Conversations focused on lessons learned, facilitators to success, and barriers to implementation.

Client Interviews and Focus Groups. RDA spoke with a total of fifteen clients (via phone or Zoom) to gather in-depth qualitative data about client experiences and perceived outcomes related to program implementation. Program staff invited clients to participate in interviews. RDA offered clients a $25 gift card to thank them for participating in an interview or focus group.

Thematic Analysis. Data collected during interviews were transcribed, quality checked, and coded using the qualitative data analysis software NVivo to identify themes and patterns. Using a combination of inductive and deductive coding, RDA developed a codebook to systematically analyze each transcript. The research team then identified themes and patterns in the codes to synthesize them into key findings and triangulate them with the quantitative data.

Limitations. While RDA spoke with many Prop 47 stakeholders at all levels of involvement during the qualitative data collection process, a few factors may have impacted the amount and quality of data collected. Firstly, the research team only spoke to those who agreed to be interviewed. The individuals interested and able to participate in interviews represent a small fraction of the number of clients served through the Prop 47 program. Therefore, it is possible that those who participated in data collection have different characteristics (e.g., more communicative or actively engaged with the program) than those who did not participate. Relatedly, RDA was unable to speak with a representative sample due to client and provider availability. For example, RDA was unable to schedule a client focus group with the SUD provider, CURA, despite efforts to reschedule.

Quantitative Data Collection Methodology

RDA requested data for individuals participating in each of the Prop 47 services. Due to several factors including the COVID-19 pandemic, Cohort II services began serving clients at different times during the grant period. The evaluation team worked with programs to gather data for this report, striving to get as much data as possible for the programs that began implementation later in the grant period. Data reported in this evaluation is from the time periods described Table 2.

Table 2. Service and Data Time Periods

Program	Time Period
Mental Health RTT Program	Served clients in Cohort II from April 1, 2021, through February 15, 2023. Data is reported from April 1, 2021, through February 15, 2023.
SUD Program	Served clients in Cohort II from July 1, 2020, through June 30, 2022. Data is reported from July 1, 2020, through June 30, 2022.
Housing Program	Served clients in Cohort II from August 1, 2019, through February 15, 2023. Data is reported from January 1, 2021[10], - February 15, 2023.
Diversion Program	Served clients in Cohort II from February 1, 2021, through February 15, 2023. Data is reported from February 1, 2021, through February 15, 2023.

RDA also analyzed recidivism rates using data from The Alameda County Sheriff's Office to identify conviction dates for individuals who have participated in a Prop 47 program. Additional key data utilized in this evaluation are summarized in Table 3. As indicated, data availability differed by program.

Table 3. Key Quantitative Data Elements

MH: Reentry Treatment Teams (RTT)	SUD	Housing Assistance	Diversion: CARES Navigation Center
• Clients served • Services provided • Primary diagnoses • Adult Strengths and Needs Assessment scores	• Service date • Provider • Number of bed days • SUD diagnosis • Discharge date/status	• Service date • Service type • Amount spent per service	• Service date • Lead charge • Referral source • Diversion type

[10] Although Cohort II housing services began August 1, 2019, housing providers were not yet providing services. In the data received, no observations for housing services were recorded prior to January 1, 2021. Therefore, the reporting period begins on the date of the first observation.

Data Preparation and Quality Assurance. RDA received data in multiple spreadsheets representing different components of the analysis. Where necessary, the research team merged the data on one or more identifiers. To match probation and recidivism data to Prop 47 service clients, RDA matched clients in each dataset using their first and last name and date of birth (when possible).

Descriptive Statistics. RDA used descriptive analytic techniques to summarize clients' demographic characteristics, types of services received, service characteristics, and short-term programmatic outcomes. The research team also examined characteristics and trends by service type for all participants over time.

Limitations. Firstly, the analyses in this report do not provide causal evidence for Prop 47's influence on outcomes. While the outcomes in this report are likely associated with Prop 47 programs, the research design cannot say with certainty that they were the result of them. Additionally, the quality of the analysis is limited by the quality of the data available. While most data provided was thorough, there are inevitably errors that may influence the outcome analysis, despite RDA's data cleaning and efforts to resolve issues. These limitations are described below:

SUD. The data available for Center Point, the SUD hotline, from ACBH's Data Services Team (DST) was inconsistent with that collected directly by Center Point itself. Unable to resolve the issues prior to the writing of this report, RDA determined that appending the two datasets would be the most accurate way to analyze calls to Center Point for Cohort II. Unfortunately, it was not possible to match unique individuals between the two datasets because not enough identifying variables (e.g., date of birth, name, ID) were available. Therefore, although each observation in the combined dataset represented a unique call, it is not possible to determine if the same person made a call that was recorded in the other dataset.

Center Point's service data was also limited for two reasons: 1) The data provided directly from Center Point did not contain any service data. Therefore, service delivery outcomes are based on data from ACBH's dataset, only. While this dataset appears to be accurate prior to 7/1/2021, the number of calls after this date does not align with the number reported by Center Point. Therefore, it is difficult to conclude the accuracy of services delivered after this date, but it is likely lower than the actual number.

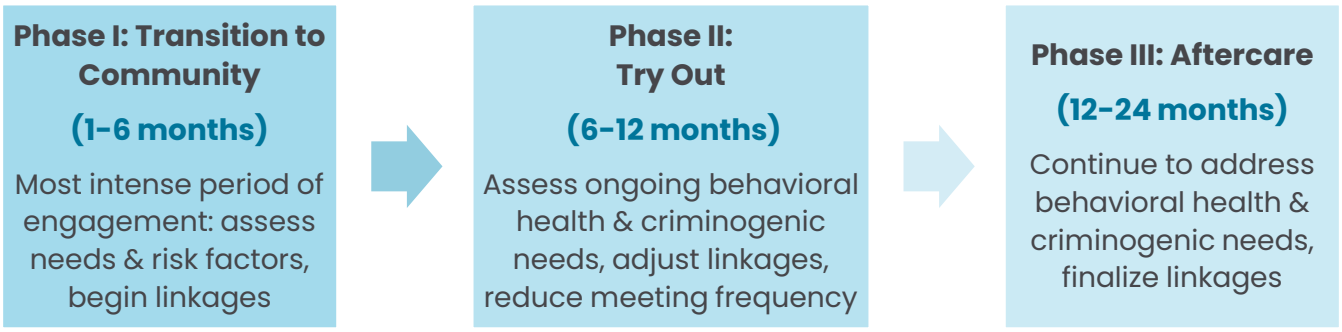
Diversion. Date of birth was not available in the diversion data, and therefore recidivism rates had to be calculated by name, which has a higher likelihood to cause error if two people have the same name or in the case of misspellings.

Mental Health Reentry Treatment Team (RTT) Program

The Alameda County Prop 47 Cohort II grant funding was used to launch one RTT that delivers comprehensive case management and treatment to justice-involved individuals with serious mental illness. The Cohort II RTT is run by Bay Area Community Services (BACS). The RTT is designed to provide 80 clients with services and resources to reduce mental health impairment over a 12- to 24-month enrollment period, using a Critical Time Intervention (CTI)-based model to step-down clients over the course of enrollment. The program is intended to provide psychiatric treatment; intensive care coordination/case management; housing support; connection to community resources; employment support; and linkages to mental health, substance abuse, legal, and life skills services.

The model has a client to staff ratio of 13:1, with the team consisting of one full-time equivalent (FTE) clinical supervisor, three FTE social worker clinicians, three FTE peer counselors, and one .15 FTE psychiatrist. The Cohort II program is similar to the Cohort I model but added two positions. One FTE nurse was added to support clients with medical complications resulting from homelessness and incarceration and one FTE housing navigator was added to provide connections to housing services. RTT funding through Prop 47 will be discontinued in Cohort III, a joint decision made by the County and the provider; moving forward the program will be supported by Mental Health Services Act (MHSA) funds. Figure 2 illustrates the CTI treatment model used for RTT clients in Alameda County.

Figure 2. Prop 47 CTI Treatment Model



Program Profile

This section describes the services provided through the Mental Health RTT program; the demographics of clients; and program outcomes, including engagement with services and recidivism.

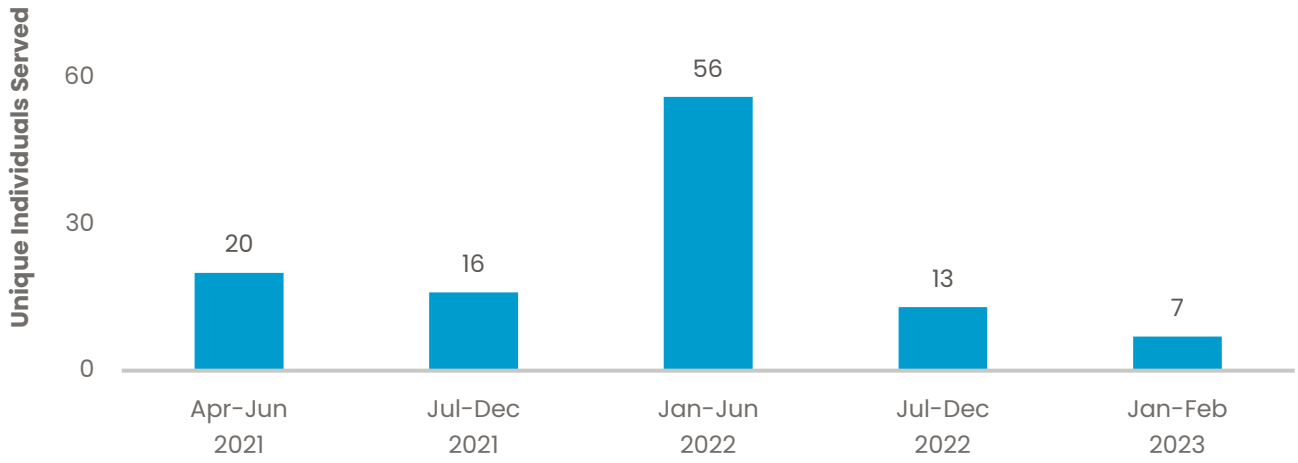
RTT Services

From April 1, 2021-February 15, 2023, 112 unique individuals received Prop 47-funded mental health services—averaging approximately 60 individuals annually. Thus, the program did not reach its intended enrollment capacity of 80 individuals per year. Figure 3 shows the number of unique enrollments by six-month periods. Of the 112 individuals enrolled in mental health services, 71 (63%) were previously incarcerated and two (2%) were referred through Behavioral Health Court or by a criminal justice agency, which may include the jail, Probation Department, Public Defender, or District Attorney.

112

clients served

Figure 3. Unique Individuals Newly Enrolled in RTTs (n=112)



933

services provided

A total of 933 mental health services were provided through February 15, 2023. As illustrated in Table 4, individual therapy constituted the majority of mental health services (43%), followed by brokerage (34%). Over one-third (42%) of individuals received two or more mental health services within 30 days of enrollment.

Table 4. Mental Health Services by Service Category (n = 933)

Mental Health Services	Number	Percent
Individual Therapy	398	43%
Brokerage (services to bridge the gap between individuals and access to appropriate primary care for groups experiencing vulnerability)	319	34%
Assessment & Evaluation of mental health and clinical history	129	14%
Medications	40	4%
Plan Development	24	3%
Collateral (consult with client's significant support person, track family engagement)	13	1%
Group Therapy	6	1%
Crisis Intervention	1	<1%

Client Profile

The average RTT client was 45 years old and male (65%). Approximately half (44%) of the clients were Black, with 20% White and 10% Hispanic/Latino (see Table 5).[11]

Table 5. Race/Ethnicity of RTT Clients (n = 112)

Race/Ethnicity	Number	Percent
Black	49	44%
White	22	20%
Hispanic/Latino	11	10%
Asian/Pacific Islander	4	4%
Native American or Hawaiian Native	3	3%
Other/Unknown	26	23%

[11] Some clients identified with more than one ethnicity. For this reason, the percentages total more than 100%.

The most frequent primary diagnosis of RTT clients was a mood disorder (59%), which was most commonly bipolar disorder or major depressive disorder (see Table 6). Post-traumatic stress disorder was the most common anxiety disorder diagnosis.

Table 6. Mental Health Diagnoses of RTT Clients (n = 112)

Primary Diagnosis	Number	Percent
Mood Disorder	66	59%
Anxiety Disorder	28	25%
Psychotic Disorder	17	15%
Other or Unspecified	1	1%

SUDs include the recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment. Among the 112 RTT clients, 11% had a co-occurring SUD.

RTT providers administer the Adult Strengths and Needs Assessment (ANSA) to inform case plans and monitor client progress. Of the 58 RTT clients with initial ANSA scores, clients' initial assessment results indicated:

- 74% experienced moderate to severe depression.
- 33% had moderate to severe legal difficulties.
- 66% had moderate to severe levels of residential instability issues (e.g., moved multiple times over the past year, experienced periods of homelessness).
- 38% experienced moderate or severe sexual, physical, and/or emotional abuse as children.

Outcomes

Of the 112 individuals enrolled in mental health services, 89 (80%) individuals exited the program (including 39 with unknown reasons for exit), with an average time from enrollment to exit of 9.5 months (286 days). [12] Of the 50 clients with known reasons for exit, 32% exited with a case plan or treatment goals partially or fully reached, and 68% did not (see Table 7).

[12] 39 exited clients were missing a discharge date and were given a discharge date of February 15, 2023.

Table 7. Mental Health Service Enrollment Status (n = 112)

Exit Status	Number	Percent
Exited with Case Plan or Treatment Goals Partially or Fully Reached	**16**	**14%**
Mutual Agreement/Treatment Goals Reached	7	6%
Mutual Agreement/Treatment Goals Partially Reached	6	5%
Client Withdrew: Treatment Goal Partially Reached	3	3%
Exited Services Without Completing	**22**	**20%**
Mutual Agreement/Treatment Goals Not Reached	7	6%
Client Withdrew: No Improvement	15	13%
Other	**12**	**11%**
Client Incarcerated	1	1%
Client Discharged/Administrative Reasons	1	1%
Client Discharged/Program Unilateral Decision	1	1%
Client Moved Out of Service Area	2	2%
Client Died	5	4%
Consumer Choice/Unspecified	1	1%
Other	1	1%
Unknown	**39**	**35%**
Continued Enrollment	**23**	**21%**

Changes in Needs After the Mental Health Program. The ANSA identifies client needs across six domains: traumatic/adverse childhood experiences, life domain functioning, individual strengths, cultural factors, behavioral health needs, and risk behaviors. Of the 98 clients with ANSA scores, 58 completed both the initial and follow-up assessment. When comparing results from those 58 clients'

first and last ANSA assessments, 38% of clients experienced improvement in the strengths domain, which includes aspects such as social support and connections, personal skills and interests, and resilience and resourcefulness.[13] Additionally, 28% of clients improved in life functioning domain, which includes physical/medical health, family relationships, social functioning, and residential stability.[14] Lastly, 19% of clients' behavioral health needs decreased (measured across areas such as psychosis, impulse control, depression, and anxiety).[15]

38%

improved their connections, personal skills and interests, and resilience and resourcefulness

28%

improved their physical/medical health, family relationships, social functioning, and residential stability

Psychiatric Hospitalizations. One year prior to enrollment in an RTT, 22 of the 112 enrolled clients (20%) had at least one psychiatric hospitalization. After enrolling in an RTT, 17 clients (15%) had at least one psychiatric hospitalization. Comparing psychiatric hospitalizations between a comparable number of days prior to enrollment and during enrollment, 11 (30%) had a decrease in psychiatric hospitalizations, 12 clients (32%) had the same number of psychiatric hospitalizations, and 14 (38%) had an increase.

Recidivism. During participation in the RTT program, zero individuals were booked into jail in Alameda County. As of February 15, 2023, 18 of the 112 enrolled clients (16%) were convicted of a new criminal offense committed after exiting the program. Therefore, the large majority of clients (84%) did not recidivate after enrolling in the RTT program.[16]

84%

did not recidivate

Program Strengths and Barriers

Program Strengths

Word of mouth referrals are helpful in establishing initial trust. Staff shared that they primarily receive referrals from collaborative courts, public defenders, other agencies, and word of mouth from current and former clients. They shared that clients who are referred by word of mouth are often more engaged early on; someone has already "vouched" for the quality of services that BACS

[13] 47% of clients' strengths domain needs remained the same and 16% worsened.

[14] 38% of clients' life functioning domain needs remained the same and 34% worsened.

[15] 57% of clients' behavioral health domain needs remained the same and 24% worsened.

[16] The average time between enrolling in RTT and February 15, 2022 was 1 year. Recidivism data is only for convictions in Alameda County.

provides, which helps clients feel safe. It also increases the likelihood that clients know what services are offered and what to expect from the program.

Intensive, individualized services increase client engagement. Because staff are working with clients on goals that are important to them, they shared that clients are often highly engaged in services. Clinical staff conduct a formalized assessment and develop treatment plans with all clients and check in with clients weekly to provide ongoing therapeutic support. Staff meet clients where they are located in the community, reducing barriers to accessing services. Staff can also provide incentives like basic needs assistance to increase client engagement. Some clients shared that they feel like they always get everything they need from BACS.

The multidisciplinary staff structure has created a strong team dynamic and supports high quality services for clients. Staff shared that the Cohort II model of having a clinician and care coordinator work in tandem has been very helpful for case consultation and keeping track of which clients need to be seen. One staff member mentioned that having a team room has been helpful for collaboration, calling it "life changing." Staff mentioned feeling very supported by the agency with effective training and hands-on clinical supervision. Agency leadership shared that having a multidisciplinary model allows staff with complementary skill sets to provide high quality care to clients. Clients felt that staff are always there for them and are easy to talk to. They shared that staff are passionate about what they do and are invested in the work.

"Every caseworker loved me, showed me respect, always wanted to help me."
-Client Focus Group Participant

Services have a significant impact on client mental health, housing, social support, and other outcomes. Leadership shared that having embedded psychiatry services has helped clients get the most out of the program, as clients with unmanaged mental health symptoms have a difficult time engaging in services. Staff described several examples of their services having an impact on client mental health, including providing services outside to get fresh air, talking with clients about things that they had never shared before, and coordinating outings with other clients to help them build a support network. One staff member pointed to the importance of the staff-client relationship in the client's mental health outcomes, noting what a positive experience it can be for someone to have an ally who can make them feel like they belong.

"For the first time in a long time, they feel like they have someone who cares about them."
-Staff Focus Group Participant

Most clients reported that assistance and referrals related to housing have been the most helpful services provided. One client shared that they've "never been on the streets [...] when BACS is helping

me." Though BACS does not directly provide housing assistance to RTT clients, they do have a housing program within the agency. It is unclear whether clients were referring to this housing program or referrals to external housing programs. Staff also reported that the program connects clients to employment, education, and reduction in substance use.

Program Barriers

The program is not engaging individuals who are currently incarcerated or re-entering. Some staff mentioned that most of the clients they work with have not been recently incarcerated, and that most of their incarceration history is from years prior. Staff expressed a desire to reach more individuals currently incarcerated or about to be released. They shared that they do get referrals from adult forensic behavioral health and probation departments for those re-entering, but they do not always receive enough information to be able to contact the person.

Misaligned client and provider expectations can impact client engagement. Staff shared that clients are often interested in receiving services for housing, but BACS does not provide this service directly. This can lead to some confusion and a reduction in client engagement. Client engagement is also reduced when there is an absence of a warm handoff between programs, making it difficult for staff to connect with clients at the onset. In addition, some clients referred are not always eligible. Other times, they are simply not interested in the program, which further complicates client engagement.

Staying in communication with clients can be a challenge for staff. Staff explained that staying in touch with clients is particularly challenging. For example, not all clients have permanent phone numbers. This makes it difficult to keep in contact with clients and schedule appointments. Staff also shared that it can be challenging to engage with someone who is actively using substances, as RTT is not designed to support those with co-occurring disorders. On the other hand, for clients who have been in services longer and are employed, staff find it difficult to find time to meet, particularly for clients who work full-time or overtime.

Services are not able to meet the breadth and the depth of client needs. Many clients need housing and substance use services. Staff explained that clients really need housing and financial support, but this is not a service directly provided to RTT clients. Others expressed frustration at not being able to provide substance use services despite many clients having dual diagnoses. Staff also shared that clients often need more permanent support, and that not all clients are ready to exit the program at 18 months. This has been particularly true during the pandemic since some shelters and crisis stabilization units are still closed.

Staff have limited capacity, which may have implications for the intensity of services provided. Staff shared that they consistently have a full caseload and feel like they are "always playing catch up." This can make it difficult to find time to follow up with clients who have reduced engagement.

"I can think of 100 things I could do for each client that I don't have the capacity for."
-Staff Focus Group Participant

Staff shared that, even though they have full caseloads, they are conducting outreach visits to other BACS shelters. They have found it difficult to balance this work with their existing case load, and do not have room for more clients interested in receiving services.

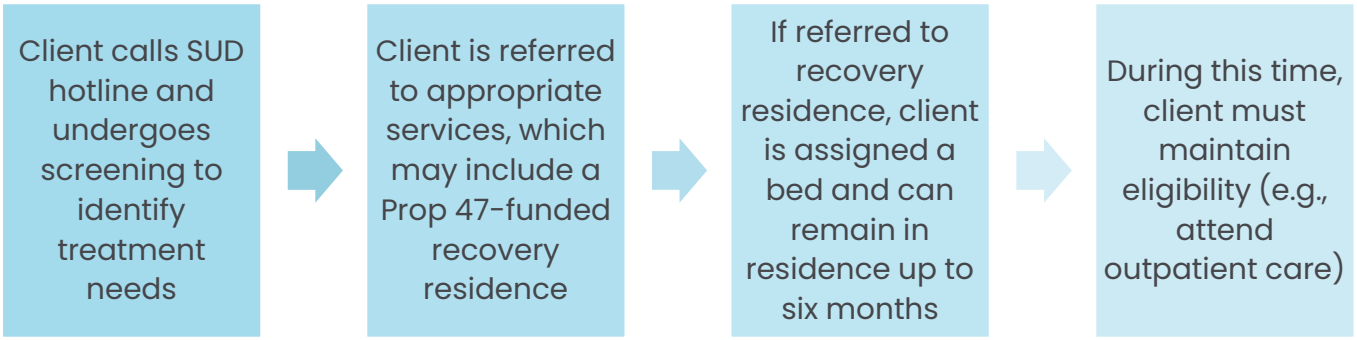
Clients reported varying levels of satisfaction with the program. Most clients are very satisfied with the services they receive from the program, but a couple of clients shared that they have been asking for help but have not received it. One client shared a perception that new caseworkers do not have as many resources as more experienced caseworkers and may not have as much experience working with specific populations. Another client shared an experience working with a staff member who they felt was too busy, and because of that they did not get the support they needed.

"There's a lot on [my caseworker's] plate. I need help. She did what she could. I'm voicing what I need. I found a job and did it myself…I had to do it myself. I don't know if BACS is supposed to help. They probably just have a lot of caseloads."
-Client Focus Group Participant

Substance Use Disorder (SUD) Program

Through Prop 47, Alameda County augmented preexisting SUD contracts over the course of three years to support a client-centered and clinically-driven system of care. Services were funded by Prop 47 until funding was fully disbursed in June 2022.[17] The Alameda County Prop 47 Cohort II SUD program consists of a SUD referral telephone hotline managed by Center Point and eleven beds across two recovery residences. The two recovery residences are run by CURA, providing services to individuals in North County, and Second Chance, providing services to individuals in East, Central, and South County. The number of beds in each facility is based on the need in these regions. CURA has seven beds and Second Chance originally had fifteen, which was later increased to nineteen to better accommodate the growing need. Center Point staff screens callers' level of need, using American Society of Addiction Medicine's (ASAM) criteria, and refers them to the appropriate level of care. Figure 4 illustrates the Prop 47 SUD program model implemented in Alameda County.

Figure 4. Prop 47 SUD Program Model



Recovery residences provide clients with stable housing, food, and a structured living environment for up to a six-month period. The program is designed to serve 66 unique clients annually across both recovery residences. Each residence is staffed by individuals with lived SUD experience. While at the recovery residence, clients are required to participate in outpatient care and attend other programs or classes (e.g., Alcoholics Anonymous or domestic violence classes) as assigned. In some cases, clients are connected to nearby employment to reduce barriers related to transportation availability and transit costs.

[17] Bed costs increased during Cohort II, causing funds to be depleted earlier than expected.

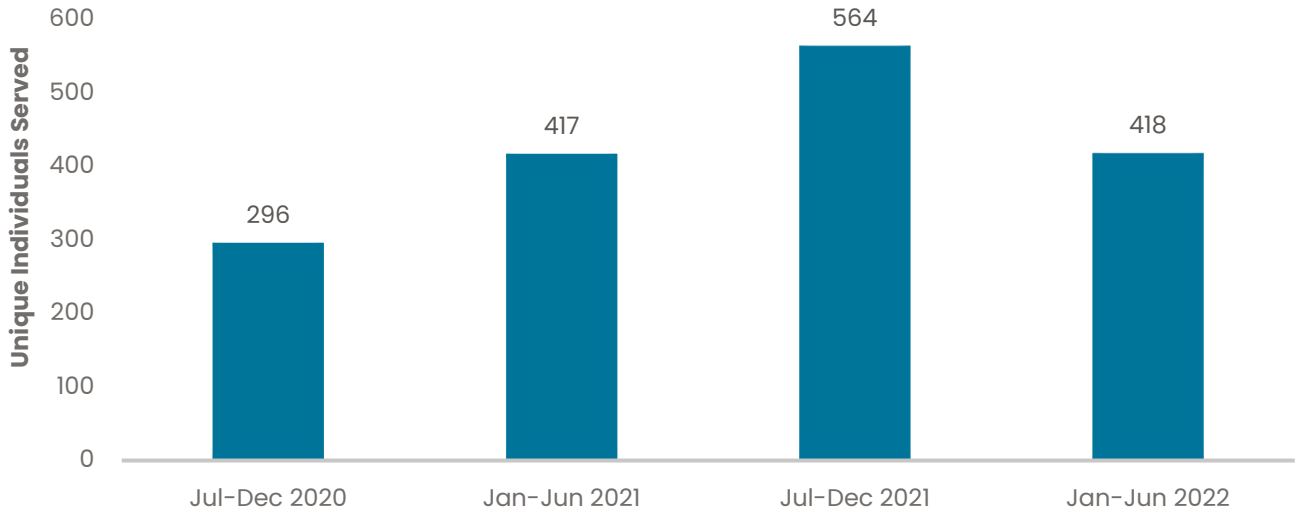
Program Profile

This section describes the services provided through the telephone hotline and recovery residences; the demographics of hotline and recovery residence clients; and program outcomes, including recovery residence exit types and recidivism.

Hotline Services

A total of 1,695 unique individuals received assessment and referral services from the Alameda County SUD hotline between July 2020 and June 2022.[18,19,20] As shown in Figure 5, hotline call volume increased as the COVID-19 pandemic continued through 2022.

Figure 5. Individuals Served by Hotline (n = 1,695)



Just over half (57%) of the 1,695 services provided by the hotline were for screening and referral. Most other services (41%) were follow-up and care navigation. The remaining calls were missed appointments or no-shows. Half (50%) of the 1,695 individuals who received services through the hotline were connected to some type of SUD service.[21]

Hotline Client Profile

Overall, over half (64%) of the hotline callers were male, with an average age of 41. Over a third of the clients were Black (34%) or White (33%), and 19% were Hispanic/Latino (see Table 8).

[18] Approximately 33% (237) of the callers for whom jail discharge date was available exited jail prior to calling the hotline. Jail discharge date was unavailable for 982 clients.

[19] Center Point screened additional individuals through the hotline who were not justice-involved.

[20] This number may include duplicates due to inconsistencies between the two datasets available. Refer to the Limitations section on page 12 for more detail.

[21] Service data was unavailable for 493 clients.

Table 8. Race/Ethnicity of Hotline Clients (n = 1,695) [22]

Race/Ethnicity	Number	Percent
Black	584	34%
White	554	33%
Hispanic/Latino	329	19%
Asian/Pacific Islander	82	5%
Native American or Hawaiian Native	55	3%
Other/Unknown	307	18%

Recovery Residence Services

171

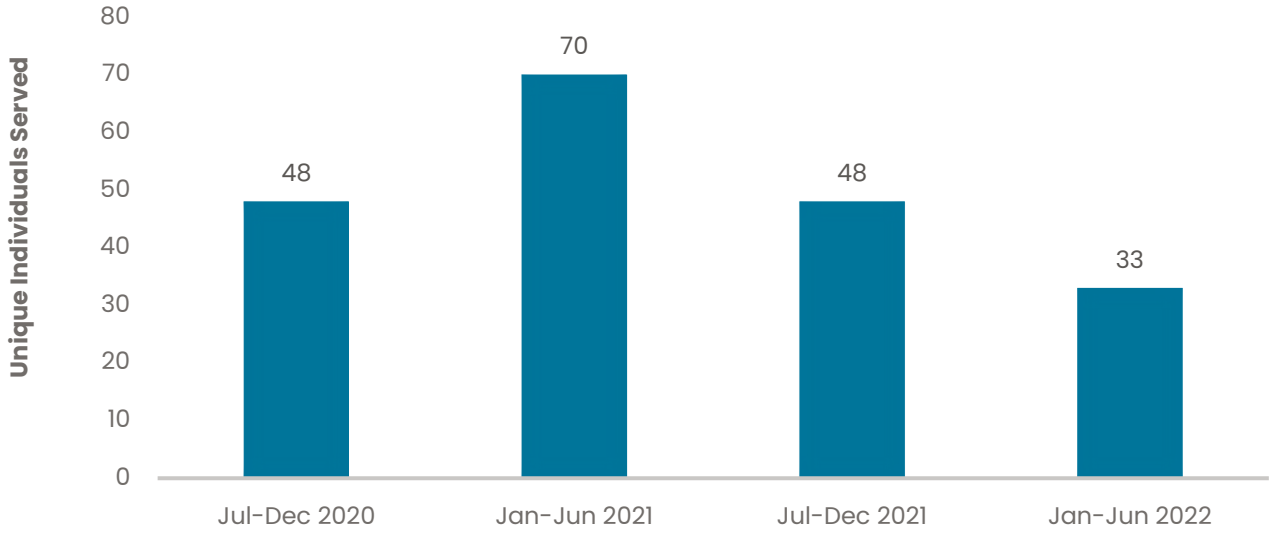
clients served

In the 24 months between July 2020 and the end of June 2022, 171 unique individuals enrolled at recovery residences (91 at CURA and 84 at Second Chance)—averaging 86 individuals a year. Thus, Alameda County met its intended capacity of 66 individuals per year. The number of unique individuals enrolled at recovery residences varied widely, from 33 individuals to 70 in any given six-month period (see Figure 6). Program staff shared that the increase in enrollment in early 2021 was likely due to an increased need for shelter beds due to the COVID-19 pandemic and the resulting increase in the number of recovery residence beds at Second Chance[23] to meet the need.

[22] Some clients identified with more than one ethnicity. For this reason, the percentages total more than 100%.

[23] Second Chance originally had fifteen Prop 47 beds. This was increased to nineteen out of their total of 32 beds in response to the pandemic.

Figure 6. Unique Individuals Newly Enrolled at Recovery Residences (n = 171)



The average stay of recovery residence clients was 81 days. Of the 171 individuals who stayed at recovery residences, 25 had multiple stays (i.e., exited and then returned to the recovery residence) for a total of 196 individual stays.[24]

Recovery Residence Client Profile

The majority of recovery residence clients were male (78%), with an average age of 42. At Second Chance, 55% of clients were male and 45% were female. On the other hand, CURA was an all-male residence, contributing to the gender differential and the greater representation of male clients across the two recovery residences. The largest proportion of recovery residence clients were Hispanic/Latino (38%), with over a third (36%) White, and 32% Black (see Table 9).[25]

[24] This calculation considers an individual to have multiple stays if there are more than five days between discharge and re-enrollment.

[25] Some clients identified with more than one ethnicity. For this reason, the percentages total more than 100%.

Table 9. Race/Ethnicity of Recovery Residence Clients (n = 171)

Race/Ethnicity	Number	Percent
Hispanic/Latino	65	38%
White	61	36%
Black	54	32%
Asian/Pacific Islander	10	6%
Hawaiian Native or Native American	3	2%
Other/Unknown	60	35%

Of the 171 recovery residence clients, 22 (13%) were under probation supervision in Alameda County at some point during their stay at a recovery residence (two at CURA and 20 at Second Chance). The majority of clients had a primary diagnosis of either alcohol abuse/dependence (29% overall; 34% at CURA and 23% at Second Chance) or amphetamine and other stimulant abuse/dependence (38% overall; 32% at CURA and 45% at Second Chance) as shown in Table 10.

Table 10. SUD Diagnosis (n = 171)

Primary Diagnosis	Number	Percent
Amphetamine and Other Stimulants	65	38%
Alcohol	49	29%
Opioid	27	16%
Cocaine	20	12%
Cannabis	8	5%
Other Psychoactive Substances	1	<1%
Other Sedatives	1	<1%

Outcomes

Of the 171 unique recovery residence clients, three-fourths (126, 74%) exited with satisfactory progress or goals reached and approximately a quarter (45, 26%) left with unsatisfactory progress or their goals not reached (see Table 11). The average time between enrollment and exit was approximately 81 days, or nearly three months. In some circumstances, individuals could receive permission to extend their stay beyond the six-month cap, with 93 individuals staying at the recovery residence for more than six months.

74%

of clients reached or partially reached their treatment goals

Table 11. Prop 47 SUD Recovery Residence Exits (n = 171)

Exit Status	Number	Percent
Exited with Case Plan or Treatment Goals Reached or Satisfactory Progress	**126**	**74%**
Discharged with Treatment Goals Reached	21	12%
Discharged with Satisfactory Progress	105	61%
Exited Services Without Satisfactory Progress	**45**	**26%**

Outpatient Services. Of the 171 unique clients, 162 individuals (95%) received outpatient services while they stayed at a recovery residence. Approximately a quarter (28%) were enrolled in outpatient care before residing at a recovery residence, while 72% were connected to outpatient services upon or after enrolling at a recovery residence. This is illustrated in and accompanied by Figure 7, which depicts the amount of time it took for a client to start outpatient services after enrolling in a recovery residence. As shown, half of clients connected to outpatient care started services at the time of enrollment. Clients who enrolled in outpatient treatment after coming to the recovery residence remained in outpatient services for an average of 107 days.

Figure 8. Outpatient

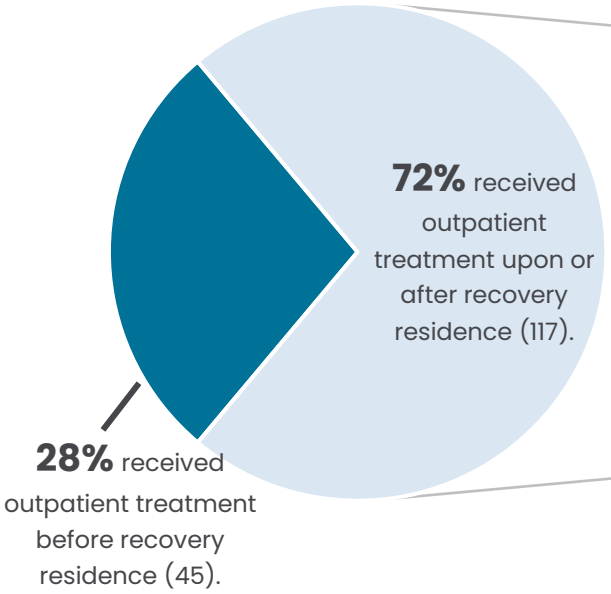
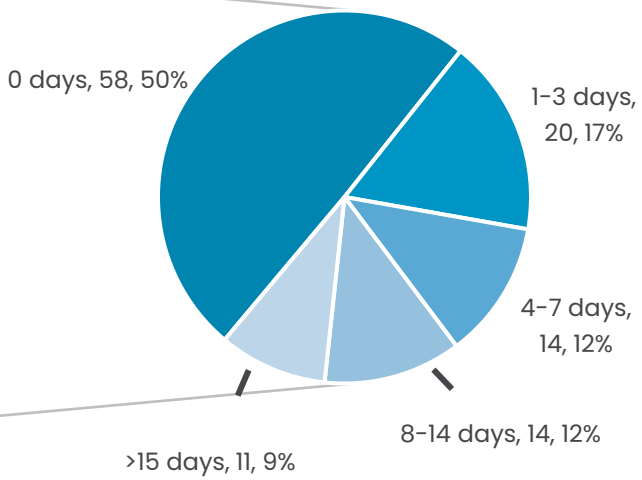


Figure 7. Time to Outpatient



86%

did not recidivate

Recidivism. While staying in a recovery residence, no individuals were booked into jail in Alameda County. After exiting a recovery residence, only 24 of the 171 individuals served (14%) re-offended. Therefore, the large majority of clients (86%) did not recidivate following their first night at a recovery residence.[26] Of the 901 individuals who called the Center Point helpline for whom name and date of birth was available, 146 individuals (16%) recidivated by February 15, 2023.[27]

Program Strengths and Barriers[28]

Program Strengths

The semi-structured environment of the recovery residences supports recovery. Many clients came to the recovery residences from highly structured residential treatment facilities, while others came from environments with little to no structure, including homelessness. Across the board, however, clients shared an appreciation for the structured and encouraging atmosphere the recovery residences provide. Clients appreciate that they have clear structure and rules, which foster a sense of accountability. Many clients noted that self-accountability is crucial when in the program and helps them stay focused on their recovery. Clients referred to the recovery residences as "safe havens" and "safe zones" where they can stay focused on their goals. At the same time, clients also appreciate the independence offered by the recovery residences. For example, clients like that they

[26] The average time between recovery residence enrollment and February 15, 2023, was 1.7 years. Recidivism data is only for convictions in Alameda County.

[27] Name and date of birth (fields used to match incarceration data) were missing for 794 clients.

[28] Most qualitative data is reflective of Second Chance, given that the research team was unable to interview staff or clients of CURA.

can leave the recovery residence when they need to, such as for appointments. Independent living in tandem with structure and rules has a positive impact on client experience in the program and their success.

"It's a safe haven to stay focused and accountable. I feel you have these resources and if you take the resources and stay on them, it gets done."
- Client Focus Group Participant

"I'm happy to be in the safe zone instead of on the streets. You stay focused. There's accountability, a treatment plan."
- Client Focus Group Participant

Clients value the peer staff at recovery residences. Clients described the staff as friendly, respectful, and fair. Clients felt "seen" by the staff and expressed that "no one is neglected" at the recovery residences. Moreover, there is a sense of respect at the residences, and clients appreciate that staff call them by their first names and treat them like adults. Additionally, although staff are friendly, they also hold clients accountable, which continues to foster self-accountability. Lastly, each residence is staffed by peers (individuals with lived SUD experience); clients expressed that staff could relate to their recovery. With the presence of staff with lived experience, clients feel like it is "a real family" at the recovery residences.

"When I feel triggered or whatever, staff can relate. They aren't saying you're not allowed to feel that way. They are empathetic. They help you to look at it from a different perspective."
- Client Focus Group Participant

"They always acknowledge me by my first name when I come in. That alone makes me feel wanted, just knowing they acknowledge me."
- Client Focus Group Participant

Both clients and staff suggested that recovery residences provide the essential foundation for successful recovery. Clients attributed their successes to the recovery residences because it provides a time for clients to step back and "rebuild themselves." Both clients and staff highlighted the importance of the connections and resources provided by the recovery residences, such as assistance with finances and insurance as well as being connected with a therapist and other mental health supports. Additionally, the recovery residences collaborate with housing service partners, such as Bonita House, La Familia, and Abode Services to link clients to more services and funding opportunities, such as rental assistance. Both clients and staff expressed that the recovery residences supply clients with the resources and tools they need to succeed. Moreover, clients noted

that they are less likely to have interactions with law enforcement when in recovery and utilizing the resources provided by the program.

"Second Chance has definitely helped me rebuild myself and build tools I need to continue to be successful."
-Client Focus Group Participant

"It was a restart. It jump-started my recovery. I was kind of spiritually bankrupt, I didn't know if I'd come back. I was given an opportunity. 'Second chance at a first-class life.'"
- Client Focus Group Participant

"They gave me enough wiggle room to figure things out. I got in touch with real feelings, doing groups, essays. Now I get a chance to look at the wreckage. It's emotional to see what I've created. Now I can do something about it."
- Client Focus Group Participant

Program Barriers

Many clients felt that there are not enough staff to meet the need, which impacts treatment timelines and creates longer wait times. Across clients, the wait times to enroll in the recovery residences fluctuated, with some clients waiting weeks before getting a bed and entering the program. Once in the program, clients noted that there are not enough counselors compared to the number of clients, which negatively impacts treatment plans. One client revealed that the start of their treatment plan was delayed twice because their counselor was busy. Additionally, clients desire more time with their counselors and felt the time allotted is not enough.

"I'd like to have more time with my counselor or meet with my counselor. I know I have one, I just haven't met with her."
- Client Focus Group Participant

Recovery residences encounter clients that require a higher level of care than the program can provide. Staff explained that the initial information they receive from potential clients over the phone can be limited, with clients occasionally omitting information to ensure they receive a bed. Thus, there are instances when staff encounter clients in-person with erratic behavior or other challenges that require a higher level of care than they can provide at the recovery residence. This results in staff turning clients away, which staff members have found difficult for them personally and challenging to process.

"It can be difficult at times because we're only getting information the client is giving you on the phone. We've had a couple people that needed a higher level of care than we could provide."
- Staff Focus Group Participant

"What happens is we get people that already went through mental health services and their behavior was a problem at the other place. They come to us as a last resort, but we can't tolerate as much anymore. But it feels like we're throwing someone away…"
- Staff Focus Group Participant

External factors, such as limited funding and the COVID-19 pandemic, impacts service provision and the client experience. Staff reiterated that insufficient funding makes it difficult to connect clients with resources. Many services, such as mental health and housing services (e.g., Section 8/The Housing Choice Voucher program), have wait lists and it discourages clients while on the road to recovery. From the client's perspective, the pandemic compounded funding challenges. For example, clients noted that there are a lack of events and opportunities to gather socially at the recovery residences, such as sober dances, celebrating holidays, decorating, and making meals together. Providers had to indefinitely postpone most of these events because of the pandemic and they have been slow to restart.

"It seems like ever since COVID-19, they changed things. You can see picture collages that they used to celebrate holidays. Since COVID-19 they shut down some things other people think aren't necessary to celebrate, like decorations and everyone getting together."
- Client Focus Group Participant

Staff highlighted that the time clients stay in the program is not long enough to address needs, which impedes success after the program. Staff felt that the six-month timeframe of the recovery residences is not enough time to address all needs, such as housing, employment, etc. Staff noted that external stressors (e.g., paying rent, finding employment, affording food, homelessness, etc.) create barriers to sobriety and overall success after the program. Most notably, a lack of housing and employment after the program can jeopardize clients' long-term recovery. Permanent housing supports sobriety, and employment provides not only the financial support to maintain housing but an added structure that can also support recovery.

Moreover, staff reported a lack of follow-up on referrals after the program, wherein staff are unable to monitor what happens to a client post-program. The reason for this is unclear but could include challenges such as getting client contact information from referring partners, or difficulty connecting

with a client via phone or other outreach efforts. Nevertheless, a lack of follow-up is especially worrisome if the clients do not have their needs met and are not in stable positions to maintain sobriety upon leaving the recovery residence.

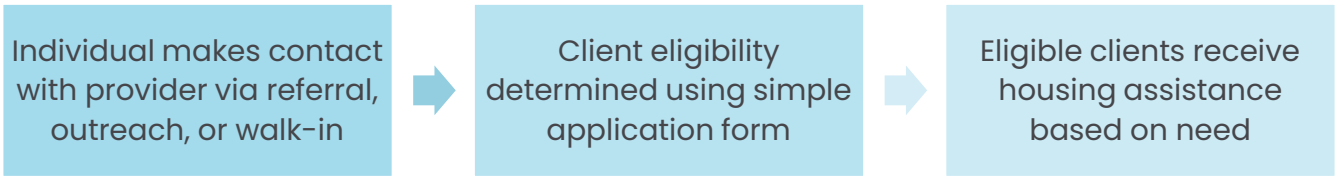
"But after six months and there's no housing and nowhere to go, they start to panic. Pedals go backward and they're gonna do what they're gonna do and go back."

- Staff Focus Group Participant

Housing Assistance Program

The Alameda County Prop 47 housing assistance program provides financial housing support to justice-involved individuals with mental illness and/or substance use disorders. Three community-based providers are contracted to provide housing assistance: Bay Area Community Services (BACS), La Familia Counseling Services (La Familia), and Roots Community Health Center (Roots). These organizations provide each client with up to $5,000 for eligible expenditures, including but not limited to rental assistance, security deposit, utilities, furniture, minor home repairs, credit repair, assistance with poor rental history, and moving expenses. Figure 9 illustrates the Prop 47 housing assistance program model.

Figure 9. Prop 47 Housing Assistance Program Model



Program Profile

This section describes the services provided through the housing assistance program, the characteristics of housing clients, and recidivism outcomes.

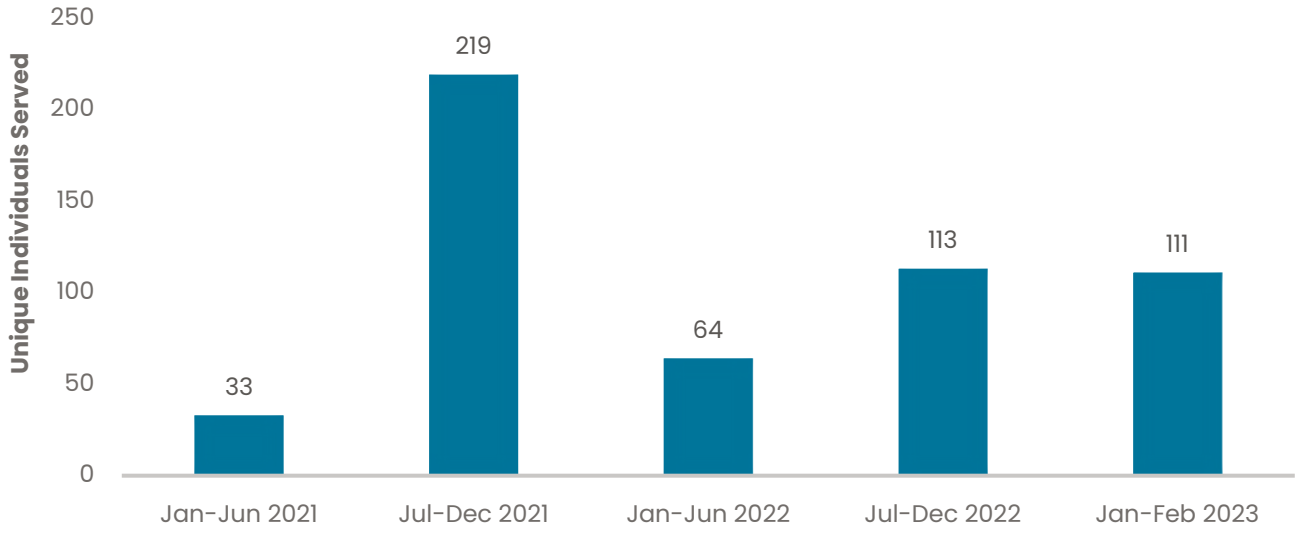
Housing Services

540

clients served

A total of 540 unique clients received Prop 47 housing financial assistance through 1,260 financial allocations from January 2021-February 2023. Clients were eligible to receive allocations up to a maximum of $5,000, a decision made by the Alameda County Board of Supervisors (BOS). The total clients served and total allocations were significantly lower compared to Cohort I, largely due to the pandemic and program closures. Figure 10 illustrates the number of unique clients who received funding for the first time in each six-month period. Program staff explained that the increase in individuals served in the latter half of 2021 is largely due to the program waiting to disburse funds until the contract was secured.

Figure 10. Unique Clients Receiving Housing Financial Assistance (n = 540)



Providers distributed a total of $1.9 million to individuals for an array of eligible housing-related expenses, averaging $3,529 per client. Table 12 summarizes the number and percentage of individuals using housing financial assistance for each expenditure type and the total amount spent on each (e.g., rental assistance, security deposit). Rental assistance was the most frequently provided expenditure and comprised the majority of the total funding disbursed. Furniture was the second most distributed fund and made up 15% of all funding expenses. Furniture expenditures more than doubled since Cohort I, where they made up 7% of spending. Program staff explained that some individuals from Cohort I who moved into Cohort II were able to use the additional funding for furniture expenses.

$1.9m

distributed

Table 12. Housing Expenditures by Type and Amount Spent

Expenditure Type	Amount Spent	% of Spending
Rental Assistance (excluding back pay)	$953,341	50%
Furniture/Furnishings	$290,909	15%
Backpay (past due rent)	$241,034	13%
Security Deposit	$238,386	13%
Hotel/Emergency Stay	$119,452	6%
Moving Expenses	$24,316	1%
Utilities	$10,625	1%

Other		$10,175	1%
Credit Repair		$6,106	<1%
	Total	**$1,905,525**	**100%**

To target funding based on need, Prop 47 housing funds were allocated by district based on the distribution of probation clients, which served as a proxy for the justice-involved population, across supervisorial districts. Table 13 displays spending across districts through February 2023.[29]

Table 13. Housing Services by Supervisorial District

District	Amount Spent	% of Spending
District 1	$117,540	6%
District 2	$431,902	23%
District 3	$622,799	33%
District 4	$349,308	18%
District 5	$375,120	20%

Client Profile

Among the 540 housing assistance recipients, 332 clients (61%) had a mental health diagnosis and 299 individuals (55%) had a SUD need, with 108 (20%) indicating a co-occurring disorder (both mental health diagnosis and SUD need).[30] The average age of clients was 45 years old.[31] At the time financial assistance was first provided, most individuals (67%) were experiencing homelessness or at risk of homelessness.[32] This is significantly lower than in Cohort I, where almost all individuals (93%) were experiencing homelessness or at risk of homelessness.[33]

[29] $8,856 worth of housing disbursements did not have a district listed.

[30] Data may underestimate the number of individuals with SUDs because indicating a mental health need alone is sufficient to qualify for Prop 47-funded services. Therefore, providers may not identify an individual's SUD if the individual has an identified mental health need, particularly if the individual is concerned about the stigma of SUD need.

[31] Birthdate not available for six unique individuals.

[32] Twenty-seven percent were experiencing homelessness and 40% were at risk of homelessness. Housing status was not provided for two individuals.

[33] Sixty-five percent were experiencing homelessness and 28% were at risk of homelessness.

Outcomes

Recidivism. Within a month of receiving housing assistance, only one out of the 540 enrolled clients (<1%) was booked into jail in Alameda County. As of February 15, 2023, sixteen individuals (3%) who received housing assistance were convicted of a new criminal offense committed after receiving their first housing assistance disbursement. Therefore, the large majority of clients (97%) did not recidivate since first receiving financial housing support.[34]

97%

did not recidivate

Program Strengths and Barriers

Program Strengths

The Prop 47 housing assistance program enables providers to use funds flexibly to support clients with a wide array of needs. Service providers and clients appreciate that the overall enrollment process is straightforward and simple, with low barriers to entry, and the flexible funding structure allows service providers to distribute assistance on short timelines. Eligible recipients are typically able to receive funding in less than a week–often within a few days—to support their housing needs, although one client noted that rent checks from the housing assistance program did not always arrive on the same day each month.

Moreover, the flexible disbursement structure allows staff to utilize funds in a way that is most appropriate for clients' needs. Most notably, clients and staff both expressed that back rent and rental assistance are the most helpful funding allocations. Staff went on to say that there are not many programs that provide this type of assistance and that Prop 47 has been the most stable and reliable funding source since the pandemic.

"The flexibility works well…We can help people with more things than what other programs can offer. Prop 47 gives more flexibility."
- Staff Focus Group Participant

The Prop 47 housing assistance program helps clients obtain short-term housing stability, which supports clients' mental health, education, and financial self-sufficiency. Providers work with clients to identify any housing options that are available to support their stability. Above all, providers noted that having temporary housing provides enough short-term stability to help clients achieve longer-term stability. With the help of housing assistance, clients expressed a sense of financial stability, such as putting the money that would have gone to housing into a savings account or to pay back debt. Additionally, clients noted that they could use the money saved for their families and

[34] The average time between receiving housing support and February 15, 2022, was one year. Recidivism data is only for convictions in Alameda County.

any household needs. For some, stable housing also meant improved mental health and relief from chronic financial worry. Notably, clients expressed a sense of self-worth, confidence, and accomplishment as a result of feeling more financially secure. Moreover, clients mentioned that housing assistance impacts other areas of their lives, including education. A client shared that the assistance allows them to focus on school and not worry about working part time to make ends meet.

"It was a tangible amount that covered two months of rent; that decreased my worries and improved my mental health…when you're in this situation, it increases your depression…"
- Client Focus Group Participant

"With the rent that they paid, I was able to put money away…now I'm able to move out of my current place. I was able to save a little and pay some bills that seemed unattainable…I didn't think I would ever get any bill down."
- Client Focus Group Participant

"La Familia's support helped me stay focused and driven and stay on the right track. There's no future with criminality and drugs…La Familia allows me to start saving money and helps me gain confidence…I still have a secure home and a safe place…"
- Client Focus Group Participant

Clients feel that program staff are helpful, compassionate, respectful, and professional. Clients appreciate that staff genuinely care about them and want to help. Staff have a professional and attentive work style in which clients feel respected and not looked down upon. Instead, clients feel prioritized because staff focus on them and show genuine concern. Clients noted receiving prompt communication from staff and appreciate that staff make sure their needs are met.

"They go over the top for you. While they're navigating for you, they're navigating other people too, but they never lose focus on you."
- Client Focus Group Participant

Program Barriers

COVID-19 and other external factors limit the system's capacity to address client needs. Staff revealed that it is challenging to connect clients to necessary resources because resources once available during the pandemic are no longer available or are working at limited capacity. Most notably, staff expressed that finding available and affordable housing for clients in Alameda County

is challenging, and COVID-19 resulted in a heightened need for housing overall. As is the case for many parts of California, affordable housing is limited in the Bay Area, particularly for individuals with criminal records and substance use or mental health needs. The pandemic further limited housing options due to lowered capacity in shelters and other shared living environments.

"Finding people housing is the hard part and paying is easier."
- Staff Focus Group Participant

The Prop 47 housing assistance program efficiently and effectively offers short-term housing relief; however, some service providers and clients suggested it is less effective supporting long-term housing stability. In Alameda County, where the cost of living is extremely high, $5,000 is not always sufficient to provide long-term housing relief for individuals who earn low wages or have larger families to support. Clients explained that even with the funding, they are still behind on rent. The $5,000 does not last long, and once it is spent, clients face the remaining costs, and many revealed that they cannot afford to fill that gap by themselves. Overall, many clients reported that they are not stabilized long-term and are still behind on rent or looking for new housing.

"I'm still struggling and behind on rent. Obviously there's a limit on what La Familia can do but wish they could cover more…I'm still in the hole. I have 2 kids, and it seems impossible to get out."
- Client Focus Group Participant

There is still confusion among the community about what the program is, who is eligible, and what the program covers. Many potential clients are referred to the housing assistance program through word of mouth in the community. Unlike formal referrals through channels such as 211, providers, and probation or parole, referrals through word of mouth often result in individuals arriving at the program who are not eligible. Staff reported that the eligibility requirements limit who the program can serve, while many others could benefit from assistance. In addition to eligibility, there seems to be confusion around what expenses the housing assistance covered. For example, a client expressed frustration that the program does not cover back rent when the program does in fact cover this expense as a form of housing assistance. It is clear that among the group of clients that the evaluation team spoke with, there seems to be some confusion as to what the program covers. Although the evaluation team spoke to only a subset of clients, this instance could potentially point to aspects of the program not fully understood by clients and the community.

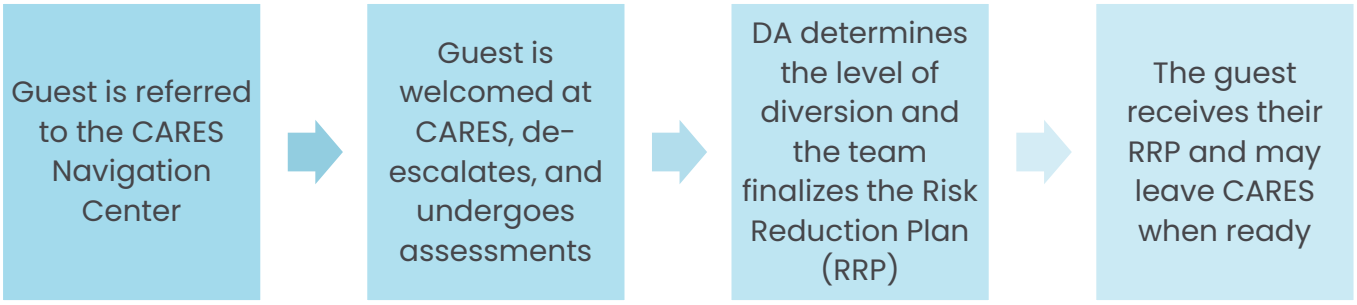
It is difficult to identify clients with plans for long-term housing, which is necessary for disbursing funds appropriately. Staff explained that it is challenging to know which clients have plans for long-term housing and which do not. Knowing whether clients have long-term housing plans dictates the type of funding that would be most appropriate, as the funding is limited and should be used to

maximize a client's chance at long-term housing stability. For example, funding a hotel stay would be a good use of funds if a person is approved for housing and needs somewhere to stay in the interim. However, it would not be advantageous to fund a hotel stay for someone without a plan for housing afterwards.

Diversion Program

The Alameda County Prop 47 diversion program, the Community Assessment, Referral, and Engagement Services (CARES) Navigation Center, was newly created in Cohort II. The program, which operates from 11 am-7 pm, Monday through Friday, is intended to divert low-level offenders with mental health needs away from the crisis system by connecting them with community-based services. The CARES Navigation Center is operated in partnership with the Alameda County District Attorney's Office, a community-based provider, La Familia Counseling Services, and the Alameda County Probation Department. Figure 11 illustrates the navigation center model. A further explanation of each step is presented below the figure.

Figure 11. Prop 47 Diversion Program Model



Step 1: CARES Navigation Center Referral

Individuals can be referred to the Navigation Center through law enforcement officers, the District Attorney's (DA) Office, Alameda County Sheriff's Office (ASCO), the BART team, and the Mobile Assistance Community Responders of Oakland (MACRO) Program. If individuals are stopped or arrested for a misdemeanor offense[35] and display signs of a mental health or substance use disorder, referring agencies may give the individual the option to be transported to CARES, as opposed to jail. In addition to law enforcement referrals, DA staff can also make referrals based on reviews of pretrial files.

Step 2: CARES Navigation Center Respite and Assessments

Upon arrival at the CARES Navigation Center, CARES staff offer the individual food, clothing, and other basic necessities to de-escalate the situation. In accordance with the "Living Room Model" of care, the staff refer to those they serve as "guests." After staff introduce what the Navigation Center is and

[35] A limited number of misdemeanor offenses are not eligible for CARES. These are related to sex offenses, domestic violence, stalking, and driving under the influence. Individuals who are violent or combative with law enforcement officers or require medical treatment are not eligible for the program.

have the guest sign the agreements form, they bring the guest to a space furnished intentionally with cozy chairs, couches, and artwork to create an inviting atmosphere. Following the respite period[36] (usually thirty minutes to one hour) and establishing trust with the guest, the staff conduct a barrier removal and clinical assessment to develop the preliminary Risk Reduction Plan (RRP). Upon gaining consent from the guest, the RRP is shared with the DA. When fully staffed, the CARES team is composed of five peer support specialists, one clinician, and one SUD specialist.

Step 3: Diversion Determination and Risk Reduction Plan (RRP) Finalization

In a virtual meeting, the staff and DA discuss the case and the DA determines the guest's level of diversion. Four levels of diversion are available:

- **Deflect:** Individuals who commit low-level crimes and have little criminal history may be deflected, which entails a one-day follow up to ensure they have connected with subsequent services.
- **Defer:** Deferral is granted when an individual commits a low-level crime but has more criminal history. Follow-ups for deferrals occur after one day, five days, and three weeks of engagement with diversion services.
- **Divert A and B:** Post-charge diversion is offered to individuals with more serious offenses and, generally, more extensive criminal history. Individuals in Divert A are directed to treatment and have follow-up after one day, thirty days, six months, and one year. Divert B is through collaborative court and does not require follow-up from the CARES team, since the individual will receive supervision through the court.

Once the diversion level has been set, the team finalizes the diversion recommendations and RRP.

Step 4: RRP Receipt and Exit

Once the CARES team presents the guest with his or her RRP and referrals, the guest has the option to leave the Navigation Center or remain there until 30 minutes before closing for additional respite time.

Program Profile

This section describes the services provided through the CARES Diversion program; the demographics of guests; and program outcomes, including engagement with services and recidivism.

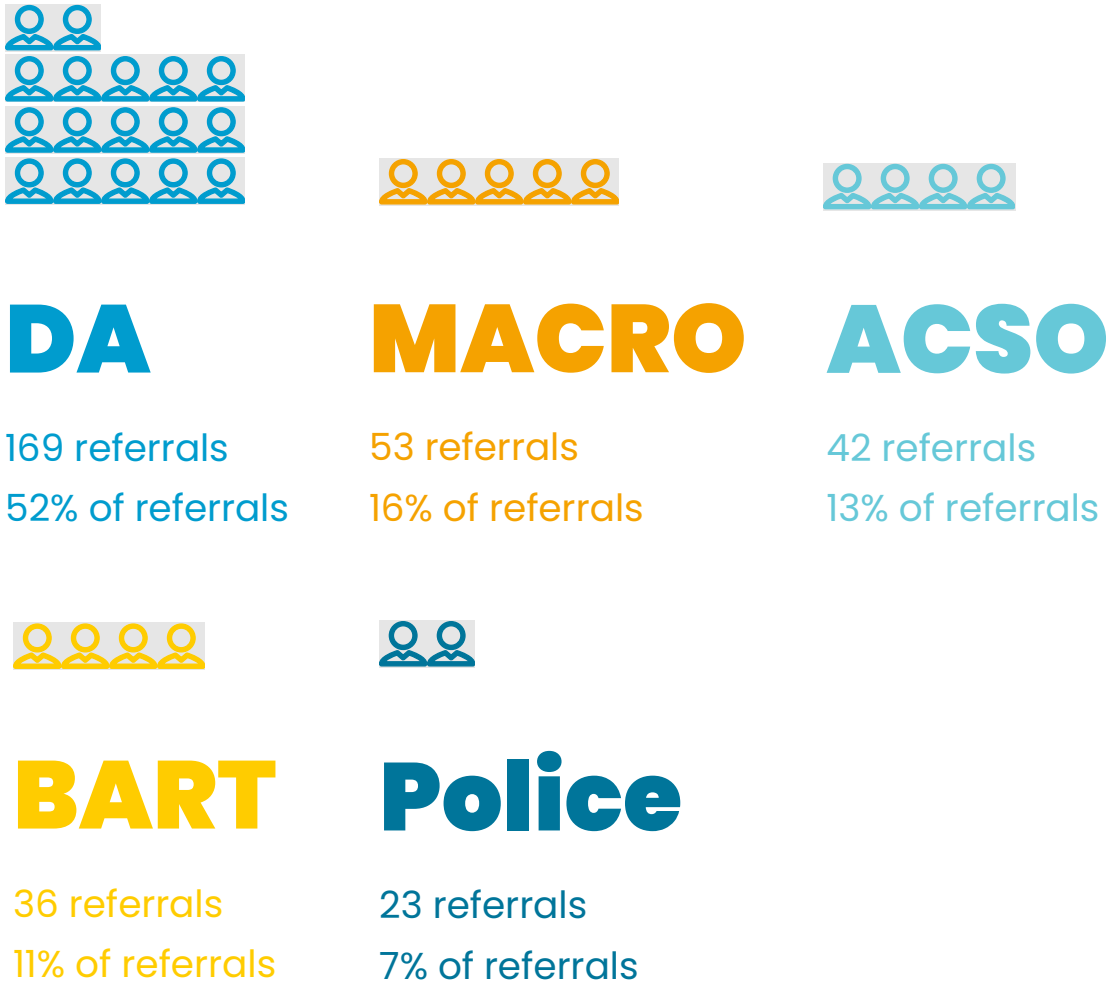
Diversion Services

The CARES Diversion program received 327 referrals for 319 unique individuals through December 2022. Figure 12 below shows the source of each referral. More than half of the 327 referrals came from the District Attorney's office, either when the individual was in court or in custody (52%). Less than 10%

[36] A short period of relief during which the guest can de-escalate.

of referrals came from police departments (7%), suggesting the need for additional outreach to law enforcement agencies.

Figure 12. Referring Agencies for CARES Referrals (n = 323)[37]



Of the 319 unique individuals who were referred, 159 engaged with the CARES team for an assessment. The team provided 162 assessments to those 159 individuals. The most common reason why someone did not engage with the CARES team was because CARES staff were unable to contact the individual or the individual never made contact with CARES for enrollment (74% of the 160 ineligible referrals), followed by an individual declining services (18% of ineligible referrals).

Of the 159 enrolled guests, 130 (82%) received referrals to a total of 41 outside agencies. Table 14 below shows the most common referral agencies guests were referred to. Most often, guests received referrals for housing/shelter (42% of the 186 total referrals), SUD outpatient services (25% of referrals), and mental health services (9% of referrals).

[37] Referring agency was missing for four referrals.

Table 14. External Referral Agencies (n = 186)

Agency	Number	Percent
La Familia	49	26%
First Presbyterian Church, Hayward	20	11%
Second Chance, Hayward	18	10%
East Oakland Community Project	16	9%
St. Vincent de Paul	14	8%
South Hayward Parish	13	7%
Other[38]	56	29%

Client Profile

CARES clients, known as guests, include all 159 individuals who were given assessments. Most guests were adults aged 25-64 (86%). A small percentage of guests were older adults 65 & up (7%) or transition age youth 16-24 (4%).[39] Almost half of guests were Black (43%), 16% were Hispanic/Latino, and 15% were White (see Table 15).

Table 15. Race/Ethnicity of CARES Guests (n=159)

Race/Ethnicity	Number	Percent
Black	68	43%
Hispanic/Latino	25	16%
White	24	15%
Native American or Hawaiian Native	5	3%

[38] Other agencies with less than ten referrals each: ABODE Services(Hayward), ACCESS, Aetna Mental & Behavioral, Alameda County Family Lawyers, Alameda County Probation Department, Alameda County Social Services, BACS, Bay Area Community Health, Building Opportunities for Self Sufficiency, Castro Valley Career & Adult Education, Center Point, Cherry Hill Detox, COHE, Eastmont Wellness Center, Family Front Door, First Pres Church, Hope 4 The Heart, Kaiser Permanente, Lao Family Community Development, Lifelong Medical Care, Love Never Fails, Men Of Valor, NAMI of Contra Costa County, Oakland Behavioral Health Clinic, Off the Street Ministry, Options Recovery Services, Ritter Center, Salvation Army, SF Adult SUD Treatment, The Village of Love, Union Gospel Mission Sacramento, VA, Warming Center, Women's Daytime Drop-In Center.

[39] Six individuals did not have a recorded age range.

Asian/Pacific Islander	3	2%
Other/Unknown	34	21%

Before arriving at CARES, 56 individuals were arrested and then brought to CARES or given a notice by mail from the DA (35%). Of those arrested, 70% were arrested on charges related to drugs or alcohol (n=39). Through the Navigation Center, 67 guests were deflected, 47 were deferred, 24 received divert A, and two received BART diversions.[40]

Outcomes

Engagement with Services. Of the 130 guests who received referrals, 112 (86%) were successfully connected to the service after coming to CARES. Table 16 below shows the percent of referrals that resulted in a successful engagement with the service for the most commonly referred services.

Table 16. Successful External Referral Services from CARES (n=260 services referred)

Service	# of Referrals	# of Successful Referrals	% of Referrals
Housing/Shelter	109	94	86%
SUD Outpatient	65	54	83%
Mental Health	24	24	100%
SUD Inpatient	16	13	81%
Employment	14	11	79%
Other[41]	32	28	88%

Recidivism. As of February 15, 2023, only 11 of the 159 individuals who received an assessment at CARES (7%) were convicted of a new criminal offense committed after engaging with the program. Therefore, most guests (93%) did not recidivate since engaging with CARES.[42]

[40] BART diversions were discontinued shortly after the reported time period. These individuals did not receive a level of diversion from the DA but were still connected to services.

[41] Other services with less than ten referrals each: Admission, Behavioral Health, Benefits Enrollment, Case Management, Education, Food, HIV Services, Legal, Obtainment of Identification, Outpatient, Prop 47, Showers, SUD Assessment, Treatment, Women's Support Group.

[42] The average time between receiving housing support and February 15, 2022, was nine months. Recidivism data is only for convictions in Alameda County.

Program Strengths and Barriers

Program Strengths

Staff go above and beyond when working with guests, which results in positive guest experience at CARES and more engagement. Guests appreciate how kind, attentive, and supportive the staff are. Through their interactions, guests know that staff want to help them, with one guest recounting that the staff "didn't want me to leave before they could take care of me." One staff member mentioned that they often talk to guests on the weekends and do all they can to get to know their guests on a personal level. Moreover, staff noted that they always take the time to explain the program to guests, tell them why they are there, and walk through each step of the process with them. This point was supported by guests who described their experience at CARES as easy, smooth, and welcoming, giving guests a sense of belonging and comfort.

Staff also highlighted that they want guests to know that someone cares about them, and by planting a "seed," guests are more likely to accept the support or return to CARES at a later point if they were not interested at first. Most notably, staff and guests underscored the importance of lived experience among staff members. Both sides expressed how peer staff relate well to guests, making guests feel like they belong, with some saying they are "treated like family."

"I really appreciate CARES for helping me through those rough times. I really needed that. What they had to offer - it was very helpful, their expertise. They're very nice and professional. It feels like a best friend trying to help me out."
- Guest Focus Group Participant

"Besides giving a sense of family, showing we care – we understand, no judgment…everyone has been in the same shoes as them, collectively all of them have been. As a whole, CARES can relate…we can relate. I think it really makes them feel a sense of belonging."
- Staff Interview Participant

Staff work well within and across providers to ensure guest success. Staff noted that collaboration and communication within their team is commonplace and integral when deciding on the best resources to address guest needs. Together, staff discuss what they collect from their interactions with a guest and move toward a shared understanding of what services the guest needs. In addition to staff communication, CARES has good communication with partner providers, some of which, like CARES, are also run by La Familia. A staff member expressed that direct communication with referring pathways leads to smoother referrals and "warm handoffs" where guest information is shared with CARES.

"At the office, we're helping each other out - staying in communication about guests."
- Staff Interview Participant

Salesforce, an integral part of the processes at CARES, is well regarded by staff for data entry. CARES uses Salesforce, an integrated Customer Relationship Management (CRM) platform, for all data collection needs, such as risk reduction plans, all contact information, and referrals. Staff expressed that Salesforce is easy to use and very thorough. Furthermore, staff do not have any issues with the platform for data collection and find it very helpful in their work.

CARES connects guests to resources that facilitate stability and successfully divert them away from system involvement. Guests noted that CARES helped them realize the resources available that they would not have known of otherwise and described the different resources they were connected to, such as housing services and SUD programs. Staff expressed similar experiences, noting that they have had success getting guests housed and keeping folks out of incarceration. Notably, staff were proud to say that they have not had many guests return to CARES due to criminal activity, as seen in the recidivism outcomes above. Overall, guests have been successful – CARES staff have seen many guests become sober, housed, and are reconnecting with their families. With these outcomes, guests are less likely to interact with law enforcement.

"We've had a few successes for folks who were homeless for 20 years – now they have their own place and have relationships with their families."
- Staff Interview Participant

"We get to plant that seed. For the majority of people who come through CARES, and it ends up not working out…they always come back and show up at our door. We literally had someone whose third time was the charm. Now he's doing great."
- Staff Interview Participant

"It all happened so fast. The following day I moved into housing. They offered to give me things that I need for the place, and they've helped me out once or twice with transit cards. I hope the funding continues and they really made an impact. God bless them. I really appreciate what they did for me."
- Guest Focus Group Participant

Program Barriers

There are instances when staff have difficulty engaging with guests. Staff reported how challenging it is to not only engage guests once they arrive at CARES, but to keep guests engaged for a few hours while they wait to be connected with their next service. Notably, it is most difficult to

engage with guests who are intoxicated or high, experiencing a mental health crisis, or if they are angry or frustrated. Staff also noted instances when guests were not open to sharing information during assessments or were not compliant with COVID-19 measures (e.g., masking), which further challenged engagement and service delivery. Staff explained that after leaving CARES, it is difficult to contact guests who do not have phones or are difficult to reach. Thus, staff said that some follow-ups are more difficult than others. A staff member noted that case management would help increase guest engagement in situations such as these. However, this is not a service provided by CARES, which is a common misunderstanding between guests and partner agencies.

"Folks coming in high or suffering from mental health…if we don't get them connected to services quickly, then they want to leave. That's the biggest challenge that we face - keeping folks connected and grounded. If we just sit through this a little longer, it'll be well worth it."
- Staff Interview Participant

The process at CARES can be time consuming, which impacts the timeliness of care, as well as guests' experiences. Staff mentioned that various parts of the CARES intake and service delivery process can take longer than expected, such as the assessments and the time it takes for CARES to connect with the DA. As a result of the extended timeframe of service delivery, guests noted experiencing longer wait times. As mentioned above, staff are aware that guests disengage if the process is not fast enough. Thus, the timeliness of services is crucial to guest engagement.

"Service delivery has been pretty smooth…the only thing, it is time consuming, and they go over the time limit. Sometimes guests end up staying a little longer and assessments take longer than expected sometimes."
- Staff Interview Participant

CARES staff cannot serve all those who are brought to the office and sometimes must turn people away due to ineligibility. Staff reported that some guests that come into CARES are immediately told they are ineligible prior to services being delivered. Such is the case when individuals come into CARES without a referral or when guests with referrals have not undergone a background check. For example, the BART Crisis Team does not run background checks when conducting outreach and it is unknown until the guest arrives at CARES that they are ineligible. Staff also noted occasions when guests complete the assessment process and are later deemed ineligible for diversion from the DA. Staff acknowledged that these situations do not happen often. However, staff feel that all could benefit from CARES navigation services and that it is difficult to turn anyone away.

There is a lack of program awareness among the community and low adoption of the program by law enforcement agencies, particularly in Oakland. A staff member noted that not enough people

know about CARES and pleaded that more should be done to spread awareness in the community. Along with increasing awareness among potential guests, the District Attorney's office has taken steps to increase awareness among law enforcement through training and referral tools. This coincided with a rise in referrals throughout Cohort II. However, staff noted continuing challenges with getting law enforcement partners to fully adopt this diversion alternative. Law enforcement agencies, particularly in Oakland, have been slower to make referrals to CARES, as shown by the low proportion of referrals made by police. Staff attributed this low adoption to the additional time required by officers to refer someone and accompany them to the CARES Navigation Center.

"The only and biggest challenge is getting law enforcement to adopt- it's the process, the drive, the amount of time the officers are off the beat…We're housed in Oakland [and] people who are eligible for CARES are walking by our office on a daily basis. We're getting referrals from Hayward, San Leandro - we need more from Oakland."
- Staff Interview Participant

Housing resources are limited in the county and guests experience barriers to accessing the resources that are available to them. Staff members noted that the most common need among their guests is housing. However, staff identified challenges in connecting guests with housing resources in the community. Staff explained that the cost of living is high and the supply of beds in the area is low, with too few emergency shelters and other housing resources available to refer guests to. Additionally, both staff and guests reported barriers that prevent guests from accessing housing services, such as criminal history and COVID-19 regulations at shelters and different housing options (e.g., requiring guests to be fully vaccinated and boosted).

"When I was in the office, they called a couple places and because of my criminal background, some places wouldn't take me. They were making many, many phone calls to different organizations."
- Guest Focus Group Participant

Staff experience difficulty utilizing Salesforce for reporting data. Although staff shared that Salesforce is great when collecting guest data through the intake process, they noted that Salesforce is not equipped to report on the specific measures required by Prop 47. Staff expressed that pulling specific data from Salesforce is a challenge despite the ease staff had with collecting and inputting data into the system.

Cross-Cutting Findings & Recommendations

This section highlights common findings across all four Prop 47 program areas and recommendations for future cohorts.

Services are high quality and clients are satisfied overall with the services they receive. For individuals who are eligible and able to access them, Alameda County's Prop 47 services are working well. Evidenced by the quantitative and qualitative findings in this evaluation, programs funded by Prop 47 are achieving their goals of improving housing stability, supporting clients' mental health needs, connecting individuals with substance use services, and generally meeting client needs. Staff and clients report excellent relationships with one another across programs, even though many programs are at capacity and staff are stretched thin. **Prop 47 should continue to support increased program capacity, so staff can keep providing high quality services.**

Prop 47-funded programs are associated with a reduction in recidivism. All programs reviewed in this evaluation report have recidivism rates under 20% (16% for mental health RTTs, 14% for SUD services, 3% for housing assistance, and 7% for diversion). This suggests that addressing people's basic needs and treating upstream factors may help keep individuals out of the criminal justice system.

However, inconsistent data collection practices across providers make it difficult to effectively communicate this impact. Some programs use sophisticated case management systems or electronic health records systems, which feed into the county's behavioral health reporting system Yellowfin. Other programs use internal Excel spreadsheets to track aggregate client counts. This makes describing the impact of Prop 47 inequitable across programs because the quality of the data varies widely. **Prop 47 should more closely monitor data collection activities, set standards across programs when possible, and provide technical assistance and funding to build or improve data infrastructure.**

Service providers appreciated coordination across Prop 47 service providers as an efficient way to help clients address a variety of needs. The CARES Navigation Center, for example, expressed that its direct relationship with other La Familia services allowed them to make timely warm hand-offs, which is essential for maintaining client engagement. Second Chance, too, expressed gratitude for the ability to refer clients to services they do not provide themselves. This finding is consistent with Cohort I as well. **Prop 47 should continue to encourage direct relationships between providers in which they can coordinate and refer clients to one another to improve client engagement and provide more individuals with well-rounded support.** Furthermore, by connecting Prop 47 providers

with one another, providers are more likely to receive clients who they know are eligible for their services, making this an effective strategy for getting more individuals the help they need.

Clients and providers all highlighted increased housing assistance and stability as a critical need that has implications on other areas of an individual's life. As in prior evaluations, RDA found that the $5,000 allocated for housing assistance is not enough to stabilize a client's housing situation. As a result, clients face additional challenges if their housing needs are not met. This makes providers' jobs more challenging, too, given that a client with unstable housing will have a more difficult time engaging in services. **Prop 47 should continue to invest in housing assistance by seeking additional funding, strengthening existing partnerships, and exploring new ones with landlords and other housing providers.** Considering that clients and providers have said that their programs often do not last long enough to find stability, lengthening program duration as well as funding amount, could improve clients' chances of success.

Both staff and clients highlighted the benefits of having peer staff available across programs. Like Cohort I, clients appreciated the peer staff's ability to relate to them and their experiences. Clients felt a sense of belonging and were part of a "family" with others with similar life experiences. **Prop 47 should continue investing in their peer staff and utilizing funding to hire more staff with lived experience.** Through strengthening the peer workforce, Prop 47 programs can leverage the benefits of having peers on staff and create opportunities for former clients to use their experiences to support others in similar situations.

Client engagement was commonly cited by staff as a challenge to service delivery. Staff expressed challenges with client engagement at different points of service delivery, such as initial engagement with clients at first contact, during services, and at follow-up. The population served by Prop 47 has complex needs, such as SUD, SMI, or co-occurring disorders. These complex needs can make engagement difficult, and some clients may require a higher level of care than provided by service providers. Moreover, some clients were also challenging to contact, and the reasons for this varied (e.g., clients not owning a phone, changing phone numbers often, etc.). As a result, staff had difficulty initially connecting with these clients, helping schedule appointments, or following up with clients after services were delivered. **In the future, Prop 47 should focus on building up client engagement strategies across program areas and at different engagement points.**

Many of these challenges have persisted since Cohort I. Issues like client engagement, limited staff capacity, and the significant need for housing services have remained constant since Cohort I. The evaluation team has gathered relevant and useful feedback from clients and providers about how to improve the program, but explicit focus on developing and implementing solutions is needed for Cohort III. **Prop 47 funds should include opportunities for service providers and clients to actively participate in the design of future cohorts.**

Appendix A. Alameda County Local Advisory Committee (LAC) Members

- Melody Parker, Community Representative
- Ashley Davis, Community Representative
- Sholonda Jackson-Jasper, Community Representative
- Gordon Reed, Community Representative
- Anita Wills, Community Representative
- William Grajeda, Community Representative
- Danielle Guerry, Clinical Director
- Rodney Brooks, Executive Program Officer
- Mas Morimoto, Supervising Deputy District Attorney
- Kelly Glossup, Youth & Family Services Bureau Alameda County
- Dr. Katherine Tribble, Alameda County Behavioral Health Services Director
- Chief Marcus Dawal, Chief Probation Officer

Appendix B. Alameda County Proposition 47 Logic Model

Process			Outcomes & Impact	
Inputs *What do we contribute to accomplish our activities?*	**Activities** *What activities does our program area do to accomplish our goals?*	**Outputs** *Once we accomplish our activities, what is the evidence of service delivery?*	**Short- & Middle-Term Outcomes** *What changes do we expect to see within 0-2 years?*	**Long-Term Outcomes and Impacts** *What changes do we expect to see within 3-5 years?*
Funding • BSCC Prop 47 grant funding • Leveraged funds **Leadership, Oversight, and Staffing** • Health Care Services Agency • District Attorney • Probation Department • Local Advisory Committee (LAC) • Funded Providers o Bay Area Community Services o Center Point o Canales Unidos Reformando Adictos (CURA) o La Familia Counseling Services o Roots Community Health Center o Second Chance, Inc. **Training & EBPs** • BSCC guiding principles • Multidisciplinary Reentry Team (MRT) • Trauma-Informed Care • Restorative Justice • Evidence Based Risk/Needs Assessment Tools • Cognitive Behavioral Therapy • Motivational Interviewing	**Mental Health (MH) Services** • Administer and analyze intake assessments • Intensive case management • MH treatment • Peer Navigation • Referrals for other services **Substance Use Disorder (SUD) Services** • Screen and refer SUD clients • Recovery residences **Housing Support Services** • Housing supports **Diversion Program** • Law enforcement identification of eligible individuals and transport to the Navigation Center • Administer and analyze intake assessments • Deflect, defer, or divert individuals	**Mental Health (MH) Services** • # of RTT staff • # previously incarcerated staff • RTT client/staff ratio • # individuals enrolled in MH services • # who had 2+ treatment sessions within 30 days after enrollment • Service hours provided and number served **Substance Use Disorder (SUD) Services** • # individuals screened for SUD • # individuals enrolled in recovery residences **Housing Support Services** • # individuals provided funding or other services, by service type and/or funding amount **Diversion Program** • # staff trainings • # individuals receiving services at the Navigation Center • # individuals deflected, deferred, and diverted	**Mental Health** • Clients show decrease in functional impairment as measured by repeated adult needs and strengths assessment (ANSA) • Reduction in psychiatric hospitalizations & psychiatric emergency room admissions • Clients maintain engagement in mental health treatment & services or successfully complete treatment during the treatment period **Substance Use** • Clients connected to treatment • Clients maintain engagement in SUD treatment services throughout the entire treatment period • Clients successfully complete treatment • Clients do not experience relapse **Housing** • Clients are provided housing supports **Diversion** • Clients deflected, deferred, & diverted from the criminal justice system • Clients on probation complete probation without violations or new convictions **Criminal Justice** • Clients reduce rate of recidivism, per the BSCC's definition • Clients do not return to jail **System Level Outcomes** • Improved coordination between agencies & organizations	**Mental Health** • Formerly incarcerated individuals with moderate severe or serious & persistent mental illness are stabilized through community-based mental health treatment & services and do not reoffend **Substance Use** • Formerly incarcerated individuals with substance use disorders are stabilized through community-based treatment and services & do not reoffend **Housing Condition** • Formerly incarcerated individuals with emergency housing needs are stabilized through community-based treatment & services & do not reoffend **Diversion** • Justice-involved individuals with behavioral health needs who have contact with law enforcement and/or have engaged in misdemeanor criminal conduct are stabilized through community-based services to avoid incarceration **System Level Outcomes** • Community partnerships and collaboration for MH/SUD treatment & housing

Appendix C. Progress Toward Proposition 47 Objectives

Goals	Objectives	Progress
Formerly incarcerated individuals with SMI are stabilized through community-based MH treatment and services and do not reoffend.	65% of clients who enroll in RTT have 2+ treatment sessions within 60 days of admission.	82% of clients who enrolled in RTT has 2+ treatment sessions within 60 days of admission
	Upon program completion, 50% of RTT clients show a decrease in functional impairment as measured by repeated Adult Needs and Strengths Assessment.	28% of clients improved in life functioning domain, which includes physical/medical health, family relationships, social functioning, and residential stability.
	75% of RTT clients maintain engagement in MH treatment and services or successfully complete treatment during the 12-24 month treatment period.	82% of clients did not exit with a case plan or treatment goal partially or fully reached. On average, 80% of individuals who were enrolled in the program were enrolled for an average of 9.5 months (286 days). 44% had an unknown exit status, therefore it is unclear whether this objective was reached.
	75% of disabled clients without SSI are successfully connected with an SSI Advocate.	No data available
	80% of RTT clients do not recidivate during the treatment period.	84% of RTT clients did not recidivate during or after the treatment period through February 15, 2023.
Formerly incarcerated individuals with substance use disorders are stabilized through community-based	60% of Prop 47 clients referred to SUD programs enroll in ACBH SUD programs.	54% individuals who called the SUD hotline were connected to ACBH programs.
	80% of Prop 47 recovery residence clients enroll in SUD outpatient treatment and services.	72% enrolled in SUD outpatient treatment upon or after entering a recovery residence.

treatment and services and do not reoffend.	50% of recovery residence clients exit recovery residences with successful progress.	74% of clients reached or partially reached (determined to be satisfactory progress) their treatment goals.
	50% of recovery residence clients reduce admission to detox programs.	The evaluation was unable to conduct a pre-/post-analysis of admissions to detox programs (detox admissions prior to enrollment were not tracked).
	80% of SUD clients do not recidivate during the treatment period.	86% of clients did not recidivate following their first night in a recovery residence
Justice-involved individuals with any mental illness who have contact with law enforcement and/or have engaged in misdemeanor criminal conduct are stabilized through community-based services to avoid incarceration.	50% of individuals deflected from the criminal justice system do not recidivate.	93% of individuals deflected from the justice system did not recidivate.
	65% of individuals deferred from the criminal justice system are not charged.	65% of individuals deferred from the criminal justice system are not charged.[43]
	65% of individuals diverted from the criminal justice system are not convicted.	Additional data collection and monitoring procedures will be pursued in Cohort III.
	50% of individuals on the behavioral health/diversion probation caseload complete probation without a violation or new conviction.	Additional data collection and monitoring procedures will be pursued in Cohort III.

[43] This statistic is based on written confirmation from the District Attorney's office. Additional data collection and monitoring procedures will be pursued in Cohort III.

Appendix D. Process Evaluation Measures

Activity	Quantitative Data	Qualitative Data
Mental Health MRTs	• Staff & Clients ○ # of RTT staff ○ Staff demographic characteristics ○ # previously incarcerated staff ○ MRT client/staff ratio ○ # individuals enrolled in MH services ○ Client demographic characteristics ○ Client education, housing, and employment status & needs ○ Client MH diagnoses • Services ○ # with 2+ treatment sessions within 30 days after enrollment ○ Service hours, service type, and date of service per client	• Interviews with Prop 47 management ○ Collaboration and coordination ○ Use of EBPs and best practices including trauma informed care, cultural competence, and restorative justice ○ Community engagement • Interviews with supervisors/managers ○ Collaboration and coordination ○ Training needs ○ Experiences with staff, including hiring, training, and retention ○ Experiences with clients ○ Perceived impact on clients ○ Barriers and facilitators encountered ○ Use of EBPs and best practices ○ Community engagement • Focus groups with line staff ○ Experiences with leadership ○ Collaboration and communication ○ Experience with clients ○ Perceived impacts on clients ○ Perception of training ○ Barriers and facilitators encountered • Focus groups with clients ○ Experiences with staff ○ Awareness of services ○ Perception of services ○ Barriers and facilitators encountered
SUD Screening/Referral and Recovery Residences	• Staff and Clients ○ Client demographic characteristics ○ Client education, housing, and employment status & needs ○ Client SUD diagnoses • Services ○ # clients screened for SUD & date of screening ○ # individuals enrolled in SUD programs & date of enrollment ▪ # individuals enrolled in recovery residences ▪ # individuals enrolled in outpatient treatment	

Housing Support Services	• Staff and clients
	  ○ Client demographic characteristics
	  ○ Client MH and SUD needs
	• Services
	  ○ # clients provided funding or other services, by service type, provider, and funding amount	

Diversion	• Staff and clients
	  ○ Client demographic characteristics
	  ○ Client MH and SUD needs
	  ○ Client education, housing, and employment status & needs
	• Services
	  ○ # clients referred to diversion program and assessed by diversion team
	  ○ # clients receiving services at the Navigation Center
	  ○ # deflected, deferred, and diverted
	  ○ # clients on Behavioral Health Probation Officer caseload	