Community Assessment, Response & Engagement

CARE Program Report

Stanislaus County

City of Modesto California

Contents

Introduction

Homelessness is an issue that is immensely disconcerting in Stanislaus County. This challenge is not unique to our community and represents a crisis throughout the State of California and beyond.

In Stanislaus County alone, data over last several years reveal that on average 1,400 individuals are experiencing homelessness[1] with many more at risk of homelessness while struggling with the lack of safe and affordable housing. For the last few years, efforts such as Focus on Prevention have begun to make progress in strengthening the community's system of care. However, even with these efforts, this population continues to cause significant distress for themselves and in the community. Some of these individuals may have severe and persistent mental illness, exhibit high-risk health and safety behaviors, engage in vagrancy-related criminal behavior, and experience severe substance use disorders; and for a variety of reasons, they are not accessing or accepting services.

Community members often see individuals wandering through the streets and throughout Downtown Modesto and along McHenry Avenue in what seems in obvious distress, and ask: "Is anything being done to help these people?" There appears to be a new norm in what is acceptable when it comes to individuals living in distress in the community. **The most compelling statistic that has emerged from the CARE planning efforts is that during the course of planning meetings since December, seven individuals identified within the priority population have passed away.** This report outlines how Stanislaus County and the City of Modesto are joining together to take immediate and direct action to no longer accept this as the norm in our community. Although this initial work is focused on the CARE population in the City of Modesto, the County intends to expand this effort throughout the community as the program model is established and becomes operational.

Leadership and Planning Process

To lead this effort, on December 11, 2017 the City of Modesto and the Stanislaus County Chief Executive Office convened over 50 public and private sector leaders (see Attachment A) who had the authority over resources or policies that had a direct responsibility to serve this population. The invitation to this leadership group was contingent on individuals' willingness to commit and be accountable to addressing this issue collaboratively. In addition to shared commitment and accountability, members of the leadership group were asked to commit themselves or a representative to participate in a 90-day planning process. The first CARE workgroup (see Attachment B) meeting was held December 21, 2017, and the meeting series was completed on March 21, 2018.

During the 90-day planning process, the CARE workgroup was guided by these simple questions for this population:

- What results need to be achieved?
- What works, what could be improved?
- What are the proposed solutions?
- What partners have a potential role in the proposed solutions?

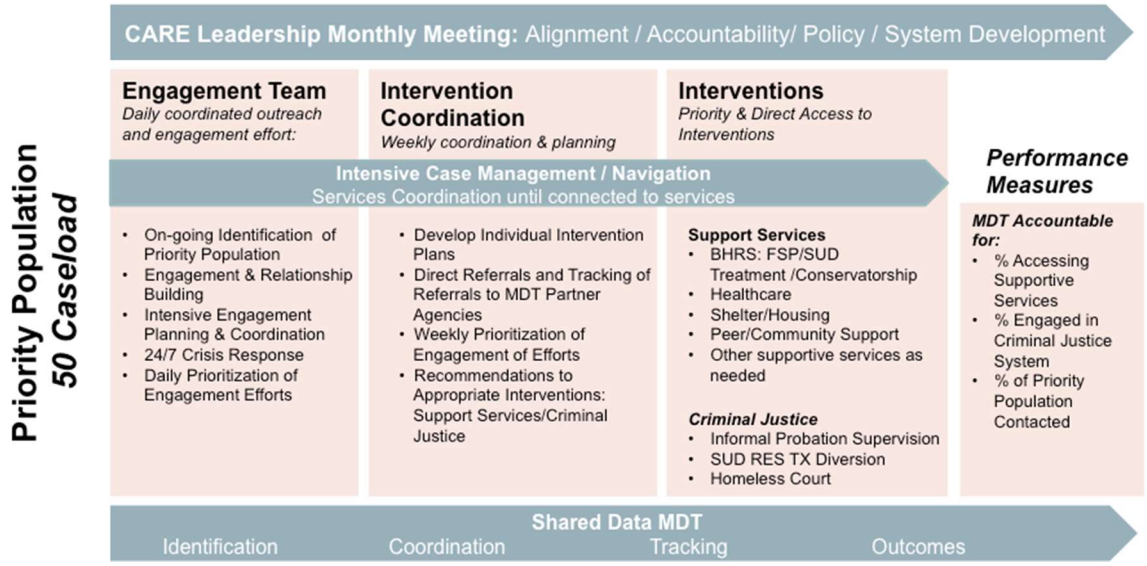
In addition to answering these questions, the planning process also involved the CARE workgroup being tasked with identifying and completing two of the three phases by the 90-day benchmark. Phase I: Identification and Scope was completed through consensus of priority, establishment of a work team and project framework, and gathering of data. As a result of completion of Phase I, the CARE workgroup identified the Multidisciplinary Team (MDT) Model as the strategy to respond to this priority population. Phase II: Assessment and Strategic Directions was also completed through data analysis and asset mapping, developing strategic initiatives and engagement strategies by category, and conducting a cost analysis. The next phase to be implemented, Phase III: Implementation and Engagement, will be to review the strategic plan, achieve shared commitment, and obtain approval for implementation.

This report outlines the work that was completed in Phase I and II, specifically, the MDT Model, its legal structure, data development and analysis, pilot program and data, outcomes and evaluation plan, and fiscal analysis.

Program Design

Multidisciplinary Team Model

The Multidisciplinary Team (MDT) Model is a team of mental health, criminal justice, and other service providers who facilitate, provide, and share responsibilities in, assessment coordination and treatment services to most appropriately meet the complex mental, physical, and social needs of the targeted population. The MDT will develop coordinated individualized intervention plans for this population with a focus on connecting individuals with appropriate services and community supports through an intensive engagement and case management "warm hand-off" approach whereby the team ensures that the individual who is referred to services is actually engaged by the service provider. The overarching goal is to see an increase in the priority population to transition from saying "no" to help to saying "yes" to help.



Engagement Team
Daily coordinated outreach and engagement effort:

The Engagement Team will conduct and coordinate daily outreach and engagement in Downtown Modesto, the McHenry Avenue corridor, and surrounding parks with the aim of building trusting relationships, implementing coordinated individualized intervention plans, and connecting individuals directly to services. The team will attempt to connect

with those most in need and will be available to respond to crisis situations to ensure that the target population will not "fall through the cracks." The Engagement Team consists of representatives from key social services and law enforcement agencies that can provide specialized services in the field; and direct responsive access to their respective agencies' services as well. The City of Modesto will reassign their Homeless Engagement and Response Team (HEART) to join the CARE Team. This team already has been providing intensive outreach and engagement over the last year. Led by a Supervising Deputy Probation Officer, the CARE workgroup determined that the most effective team structure for the Engagement Team would include:

- Case Manager/Service Coordinators
- Firefighter – Paramedic (HEART Team)
- Mental Health Clinician
- Police Officer (HEART Team)
- Police Sergeant (HEART Team)
- Probation Officer
- Public Health Nurse
- Social Worker

The CARE workgroup collectively agreed that a role that was missing from current efforts to serve the CARE population was a case manager who could monitor and assist individuals to navigate the various systems to help them avoid from "falling through the cracks." The MDT Case Managers will provide support to the team, help broker access to service and community supports, and ensure that each client is tracked throughout the entire engagement process. They will implement an intensive case management approach with a low staff-to-client ratio—1 case manager for approximately every 15 clients. The low staff-to-client ratio is informed by best practices and will allow frequent daily and weekly engagement with clients. In short, the Case Manager will continuously engage and monitor individuals who might otherwise be ineligible for traditional case management services because of their initial refusal for services.

The Engagement Team's objectives will be to provide:

- On-going Identification of Priority Population
- Engagement and Relationship Building
- Intensive Engagement Planning and Coordination
- Crisis Response
- Daily Prioritization of Engagement Efforts

Intervention Coordination
Weekly coordination & planning

As with the Engagement Team, the Intervention Team is multidisciplinary and consists of representatives from key agencies—Behavioral Health and Recovery Services, City Attorney's Office, Community Services Agency, District Attorney's Office, Sherriff's Department, Modesto Police Department, Probation Department, Public Defender, and emergency shelter and healthcare representatives—that provide direct and indirect services to the CARE population. The Intervention Team will meet weekly to develop coordinated individualized intervention plans for each of the individuals identified through the CARE Engagement Team's outreach efforts. These intervention plans will be based on the specific needs of the individual and include strategies to connect them with services and supports. This multidisciplinary planning process will allow all stakeholders to clearly understand the plan for each client, their agency's role in that plan, and develop shared agreement on how their respective agencies will respond and/or provide access once a CARE referral is initiated.

The Intervention Team will meet weekly to strategically:

- Develop coordinated individualized intervention plans
- Direct and track referrals to partner agencies
- Identify gaps and deficiencies during the referral process
- Prioritize engagement efforts
- Recommend appropriate referrals to support services or criminal justice interventions

Interventions
Priority & Direct Access to Interventions

Direct Access to Support Services

The MDT Intervention Team will engage clients and connect them with existing services. The aim is for services to be readily available within hours or days of acceptance for when an individual says, "yes." By having representatives from each of the major service organizations on the MDT team, the staff from their respective agencies will be able to coordinate direct access to these programs.

The CARE workgroup identified existing programs and services that serve the CARE population. These services are already serving the broader population in the community

and are limited in the number of individuals they can serve, but the CARE MDT and CARE Leadership Collaborative (explained in the next section) will work with service providers to create priority access for CARE referrals and address system capacity issues. These services are:

- Mental Health Treatment: Full Service Partnership (FSP)[2]
- Residential Treatment and Detox for Substance Use Disorders (SUD)[3]
- Housing and Emergency Shelter[4]
- Supportive Services[5]

Criminal Justice Interventions

Currently, low-level offenders who are on informal probation are not supervised by an assigned Probation Officer and are only contacted as needed. The CARE population has a high number of individuals on this lower level of probation in addition to a smaller group on the higher level of formal probation. By assigning a Probation Officer to the CARE Engagement Team, both formal and informal probationers will be supervised in person and receive the services of a designated Probation Officer whose caseload will consist of those who are part of the CARE population. The Probation Officer will build a rapport with those offenders they supervise, make street-level contact with this population, enforce the terms and conditions of court orders, assist with transport to and entry into residential treatment, and refer to appropriate programming, as well as communicate with the Sheriff's Department and District Attorney's Office, and other justice partners regarding non-compliant individuals. The Probation Officer will also assist the CARE MDT by having instant access to probation, treatment, GPS, and personal history records.

In addition, a Deputy District Attorney (DDA) and Deputy Public Defender will be Intervention Team members, attending the weekly meetings to work intentionally and collaboratively with the Intervention Team to ensure that the CARE individuals' pending criminal cases will be taken into consideration when developing coordinated individualized treatment plans. Each individual's history and current legal status will be reviewed with the aim of offering rehabilitative options. The assigned DDA will be responsible to vertically prosecute[6] the CARE caseload. This vertical prosecution model will allow for an informed argument based on consistent case disposition and coordination of the MDT goals in the handling of CARE criminal cases. The assigned DDA will be responsible for case review, filing decisions, and all court appearances. The assigned DDA will maintain records, documentation, and report back to the MDT regarding any case, including any identified CARE individuals as a suspect, victim, or witness.

The priority is to connect individuals with services to help them recover. However, the criminal justice interventions will include strategies to hold individuals accountable for their criminal behavior and not allow repeated misdemeanor-level criminal activity to go without an intentional set of interventions. Each intervention plan will be documented concretely and reviewed for lessons learned in the areas of barriers and success. If the CARE Intervention Team encounters legal barriers beyond their control, such barriers will be documented and presented to the City of Modesto and County Board of Supervisors for their input and to consider further action.

CARE Leadership Monthly Meeting: Alignment / Accountability/ Policy / System Development

Leadership Collaborative

The ongoing support of leadership will be key to the success of the MDT. The Leadership Group is comprised of senior-level leaders who have some level of authority—delegated or direct—over resources or/and policy related to serving this population. The main role of the MDT Leadership meeting is to ensure accountability among the multiple partners and to address any system-level barriers. Facilitated by senior leaders from Stanislaus County and the City of Modesto, the MDT Leadership meeting will convene at least bi-monthly to focus on:

- Alignment – ensuring efforts are coordinated and strategic
- Accountability – reviewing MDT performance measures and support on-going learning efforts
- Policy – addressing any policy issues that impede or can improve the work of the MDT
- System Development – develop and act on plans to further develop and build capacity of the local service system

Program Performance Measures

In addition to ensuring alignment of efforts, the MDT Leadership Group will monitor these initial performance measures. These performance measures will be reviewed at least bi-monthly in the MDT Leadership meeting.

Program Success Measures

These measures assess the quantity/quality of change for the better for individuals served through CARE MDT.

1. Improvements in health (behavioral and physical)

2. Reduction in homelessness
3. Reduction in incarcerations
4. Reductions in hospitalization
5. Decrease the occurrences of public anti-social behavior

How Much and How Well Program Performance Measures

These measures assess how much service is provided and how well those services are provided.

1. Individuals engaged in services and interventions 1-3-6-12 months after initial referral
2. Engagement contacts per individual
3. Say “yes” / “no” to services
4. Access supportive services such as housing/behavioral health/healthcare services
5. Engaged in the criminal justice system
    a. Agree to services in-custody
    b. Access services post-custody

Establishing the MDT

On January 1, 2018, California Welfare & Institutions Code section 18999.8 became effective. That section authorizes the establishment within counties of Multidisciplinary Personnel Teams (“MDT”s) in order to address homelessness within the county’s jurisdiction. Under the new law, the goals of a multidisciplinary team are:

- Facilitate the identification, assessment, and linkage of homeless individuals and families to housing and supportive services.
- Provide the above activities in an expedited manner.
- Utilize multiple departments, agencies, governmental entities (i.e., cities and special districts), community-based organizations (CBO), non-profit corporations, and others to perform the above activities and supply members to the MDT.
- Coordinate housing and supportive services to ensure continuity of care.
- Share relevant, confidential information among the provider agencies and MDT members for the above purposes.

The CARE MDT is subject to the provisions of Welfare and Institutions Code section 18999.8. Members of CARE engaged in the identification, assessment, and linkage of housing and supportive services to homeless adults or families may disclose to, and exchange with, one another information and writings that relate to any information that

may be designated as confidential under state law only so far as the member of the team having the information believes it is generally relevant to the identification, reduction, or elimination of homelessness or the provision of services designed to identify, reduce, or eliminate homelessness. Board of Supervisors' approval will establish the CARE MDT as the qualified Homeless Adult and Family Multidisciplinary Personnel Team (MDT) for Stanislaus County.

System-Level Accountability

Once a participating MDT agency receives a referral, that agency will be responsible for reporting on the success of their interventions; and the impact of the broader measures on the reduction in homelessness, incarceration, and improvement in health. The graphic below outlines which partners are accountable for reporting on the success or failure of their intervention.

It is no longer acceptable for individuals to cycle through the various systems without any accountability. CARE is unique in that there is no referral out of the program unless the individual has succeeded in one of the interventions. When a CARE referral succeeds in a program, that program will report to the MDT leadership team on the success. When a referral is unsuccessful, the program will report on this as well and begin a next phase of engagement and intervention strategies.

Data Development

Identifying the Population

Because this project's priority population resides mainly in Downtown Modesto and the surrounding areas, to better understand the CARE population, data were collected from the City of Modesto Police Department (MPD) specifically on vagrancy-related incidents, 5150 (involuntary psychiatric holds) calls for service, and Modesto Police Officers were polled to identify individuals who they routinely observed in the Downtown and McHenry Avenue corridor that appear to exhibit signs of serious mental illness and substance use disorders. This resulted in an initial list of 143 individuals who could benefit from the CARE program. The CARE workgroup agencies then cross-checked the list and identified patterns observed in their respective system.

The CARE data analysis team then analyzed the information shared by the partnering agencies to create a preliminary CARE profile, which highlights the complex and severe needs of this population. Such severity of needs is exemplified by the fact that **seven individuals have passed away since this CARE planning process began on December 11**. Thus, the urgency of accurately identifying—and assisting—this population is vital.

Statistical Population Overview of the CARE Population (n=143)

- Demographics
  - 100 are males and 43 females.
  - 106 (74%) of them are between the ages of 30 and 59.
- Criminal Justice System
  - 122 (85%) individuals have had court cases in the system.
  - 100 (70%) had a felony conviction in their past.
  - 69 (53%) individuals are on probation—11 (9%) are on formal probation.
  - 58 (45%) are on informal probation, and only 1 individual is on AB109 probation.
- Health and Treatment
  - 98 (73%) currently receive/participate, or have received/participated, in mental health treatment in either non-emergency[7] or emergency[8] services whereas 36 (27%) of them have not received/participated in any services.[9]
  - 66 (46%) individuals being a victim of a crime.
  - 4 (3%) have a developmental disability.

- Social and Emergency Services
    - 82 (57%) individuals are active recipients of one or more categories of public assistance (i.e., CalWORKS, CalFresh, Medi-Cal).
    - 86 (60%) individuals had contact with an emergency medical ambulance service.

Preliminary Pilot Data (n=28)

- Population is willing to engage, as indicated by the high percentage 21 (75%) who signed the release of information (ROI) document.
- Upon first contact, 7 (25%) immediately said “yes” to services.
- Medical and mental health insurance not an obstacle for many, as indicated by 23 (82%) having insurance.
- 17 (61%) indicated that they became homeless in Modesto.

Migration Analysis

One persistent question from the community and government alike has been: do these individuals come from another county and for what reason? The data that were used to further explore this question included the preliminary pilot data, comparing Medi-Cal records in other counties, and evaluating the point-in-time (PIT) data.

- **Preliminary Pilot Data**: 17 (61%) indicated that they became homeless in Modesto.
- **Medi-Cal Records**: Of the 143 individuals, only 3 (2%) currently have, and 3 (2%) have had, an open Medi-Cal record in another county.
- **Point-In-Time Count**: 176 of 1,356 (13%) reported that they became homeless outside of Stanislaus County.

These data are merely a preliminary snapshot of the initial data collection process and are not yet reflective of the full scope of community of origin in Stanislaus County. Given that this a persistent question within the community, questions related to community of origin will continue to be included in the CARE data collection process. As these data become available, the CARE MDT will work to develop recommendations on any further actions.

The data also confirmed the need for the CARE project, which builds on and solidifies what was already a focus and effort to respond to the concerns about the CARE population. Ultimately, it was the community’s concerns for both the CARE individuals and for the community that prompted the development of CARE, not solely what the data revealed.

What Works: Evidenced-Based, Best-Practice Research

After consulting with a number of universities and research centers,[10] it was anticipated that a major factor in servicing the CARE population would be engagement. Involuntary clients, like the CARE population, are much more likely to become engaged when they feel they have choices, have motivational congruence (mutual buy-in), and use of behavioral contracts.[11] The research evidence on outreach and engagement clearly indicates that outreach—using consumers/clients as outreach workers—is important to engaging this population in services and linking them to permanent housing, particularly for veterans who are homeless.[12] In addition, training and orienting new outreach workers to understand the central importance of relationship building is critical[13] and: "rather than expecting people to access services on their own, outreach workers across the country take services to where people are."[14]

As part of the best practice exploration, the CARE workgroup also asked local community, social services, and law enforcement leaders and experts if they had any knowledge of any state or other county effort having success with this population. It was determined that they did not have knowledge of any program or community having success with this specific population.

Although programs like CARE, in its exact form and design, have not been implemented in other jurisdictions, a number of selected efforts in other localities that were similar in scope and who were contacted were: City of Phoenix Community Action, Response, and Engagement Services (CARES); City of San Diego Misdemeanants At-Risk Track (SMART) Program; City of Long Beach Innovation Team; and the City of Sacramento Pathways to Health + Home. These selected initiatives share common components: outreach teams, basic service provision, service referrals, housing placement, and code enforcement. The following opportunity areas, though, were identified: (1) city-county government collaboration and (2) frequent accountability meetings with city-county leadership.

The CARE workgroup also has incorporated elements from the Assertive Community Treatment (ACT) model and Restorative Policing into the MDT model. ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses.[15] Another model is Restorative Policing**,** which is a law enforcement-driven collaborative that provides the required links to engage and treat the community's most difficult clients.[16]

Outcomes and Evaluation Plan

In preparation for the final phase of implementation of CARE, the project team consulted with a number of evaluation research firms,[17] which have helped to clarify, inform, and confirm the identification of critical elements of a CARE evaluation plan.

CARE will establish clear guidelines for collecting and capturing client contact information. It will be imperative to determine who will be responsible for entering and managing data. Limited data sharing will occur, and the MDT will only collect relevant pieces of information on the indicators identified, as legally permitted. As for data analysis, a real-time analysis will be conducted with flexibility for incorporating additional data, existing programs and services will be documented, gaps in program and service delivery will be identified, and client profiles will be constructed and reviewed on a set review schedule. The evaluation plan will ensure that performance measures are clearly identified and that fidelity—ensuring that the measures are actually measuring what they are intended to measure—is followed, focusing on real-time benchmarks with flexibility for change.

Pilot

A pilot test of the CARE MDT began on May 7 and ended on May 18 with the aim of implementing and assessing the initial action plan. During this pilot phase, the outreach and engagement team with representatives from Behavioral Health and Recovery Services, Community Services Agency, Fire Department, Health Services Agency, Modesto Police Department, and Probation Department engaged the priority population daily in the Downtown and McHenry Avenue corridor area. Prior to engagement, they requested the release of information (ROI) form be completed by the individuals they encountered. The team then determined what services the individuals needed, referred them to the appropriate agency, and/or collected relevant information for follow-up purposes. This team also completed the following:

1. Tested the feasibility of the immediate realignment of resources
2. Developed the initial caseload and its components
3. “Tested” for the effectiveness of:
    a. the management and team structure
    b. hours of operation
    c. priority interventions

The CARE workgroup convened a learning session to assess the data collection procedures, program operation, program feasibility, and gaps in integrated service system response. During this pilot phase, of the initial list of 143 individuals, the

Engagement Team made one or more contacts with 28 of them. The following learning highlights are a result of their preliminary assessment:

Learning Highlights

1. Given this population's complex mental health and substance abuse needs, it was recommended that an additional mental health clinician be added to the team, as to assist with to providing more timely mental health assessments and direct services.
2. Because of the multiple agencies and services involved in assisting this population, the team reinforced the need for a case manager to monitor, assess, and assist the population with these services.
3. To provide services expeditiously, transportation is needed so that when an individual agrees to services he/she, with belongings and/or pets, can be transported to the appropriate agency.
4. Since there are other outreach and engagement teams—namely, at the Outreach and Engagement Center—it is important to coordinate engagement efforts with them so that there is not duplication of efforts.
5. Having access to this population's information "in the field" via some type of mobile device would improve service delivery.
6. In the event that legal issues are discovered, partnering with the courts could help those issues to be addressed swiftly.
7. A major impediment to accessing services is someone not having his/her identification card so partnering with the Department of Motor Vehicles to expedite the process of obtaining one would be helpful.

Broader System Issues for Further Exploration

The CARE MDT is a model designed to navigate the planning and coordination of services in a complex and often compartmentalized system of care. These complexities are often due to federal and state laws, local policies, and as learned through the planning process, the interpretation of laws and policies. The current service systems are primarily designed for the broader population that have the capability and resources to access services when needed. The CARE population, however, is not seeking help, but yet accessing services through—and overwhelming—the emergency system at a higher cost and resulting in less effective treatment for their acute and chronic needs. The system is not designed for the CARE population; thus, these individuals continue to "fall through the cracks." The CARE MDT service model does not fix these issues, but rather, with the Leadership Collaborative's oversight, will respond and adapt the service system to meet the unique needs of this population in ways that are efficient and effective, and that ultimately saves lives. The broader system issues for further exploration are:

5150 Designated Sites and Medical Clearance

The 5150 designated sites in Stanislaus County and the process for obtaining medical clearance for CARE clients to access services was discussed. The current structure creates multiple challenges for the CARE population that if addressed, could lead to increased efficiencies and effective interventions.

Confidentiality Laws and Impact on Coordinating Services

Federal and State regulations restrict sharing of medical and/or clinical data for privacy protection purposes. The City of Modesto and Stanislaus County are jointly working with U.S. Department of Health and Human Services (HHS) to pursue a federal waiver or further guidance on sharing the minimum critical client information amongst the CARE Team to facilitate the expedited identification, assessment, and linkage of homeless and mentally ill individuals to housing and supportive services within Stanislaus County.

Licensed Adult Residential Facilities (ARF)

The issue raised is that County Mental Health agencies within Northern California are placing clients in local ARFs without clear plans and agreements for these individuals to return to their home county once treatment outcomes have been achieved. The concern is that some of these clients walk away from these facilities without any intervention or tracking from the referring county. The City and County will initiate meetings with local operators to explore and discuss out-of-county conservatorship placements and practices within their facilities and opportunities for process improvements.

Conservatorship

A mental health conservatorship (LPS) designates one adult (called the conservator) to be responsible for a mentally ill adult (called the conservatee). These conservatorships are only for adults with mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Across the state, counties (including Stanislaus) are reviewing this law to assess if there could be changes to ensure those most in need benefit from this level of care and treatment for their mental illness.

Fiscal Analysis

The CARE service model is designed to leverage and expand existing City and County resources, and at full operation will designate approximately $2 million per year to support 12 staff, two case managers, and an operating budget for supplies, training and/or emergency client support expenses. Multiple Stanislaus County departments are represented on the CARE Team, and the CARE model has been incorporated into the Recommended Proposed Budget 2018-2019/2019-2020. Funds have been established in the County budget if needed, although it is anticipated that most County departments will rely on existing funds and resources for their respective contributions to the CARE team. Additionally, the County and City of Modesto are inquiring with health sector leaders for a potential partnership for the health provider staff and outcomes development.

The following resources are included in the CARE plan:

- Three staff including one fire Fighter-Paramedic, one Police Officer, and one Police Sergeant provided by the City of Modesto at an estimated total cost of $616,000.
- One Health Nurse/Registered Nurse provided by external partners at an estimated total cost of $241,000.
- One Deputy District Attorney allocated to the Stanislaus County District Attorney's Office at an estimated total cost of $157,000.
- One Supervising Deputy Probation Officer and one Probation Officer provided by the Stanislaus County Probation Department at an estimated total cost of $274,000.
- Staffing and funding for one data analyst will be determined.
- One Social Worker Case Manager provided by the Stanislaus County Community Services Agency at an estimated total cost of $104,000.
- A Mental Health Team comprised of two case managers and one Mental Health Clinician provided by the Stanislaus County Behavioral Health and Recovery Services department at an estimated total cost of $273,000.
- One Public Defender provided by the Stanislaus County Public Defender's Office at an estimated total cost of $66,000.
- A placeholder of approximately $121,000, should resources be unavailable from any of the partner agencies to provide needed training, operating supplies, and/or emergency client support services that could include meals, clothing, and temporary shelter.

Legislative Action

To further support the County's CARE initiative, the Board of Supervisors has distributed a letter in support of Senate Bill 1045 (Wiener). This bill aims to connect underserved populations in San Francisco and Los Angeles Counties with services that can save their lives through a new, narrow type of conservatorship which is designed to address the homelessness epidemic in California by assigning a conservator to persons who are incapable of caring for their own health and well-being.

SB 1045 aligns with our efforts to reduce and prevent homelessness caused by substance abuse, alcoholism, and/or mental illness; and supports our legislative principle focused on *supporting appropriate state efforts that address topics such as homelessness (and) strengthening families.* Our objective is to save lives and protect our community. We hope to see this legislation amended to include Stanislaus County and believe the passing of Senate Bill 1045 would greatly assist our efforts.

Conclusion

The CARE project was initiated to address the population who are not accessing services and causing distress for themselves and the community. The CARE workgroup agreed that the short-term results of CARE would be to connect these individuals, in an integrated way, to services and community supports and, if appropriate, facilitate the process for a criminal justice system intervention.

The challenges have been, and continue to be, that current County and City systems—specifically, mental health and criminal justice—have strategies in place already to provide engagement and services/supports for the non-CARE population, but these systems are designed to serve individuals who agree to and accept services, not who refuse treatment. The CARE population often refuses treatment, overutilizes each system, and frequently commits infractions/instances of public disorder. The concern here is that there is no *coordinated* way of knowing the extent, problem, or effectiveness of each system as it relates to the individuals' needs. Ultimately, CARE will be strategic and coordinated in getting these individuals reintegrated into the appropriate system; and following and assisting them with navigating through multiple systems with the hope of positively affecting their homelessness, criminal behavior, and health.

Attachment A: CARE Leadership

Last Name	First Name	Title	Organization
Ah You	Kristi	City Council - District 3	Modesto City Council
Anderson	Tony	Executive Director	Valley Mountain Regional Center
Armendariz	Rick	Assistant Police Chief	Modesto Police Department
Basnight	Mark	Nursing Administrator	Doctor's Medical Center
Bearden	Belinda	Director, Patient Care Services	Doctor's Medical Center - Emergency/Trauma Departments
Brandvold	Ted	Mayor	City of Modesto
Buckles	Debra	Public Guardian	Stanislaus County Behavioral Health and Recovery Services
Christianson	Adam	Sheriff	Stanislaus County Sheriff's Department
Davis	Lonny	Representative	Davis Guest Homes
DeGette	Rick	Director	Stanislaus County Behavioral Health and Recovery Services
DiCiano	Francine	Chief Executive Officer/President	United Way of Stanislaus County
Douglass	Scotty	Executive Director	Stanislaus County Regional 911
Esparza	Pam	Chief, Consumer and Family Affairs	Stanislaus County Behavioral Health and Recovery Services
Ernst	Alan	Chief	Modesto Fire Department
Fladager	Birgit	District Attorney	Stanislaus County District Attorney's Office
Grewal	Daljit	Registered Nurse	Doctor's Medical Center - Behavioral Health Center
Hamasaki	Mike	Chief Probation Officer	Stanislaus County Probation Department
Hartley	Marc	Deputy County Counsel	Stanislaus County Counsel
Harwell	Kathy	Director	Stanislaus County Community Services Agency
Hawn	Brad	Stewardship Council Chair	Neighborhood's Inc.
Hayes	Jody	Chief Executive Officer	Stanislaus County Chief Executive Office
Hill-Thomas	Patricia	Chief Operating Officer	Stanislaus County Chief Executive Office
Huber	Christine	Assistant Director	Stanislaus County Community Services Agency - Adult, Child, & Family Services
Kirk	Warren	Chief Executive Officer	Doctor’s Medical Center
Lamberen	Jeff	Public Authority	Stanislaus County Community Services Agency
Lee	Mary Ann	Managing Director	Stanislaus County Health Services Agency
Lopez	Joe	Interim City Manager	City of Modesto
Meredith	Becky	Deputy Executive Officer	Stanislaus County Chief Executive Office
Mukherjee	Uday	Medical Director	Stanislaus County Behavioral Health and Recovery Services
Murdock	Richard	Chief	Modesto Fire Department
Olsen	Kristin	County Council - District 1	Stanislaus County Board of Supervisors
Palomino	Margie	Director	Stanislaus County Department of Aging and Veterans Services
Panyanouvong	Kevin	Manager IV	Stanislaus County Behavioral Health and Recovery Services
Pierce	Janice	Director, Case Management/UR/Social Services	Doctor's Medical Center - Case Management/SS
Ramirez	Juan	Manager III	Stanislaus County Community Services Agency
Rees	Annette	Deputy District Attorney	Stanislaus County District Attorney’s Office
Rocha	Tina	Deputy Executive Officer	Stanislaus County Chief Executive Office
Sandu	Sonny	Public Defender	Stanislaus County Public Defender's Office
Skiles	Dale	Fire Warden	Stanislaus County Office of Emergency Services
Stanford	Edward	Chief Medical Officer	Doctor's Medical Center
Swift	Hugh	Court Executive Officer	Superior Courts Chief Executive Office
Thrasher	Debra	Compliance/Project Manager	Stanislaus County Health Services Agency
Trompetter	Phil	Special Reserve	Modesto Police and Forensic Psychology
Vaishampayan	Julie	Public Health Officer	Stanislaus County Health Services Agency
Walker	John	Public Health Officer	Stanislaus County Health Services Agency
Warr	Jewel	Senior Management Consultant	Stanislaus County Chief Executive Office
Withrow	Terry	Board Supervisor - District 3	Stanislaus County Board of Supervisors
Zoslocki	Bill	City Council - District 4	Modesto City Council

Attachment B: CARE Workgroup

Last Name	First Name	Title	Organization
Anderson	Tony	Executive Director	Valley Mountain Regional Center
Armendariz	Rick	Assistant Police Chief	Modesto Police Department
Bettis	Alisa	Health Care Quality Services Manager	Stanislaus County Health Services Agency
Breazeale	Dwaine	Captain/County Coordinator and Corps Officer	Salvation Army
Casiano	Erlinda	Manager IV	Stanislaus County Community Services Agency
Christianson	Adam	Sheriff	Stanislaus County Sheriff's Department
Clifton	Lisa	Management Consultant	Stanislaus County Chief Executive Office
DeAlba	Rigo	Police Lieutenant	Modesto Police Department
Delgado	Martha	Lieutenant	Modesto Police Department
Dockery	Cherie	Associate Director	Stanislaus County Behavioral Health and Recovery Services
Doering	John	County Counsel	Stanislaus County Counsel
Doyle	Lance	Quality Improvement/Trauma Coordinator	Mountain-Valley EMS Agency
Erickson	Jill	Director	Stanislaus County Department of Aging and Veterans Services
Findlen	Brian	Captain	Modesto Police Department
Goulart	John	Senior Deputy City Attorney	City Attorney's Office
Graves	Heather	Public Information Officer	Modesto Police Department
Hammond	Mike	Sergeant	Modesto Police Department
Hartley	Marc	Deputy County Counsel	Stanislaus County Counsel
Herrera	Emily	Adult Division Director	Stanislaus County Probation Department
Imperial	Ruben	Deputy Executive Officer	Stanislaus County Chief Executive Office
Johnson	Barbara	Clinical Psychologist	Valley Mountain Regional Center
Kegley	Ryan	Veterans Services Representative	Stanislaus County Department of Aging and Veterans Services
Lillie	Michael	Fire Division Chief	Modesto Fire Department
Martinez	Frank	Lieutenant, Bureau of Inmate Services	Stanislaus County Sheriff's Department
Martinez	Damian	Senior Management Consultant	Stanislaus County Chief Executive Office
Meredith	Becky	Deputy Executive Officer	Stanislaus County Chief Executive Office
Muniz	Veronica	Homeless Court Coverage Supervisor	Turning Point Community Programs
Murdaugh	Cindy	Deputy Director	Mountain-Valley EMS Agency
Pannu	Sweena	Deputy Public Defender	Stanislaus County Office of the Public Defender
Ramirez	Juan	Manager III	Stanislaus County Community Services Agency
Reed	Nicholas	Crime Analyst	Modesto Police Department
Rees	Annette	Deputy District Attorney	Stanislaus County District Attorney's Office
Rocha	Tina	Deputy Executive Officer	Stanislaus County Chief Executive Office
Stanfield	Steve	Lieutenant	Modesto Police Department
Swift	Hugh	Court Executive Officer	Superior Courts Chief Executive Office
Valencia	Ivan	Lieutenant	Modesto Police Department
Vickery	Amy	Public Information Officer	Stanislaus County Chief Executive Office

[1] 2018 Stanislaus County Point-In-Time (PIT) Count Survey Results. The PIT count is a count of sheltered and unsheltered individuals who are homeless on a single day in January conducted by outreach workers.
[2] The Behavioral Health and Recovery Services (BHRS) FSP program provides culturally competent mental health services to adults ages 18 and above with serious mental illness and a history of homelessness. The program offers a low staff-to-client ratio and provides its services in the community. Clients receive group and individual support, using a "whatever-it-takes" approach and individualized recovery planning. FSP provides client support to successfully achieve personal recovery goals, as well as creating an individualized housing plan. The recovery model incorporates such approaches as motivational interviewing, cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), harm reduction, and other consumer-centered therapeutic interventions.
[3] Currently, BHRS has a residential treatment program for individuals with co-occurring SUD and mental illness, and a 12-bed social model detox program. For individuals that do not qualify for these programs, BHRS provides Intensive Outpatient treatment coupled with clean and sober living program services.
[4] Housing is a key engagement strategy in accessing services. Once people have stable housing or shelter, they are more willing to seek and accept treatment and supportive services. The MDT will use all available emergency shelter, transitional housing, and emergency shelter programs while they connect with services.
[5] A broad array of supportive services will be needed and accessed on a direct referral basis such as veterans services, healthcare, public assistance, transportation, securing critical documents, etc. These referrals will be facilitated and coordinated through the weekly MDT intervention coordination meeting.
[6] San Joaquin County. (2017). *Vertical prosecution*. Retrieved from https://www.sjgov.org/da/units/vertical-prosecution
[7] Full Service Partnership (FSP), Assertive Community Treatment (ACT), Substance Abuse Disorder (SUD) Services, Integrated Forensic Team (IFT).
[8] Community Emergency Services Response Team (CERT), Psychiatric Health Facility (PHF), Doctor's Behavioral Health Center (DBHC) acute adult inpatient psychiatric treatment center, Crisis Stabilization Unit (CSU), Garden Gate Respite Services.
[9] These percentages include individuals who participated in outreach and engagement services, as well as substance use disorder services.
[10] Center for Court Innovation, National Institute of Corrections, Ohio State University, University of Illinois at Chicago, University of Minnesota, University of Nebraska at Omaha, and Vera Institute of Justice.
[11] Rooney, R. H. (2014). *Work with reluctant, "resistant," (see involuntary!) clients* [Power Point slides]. Retrieved from http://mncamh.umn.edu/files/2017/07/webinarinvoluntary.pdf
[12] Tsai, J., Kasprow, W. J., Kane, V., & Rosenheck, R. A. (2014). Street outreach and other forms of engagement with literally homeless veterans. *Journal of Health Care for the Poor and Underdeserved, 25*(2), 694–704.
[13] Olivet, J., Bassuk, E., Elstad, E., Kenney, R., & Jassil. (2010). Outreach and engagement in homeless services: A review of the literature. *Open Health Services and Policy Journal, 3*, 53–70.
[14] Substance Abuse and Mental Health Services Administration. (2017). *Homelessness and housing*. Retrieved from https://www.samhsa.gov/homelessness-housing
[15] ACT provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, around-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, 7 days a week, 365 days a year.
[16] It is a partnership between law enforcement and treatment providers that allows community service providers to gain the type of outreach and community presence required to intervene with individuals who are homeless and mentally ill, while assisting police departments with their most difficult citizens. Each month agencies meet to discuss law enforcement-initiated case discussions. Participants include members of the criminal justice, mental health, and community services systems. Members review law enforcement requests for innovative client services and develop individualized case management plans.
[17] Choice Research Associates (Greenbelt, MD), Focus Strategies (Sacramento, CA), Improve Group (St. Paul, MN), Loyola University of Chicago (Chicago, IL), Mathematica Policy Research (Princeton, NJ), National Council on Crime and Delinquency (Oakland, CA), NPC Research (Portland, OR), Public Policy

Associates (Lansing, MI), Public Profit (Oakland, CA), Smart Start Evaluation Research (Irvine, CA), WestEd (San Francisco, CA), Westat (Rockville, MD).