

*Promoting Recovery and Services for the
Prevention of Recidivism (PRSPR)*

Two Year Preliminary Evaluation Report

San Francisco Department of Public Health

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Executive Summary

In June 2017, the San Francisco Department of Public Health (SFDPH) was awarded a three-year Proposition 47 grant from the Board of State and Community Corrections (BSCC) to implement the **Promoting Recovery and Services for the Prevention of Recidivism (PRSPR)** program. This grant is funded for \$6 million dollars for 38 months (June 16, 2017-August 15, 2020). The PRSPR program is designed to provide additional Substance Use Disorder (SUD) treatment services for individuals who have been arrested for, charged with, or convicted of a criminal offense. This grant funds 32 residential SUD treatment beds (3-6 months stay), as well as 5 social detox beds, at Salvation Army Harbor Light Center. Peer navigators from Richmond Area Multi-Services (RAMS) support participants who successfully complete the program for up to 60 days after discharge. Additionally, in order to better meet the SUD treatment needs of Transitional Age Youth (TAY) in the system of care, the grant funds a Clinical Case Manager from Felton Institute provides increased clinical support to TAY participants, as well as supporting the development of TAY specific curriculum at the residential treatment program.

Progress toward intended goals: December 2017 through March 2019

A set of goals and objectives were written into the grant by which the PRSPR program would be evaluated. The following table describes the goals, measurable objectives, and progress in reaching these goals to date.

Goal 1: Engage the target number of adults with substance use disorder (SUD) or co-occurring disorders who have a history of involvement with the criminal justice system.	
Objective	Status
1.1: The program will engage at least 64 individuals with SUD who may also have co-occurring MH issues (who meet the target criteria) annually in residential SUD treatment (equivalent to 16 individuals per quarter).	On track to meet the target. Residential treatment has actively engaged participants for six of the past seven quarters. During this time, 96 individuals have been enrolled in residential treatment, which is exactly the number that should have been reached at this point in time.
1.2: The residential program will maintain at least a 90% occupancy rate.	Target not yet achieved. The residential program occupancy rate has fluctuated, ranging from 3% to 88%, and averaging 61% across all active quarters. Although this goal came close to being achieved within the last few quarters, it has not yet been reached.
Goal 2: Participants completing treatment will have a community care plan that connects them to community-based resources that support their ongoing stabilization and recovery.	
Objective	Status
2.1: 100% of participants who complete the residential program will leave with a community care plan.	Target not yet achieved. 78% of those who successfully completed the residential treatment program have left with a community care plan.

2.2: 100% of community care plans will be individually tailored for each participant and will connect to housing, employment, medical care, mental health treatment, vocational services, and/or other resources, as needed.	On track to meet the target. 100% of community care plans have been individually tailored to address housing, employment, medical care, mental health treatment, vocational services, and/or other resources, and make connections as needed. The CCP form has been designed to ensure that each topic is addressed and that actionable goals are developed for each participant.
2.3: 90% of participants who successfully complete the residential program will be enrolled in the public benefit programs for which they are eligible (e.g., SSI, GA, CalFresh, Medi-Cal, etc.).	On track to meet the target. It is known that 89% of those who have successfully completed the residential program have been enrolled in Medi-Cal. Enrollment in other public benefit programs has not yet been collected. However, Medi-Cal enrollment alone provides numbers within close range of the target.
Goal 3: Program participants will demonstrate lower recidivism rates during and after program participation than they did during a similar period before participating in the program.	
Objective	Status
3.1: At least 50% of participants will complete 3-6 months of residential treatment.	Target not yet achieved. To date, 37% of participants who enrolled in residential treatment have successfully completed the program (i.e., no longer meet medical necessity for enrollment in the program after 3-6 months and have met all of their treatment plan goals).
3.2: As a cohort, 40% of participants will demonstrate lower recidivism rates than in a comparable period prior to admission.	On track to meet the targets. Reviewing San Francisco arrest records for PRSPR clients who exited residential treatment, only 4 had been arrested after participating in PRSPR, and only 1 had subsequently been convicted and sent to County Jail. Among the clients who successfully completed PRSPR, there are no records of arrests or convictions after participation in PRSPR.
3.3: As a cohort, participants will utilize 50% fewer jail bed days per year than they did prior to program participation.	

Project Accomplishments

In addition to meeting or coming close to meeting all of its intended objectives for program participants, other project accomplishments have included:

- **Participants have demonstrated an improved sense of wellbeing.** Although data is still being collected, preliminary survey results suggest that participation in PRSPR leads to an improved sense of wellbeing for participants. This is further supported by findings from a participant focus group at which participants expressed satisfaction with program services, a feeling of empowerment, and a sense of hope that they could attribute to the program.
- **A new, coordinated system of care is being developed in response to a need in the community.** PRSPR required the development of a system of care led by a group of partners, some of whom were working together for the first time, and at least one of whom

had never contracted with DPH before. Each partner had their own way of operating and very different program models, but they were unified under the common goal of meeting a stated need in the community, and their dedication to the work has remained unflappable. The relationships and systems that have been built and sustained by program partners can be held up as a program strength.

- **Partners have demonstrated adaptability, flexibility, and responsivity to program challenges.** The PRSPR program has experienced its share of growing pains and challenges. However, partners have remained committed to the work and have responded to each challenge with creativity and a can-do spirit. Thanks to the strong relationships and systems that have been developed as part of the coordinated system of care, challenges have not derailed programming. Rather, programming and partnerships have been strengthened in response to challenges.

"I think what I like most about this program is the fact that I have hope back in my life. It's kind of like a fresh start, but I get to utilize everything that I have learned here and just to boost myself into the direction I want to go, and I can feel it actually starting to happen, like pieces falling into place. And like how to act and how to carry myself, and that is due to this program and the stuff that I learned here. It is definitely a lot better, and I would never have had that opportunity if I wasn't here."

-PRSPR participant

Project Challenges

Among the growing pains and challenges that have surfaced during these first two years of programming:

- **Delays have surfaced as a common problem.** Delays in contracting between the DPH and partner CBOs led to a subsequent delay in the delivery of services. Although funding was made available to the program in July 2017, enrollment in residential treatment did not begin until December 2017. There have also been delays in hiring, most notably of the TAY Clinician. This had a negative impact on other program hires, as some work was dependent on the TAY Clinician being in place.
- **The referral and intake process took a long time to build, and has continuously had to be revisited.** Issues have included misconceptions among referral partners about program requirements; resistance to referral-related paperwork and duplicative assessments; unpredictable declines in referral numbers over time; and an abstinence-based program model that contrasts with approaches like harm reduction and medication-assisted treatment that have been embraced by the city.
- **It took time to understand and embrace the process of community care planning.** Community care plans (CCPs) were envisioned by the grant, but partners had their own planning documents, and were used to working independently with clients in the development of their plans. By nature, CCPs were designed to be completed one month prior to exit from treatment as part of a collaborative effort, and it took a while for the CCP process to be defined and established as part of a routine that worked for the program as it was being implemented.
- **Most participants have remained in residential treatment after their exit from PRSPR.** The complete Salvation Army treatment model allows for engagement beyond that which is deemed medically necessary by the DPH. Participants are allowed to remain in treatment under alternative funding sources after their time with PRSPR comes to an end, and most do. Much of the work envisioned by the grant assumed that participants would be

returning to the community immediately. Because this is not happening, some aspects of the program, such as the role of the peer navigator, have had to be revisited and redefined to better fit with longer term engagement in treatment.

Each of these challenges have required their own unique solutions (detailed in the main report), but they have all primarily been addressed collaboratively through implementation team work group meetings and corresponding follow up. Meetings have occurred at least quarterly since the start of the grant. The workgroup is composed of representatives from all of the core program partners, and agendas are developed to allow for review and reflection upon project implementation. If it is found that programming is not being delivered as planned, issues are identified and solutions are strategized as a group. It has also been very common for partners to schedule smaller meetings outside of the regularly scheduled work group meetings to address challenges more intensively. Team members have always come to the table prepared to share ideas and address challenges directly.

Conclusion

Is the project working as intended?

Despite some challenges and growing pains, the PRSPR program is, to a large degree, working as intended. Of the eight project objectives, five have been met, and three are close to being met. Some slight adjustments to programming have been made in response to on-the-ground experience, including revisions to the referral process, adaptations to service delivery in response to participants remaining in treatment beyond their time in PRSPR, and the corresponding reinvention of some roles such as that of the peer navigator. However, despite these changes, the fundamental program model remains intact and program partners are driven to deliver services as promised as part of a coordinated system of care.

Next Steps

Because of the delays in programming (and, thus, the expenditure of funds), a no-cost extension (until August 31, 2021) was requested and has already been accepted. At this point in time many of the pieces of the PRSPR program seem to have fallen into place, and partners are well-positioned to deliver services with fewer delays and challenges.

In addition, lessons learned from this first cohort of Prop 47 funding will be applied to a new program model (Supporting Treatment and Reducing Recidivism or STARR) that was written into a grant application for the second cohort of Prop 47 funding. This new model builds upon many of the services that are already being delivered under PRSPR, and enhances them through the integration of drop-in and outpatient services. The grant for the second cohort of funding was awarded to SFDPH and the STARR programming will run concurrently to PRSPR until the end of the no-cost extension period, at which point some services (e.g., TAY-specific support, peer navigation) will come to a conclusion and others (e.g., detox, residential treatment) will be sustained through 2022.

Overview of Funded Program

Program Background and Description

In June 2017, the San Francisco Department of Public Health (SFDPH) was awarded a three-year Proposition 47 grant from the Board of State and Community Corrections (BSCC) to implement the **Promoting Recovery and Services for the Prevention of Recidivism (PRSPR)** program. This grant is funded for \$6 million dollars for 38 months (June 16, 2017-August 15, 2020). The PRSPR program is designed to provide additional Substance Use Disorder (SUD) treatment services for individuals who have been arrested for, charged with, or convicted of a criminal offense. This grant funds 32 residential SUD treatment beds (3-6 months stay), as well as 5 social detox beds, at Salvation Army Harbor Light Center. Peer navigators from Richmond Area Multi-Services (RAMS) support participants who successfully complete the program for up to 60 days after discharge. Additionally, in order to better meet the SUD treatment needs of Transitional Age Youth (TAY) in the system of care, a Clinical Case Manager from Felton Institute provides increased clinical support to TAY participants, as well as supporting the development of TAY specific curriculum at the residential treatment program.

In accordance with grant requirements, **only the following individuals are eligible to be in the PRSPR program: 1) People who have been arrested, charged with, or convicted of a criminal offense; AND 2) have a history of mental health needs or substance use disorders.** To ensure compliance with these requirements, the evaluator, Hatchuel Tabernik & Associates (HTA), prepared cover sheets for all referring agencies to complete as part of the referral process. The coversheets include check boxes to verify that the population being reached has both a history of criminal activity and mental health/substance use disorder treatment needs. The use of a cover sheet as part of the referral process ensures that all individuals referred to the program are eligible. Only individuals for whom the check boxes are checked can be referred/accepted into the program. Cover sheets have been distributed to all referring agencies, and are shared with multiple partners (Salvation Army, HTA, SFDPH) upon completion to allow for several opportunities to verify that services are being provided to the correct population

PRSPR program partners and the services per the original grant application fall under eight main categories: 1) Referrals/Intakes, 2) Residential SUD treatment, 3) Utilization review, 4) Community care planning, 5) Peer navigation, 6) TAY linkage and services, 7) Flex funds, and 8) an Implementation team work group. Detailed descriptions of the work that falls under these categories, along with any deviations or program modifications from the initial plan, will be discussed in the Evaluation Findings, Fidelity to Implementation section.

Logic Model

HTA grounded the evaluation by working with the project manager and community-based partners to develop a logic model specifying PRSPR activities and how these additional activities are expected to lead to the outcomes specified in the grant application. The logic model is in the Appendix.

Program Goals & Objectives

As stated in the grant application:

Goal 1: Engage the target number of adults with substance use disorder (SUD) or co-occurring disorders who have a history of involvement with the criminal justice system.

- 1.1: The program will engage at least 64 individuals with SUD who may also have co-occurring MH issues (who meet the target criteria) annually in residential SUD treatment.
- 1.2: The residential program will maintain at least a 90% occupancy rate.

Goal 2: Participants completing treatment will have a community care plan that connects them to community-based resources that support their ongoing stabilization and recovery.

- 2.1: 100% of participants who complete the residential program will leave with a community care plan.
- 2.2: 100% of community care plans will be individually tailored for each participant and will connect to housing, employment, medical care, mental health treatment, vocational services, and/or other resources, as needed.
- 2.3: 90% of participants who successfully complete the residential program will be enrolled in the public benefit programs for which they are eligible (e.g., SSI, GA, CalFresh, Medi-Cal, etc.).

Goal 3: Program participants will demonstrate lower recidivism rates during and after program participation than they did during a similar period before participating in the program.

- 3.1: At least 50% of participants will complete 3-6 months of residential treatment.
- 3.2: As a cohort, 40% of participants will demonstrate lower recidivism rates than in a comparable period prior to admission.
- 3.3: As a cohort, participants will utilize 50% fewer jail bed days per year than they did prior to program participation.

Evaluation Methodology

Hatchuel Tabernik & Associates (HTA) is conducting an independent evaluation of the Promoting Recovery & Services for the Prevention of Recidivism (PRSPR) program. HTA is using a **utilization-focused approach** combining mixed methods of program data, interviews, and surveys to address the impact of the Proposition 47 grant funds on PRSPR clients. Utilization-based evaluation is an approach whereby the evaluation activities *from beginning to end* are focused on the *intended use by the intended users*.¹ Additionally, the evaluation focuses on both process and outcome elements. The process evaluation is oriented towards providing information on how to continuously revise and improve the program, as needed. The outcome evaluation is focused on describing the program's outcomes cumulatively over the three-year period.

Given the pilot, developmental nature of the implementation, a comparison group has not been identified for this evaluation to assess impact. Rather, impact will be assessed by within-group change from baseline to follow-up for PRSPR participants. If preliminary evidence from this evaluation indicates a positive impact, then the next phase of implementation will incorporate an appropriate control group for comparison. Moreover, one of the main goals of the evaluation is to collect implementation data to document fidelity to implementation for the next phase of analysis.

¹Patton, M.Q. (2012). *Essentials of Utilization-Focused Evaluation*. Thousand Oaks, CA: SAGE Publications, Inc.

Only PRSPR participants who consented to the evaluation (signed at referral) are eligible to be included in the current evaluation study.

Process Evaluation. The process evaluation includes a continuous improvement model to program implementation by addressing fidelity to the program plan and monitoring specific program goals (i.e., number engaged, criminal history, substance use history, program occupancy, length of stay, etc.). Process data includes various service utilization records including referral forms, case logs, assessments, treatment/care plans, services, referrals, and exit forms. Data is pulled through coordinated efforts from multiple sources, including Avatar (the SFDPH electronic health records system), current partner instruments, validated assessments, and case logs. Additionally, to monitor fidelity to the program model, HTA participates in quarterly implementation team meetings, and conduct periodic check-ins and interviews with program leadership and partners (e.g., SA, FI, RAMS, SFPHF, etc.) to discuss program developments. Topics of discussion includes successes/challenges in recruitment and engagement, client progress, areas for improvement, evidence-based best practices utilized, and lessons learned from the collaboration between agencies. Because this is the first time these partners have come together to collectively serve this population under the auspices of Prop 47 funding, this evaluation is largely process-oriented to help us document and learn from program implementation.

The following evaluation questions were designed to guide our process evaluation:

1. Is the target population being reached? What is the profile of individuals being referred to PRSPR residential SUD treatment?
2. What is the length of time between referral to enrollment at Salvation Army?
3. What is average length of stay in social detox and/or residential treatment?
4. What do transitions look like from residential treatment to case management (for TAY) and/or to peer navigation?
5. What services do Peer Navigators provide to PRSPR clients (including # and length of contacts)? Do services vary by population?
6. What is quality of the pairing (i.e., similar demographics, level of trust, pattern of regular connection, level of commitment and mutual satisfaction)?
7. What does TAY outreach look like?
 - o Which outreach strategies were employed? Which of those were most effective with TAY?
8. What services does the Case Manager provide to TAY clients (including # and length of contacts, types of services and referrals)?
 - o What types of support services are provided by Felton specifically to TAY youth receiving services at Salvation Army?
9. Do services for TAY differ from services provided to adult participants? If so, how?
10. How did Felton and Salvation Army work together to develop and implement a TAY-specific curriculum for participants?
11. How does the TAY-specific curriculum differ from the curriculum already in use at Salvation Army?
12. What are the successes and challenges that emerge throughout the implementation of the program?
 - o What were the providers' experiences of collaborating with each other?
 - o Are there benefits of utilizing multiple providers to support participants? Hindrances?

13. How are SF Public Health Foundation flex funds allocated? In what ways are partners supported by these flex funds?
14. Do any barriers emerge to program entry, connecting clients with services, and retention? If so, how were they overcome?

Process data is collected from program partners on a quarterly basis. Sources include:

- Salvation Army Case Log
- Felton Case Log
- RAMS Case Log
- RAMS Peer Service Logs
- Community Care Plans (CCPs)
- Quarterly Implementation Team Meeting Minutes
- Partner Interviews
- Participant Focus Groups
- TAY-specific curriculum samples
- SFPHF Monthly Program Disbursement Request Forms
- Partner Expense Tracking

Outcome Evaluation. The outcome evaluation, utilizing a pre-post design, will study whether the program achieved its stated outcomes (i.e., completion of treatment, enrollment in public benefits, lower recidivism rates, etc.). We are collecting information from program participants during three time periods: once before participants receive treatment, at their time of enrollment (baseline); once to measure outcomes immediately after treatment has concluded, at discharge; and once to measure outcomes 60 days after participants have returned to the community.

We will compare baseline indicators with post-treatment outcomes to see if changes in individual-level outcomes are not only accomplished but maintained over time. Data sources will include staff and evaluator administered assessments (e.g., the ASAM (American Society of Addiction Medicine), the CTS (Criminal Thinking Scale), and questions from the ASI (Addiction Severity Index), etc.); program intake and referral forms; and individual-level recidivism data for three years prior to participation and up to three years after (dates, arrests, convictions, re-incarceration, prior or new offenses). Analysis of these data will include the exploration of differences in outcomes by population (e.g., TAY, African American, LGBTQ, etc.).

Because recidivism is of particular interest for this grant, this outcome will be a highlight of the evaluation. For the purposes of this study, **recidivism is defined as the conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction.** We will be exploring recidivism within the SF Jail system specifically for each individual for up to three years prior and up to three years after enrollment in the PRSPR program. Because admission to the program is rolling, it will be most useful to conduct this study using a cohort model, taking into account the length of time an individual is involved with the PRSPR program. For example, an individual who enrolls at the start of the first year of programming cannot be compared equally to an individual who enrolls toward the end of the third year. More time will have passed for the first individual since discharge from treatment, allowing for more time to recidivate. Therefore,

recidivism for this study will be calculated as if they were follow-up rates, calculating pre-post recidivism rates for each individual at 6-month intervals following their enrollment in PRSPR.

The evaluation questions that were designed to guide our outcome evaluation of recidivism and all other outcome measures are as follows:

1. What is the baseline of individuals on key outcomes when they start the program?
2. What is profile of clients who successfully complete 3-6 months of residential treatment?
3. Are there differential outcomes for transitional-age youth (TAY); others?
4. Do clients re-offend?
 - If so, what type and severity of crimes?
 - Do they spend fewer days in jail?
5. Are there differential recidivism outcomes for transitional-age youth (TAY); others?

As with the process evaluation, data is collected from partners on a quarterly basis, the sources of which include:

- PRSPR SFDPH Detox Cover Sheet
- PRSPR SFDPH Referral Cover Sheet
- Salvation Army Case Log
- Participant Outcomes Form (Salvation Army Intake and Discharge)
- TCU Criminal Thinking Scale (Salvation Army Intake and Discharge)
- Wellbeing Survey (Salvation Army Intake and Discharge)
- Felton Case Log
- RAMS Peer Service Logs
- Community Care Plans (CCPs)
- Partner Interviews
- Participant Focus Groups
- SF Jail Arrest Data

Evaluation Findings: Implementation

As mentioned in the program description, there were eight planned components as per the original grant application: 1) Referrals/Intakes, 2) Residential SUD treatment, 3) Utilization review, 4) Community care planning, 5) Peer navigation, 6) TAY linkage and services, 7) Flex funds, and 8) the Implementation team work group. The following is a description of each planned component, along with details about program implementation, collaboration and services to date; and corresponding successes, challenges, and any deviations/modifications from the initial plan.

Implementation Team Work Group

As planned. A PRSPR implementation team work group, comprised of the DPH Program Director and staff from SA, FI, and RAMS, will meet at least quarterly to review and evaluate project implementation and service delivery, ensure that the referral process is serving the target population, track participants' progress, monitor treatment capacity, and ensure a coordinated system of care.

Progress to date. As of the end of Quarter 7 (Jan – Mar 2019), this group, along with the external program evaluators, and other DPH staff as needed, have met a total of twelve times. In the first few months of the grant, meetings were held twice a month, but once service delivery was up and

running, they transitioned to a quarterly schedule. All program partners have had representatives at each meeting, and meeting minutes demonstrate that individuals have always come to the table prepared to share ideas and address challenges head on. It has also been very common for partners to schedule smaller meetings outside of the regularly scheduled work group meetings. Collaboration has not been a challenge for PRSPR. The relationships that have been built and sustained by program partners can be held up as a program strength.

Referrals/Intakes

As planned. Referrals and intakes were to be conducted by four SFDPH programs: 1) Treatment Access Program (TAP); 2) Offender Treatment Program (OTP); 3) Jail Behavioral Health Services (JBHS); and 4) Law Enforcement Assisted Diversion Program (LEAD). All these programs operate within SFDPH's Behavioral Health Services division. Staff from these four programs were to conduct assessments to determine treatment needs, severity of substance use, and level of care needed; secure consent and authorization for the program; provide care coordination; and support individuals in the completion of program applications. Referrals from these four programs were to be sent directly to Salvation Army's Harbor Lights Center who would then admit the prospective client into the residential treatment program, unless the individual needed more time to prepare for residential by enrolling in the social detox program Salvation Army's Wellness Center.

Progress to date. From the start, a lot of importance was placed on referrals and intake procedures as it is the primary channel by which participants would be connected to services. To this end, the following components were modified and/or added as the program was implemented:

- **Ongoing internal discussion and problem solving around referrals.** Discussion of progress towards referral and intake goals are a standing item on the quarterly implementation team meetings at which all partners and community-based organizations attend. In addition, group case conferencing between Salvation Army and SFDPH referral sources was initiated around referrals that were not subsequently enrolled in programming to identify and address any potential barriers to entry.
- **Creation of a mutually-agreed upon program procedures and policy document.** From the first implementation team meeting, team members contributed to the development of a mutually-agreed upon PRSPR Procedures document in which the referral process was outlined in detail (see Appendix). The document was continuously updated during the first year of programming.
- **Streamlining external referral process.** A "PRSPR email" was created for all SFDPH referrals to go to one email address that is checked by several DPH staff members, rather than through a specific individual at TAP, as referrals were initially falling through the cracks. In addition, a process was set up for "self-referrals" in order to speed up time from interest to treatment. For detox, this meant that the Level of Care (LOC) recommendation form² and referral could be completed at TAP by TAP staff, after which individuals could be placed in detox prior to official authorization. For residential treatment this meant that the required LOC could be conducted by Salvation Army and then fast-tracked to SFDPH for processing. The Salvation Army Intake & Network Manager was trained and certified to administer the ASAM to accomplish this goal.
- **Expansion of external referral sources.** The pool of external partners who can make referrals to the PRSPR program, was expanded to officially include Felton Institute (for TAY), the Public Defender's Social Worker, and the Collaborative Courts. The PRSPR Project Director has begun coordination with law enforcement partners to expand the pool of referral partners even further, and better facilitate placement in the program.

² A modified version of the American Society of Addiction Medicine (ASAM) used by SFDPH.

Along the way, a few challenges with the referral process and potential barriers and delays to program entry were identified and discussed. These challenges and potential barriers included:

- **Misconceptions on CBO’s treatment approach.** There were some misconceptions among referral partners about Salvation Army’s approach to treatment that needed to be challenged and addressed so that referrals would not be inhibited (e.g., assumptions that participants were required to work, religious involvement, etc.). The PRSPR Project Director and the Salvation Army intake coordinator conducted in-person outreach with prospective referral partners at the launch of the program to address any misconceptions and explain the program. Recently, the misconceptions were re-addressed in an email from the PRSPR program director, and referral partners were re-invited to tour Salvation Army’s Harbor Light Center facilities to see for themselves what the program was like.
- **Background checks & eligibility requirements.** Salvation Army conducts background checks on all prospective clients and bars entry to individuals who have certain criminal histories. The program partners were able to discuss how to reduce these barriers, and agreed to methods which would allow temporary housing at the Wellness Center while conducting background checks. The PRSPR Procedures document was updated to specify which criminal history backgrounds would be prohibitive to entry. The PRSPR Referral Cover sheet for detox referrals was pared down to one page, to further reducing the burden of paperwork
- **Duplicative assessment forms.** Initially, Salvation Army had their own assessment form separate from DPH’s own assessment form, which could contribute to a delay in enrollment as duplicative data was captured by separate agencies. Therefore, PRSPR Referral “Cover Sheets” were designed to facilitate PRSPR referrals by SFDPH staff to Salvation Army to ensure the individuals qualified for the program and sufficient information was provided to Salvation Army to pre-emptively complete their own assessment forms.
- **Lack of MAT services.** Salvation Army operates primarily from an abstinence-oriented model for treatment, and does not traditionally offer medication-assisted treatment (MAT) while in treatment. This proved to be a barrier for some clients, especially those who had been provided with MAT while in jail or needed a step-down in substance use first. After discussions (about MAT, pain medication, exclusions from treatment, etc.) followed by group trainings (i.e., ASI/ASAM, harm reduction) and Salvation Army agreed to onboard MAT as a component of their programming. This allows for better alignment with other City programs and opens access to a larger body of potential detox and residential treatment clients.

Table 1: PRSPR Referrals and HLC Admits by Quarter, Dec 2017- Mar 2019

Quarter	Referrals	Admits
Q1 (Jul – Sept ’17)	Planning Period	
Q2 (Oct – Dec ’17)	2	1
Q3 (Jan – Mar ’18)	30	23
Q4 (Apr – Jun ’18)	29	20
Q5 (Jul – Sept ’18)	36	38
Q6 (Oct – Dec ’18)	42	41
Q7 (Jan – Mar ’19)	19	21
Total	158	144

Source: SFDPH PRSPR referral records; HLC-Salvation Army admission records

From the start of the program (December 21, 2017) through the end of Quarter 7 (March 30, 2019), there were a total of 158 referrals (149 unduplicated individuals) to Harbor Light Center at Salvation Army (see Table 1). Of these referrals, there were subsequently 144 admits (118 unduplicated

individuals) into social detox and/or residential treatment. The data shows that in Quarter 7, the number of referrals dropped dramatically, by 55%. Possible reasons for this drop will be discussed more on the following pages.

As initially planned, the four primary sources for referrals were TAP, JBHS, LEAD, and OTP. During this time, the only other referral to the program came directly from Felton Institute, the program partner specializing in TAY outreach and case management. As shown in Table 2, the vast majority of referrals have come through TAP, in part because Salvation Army partnered with them when they sourced their own referrals to the program.³ Although TAP was the primary referral partner, there was a gradual ramp up of referrals coming from the other partners through Quarter 6. However, in Quarter 7, TAP was the sole source of referrals. Therefore, the drop in referrals in Quarter 7 was primarily driven by the complete lack of referrals from JBHS, LEAD, and OTP.

Table 2: PRSPR Referral Sources by Quarter, Dec 2017- Mar 2019

Quarter	Felton - TAY	JBHS	LEAD	OTP	TAP	TOTAL
Q1 (Jul – Sept '17)	Planning Period					
Q2 (Oct – Dec '17)	0	0	0	0	2	2
Q3 (Jan – Mar '18)	0	8	2	0	20	30
Q4 (Apr – Jun '18)	1	9	0	3	16	29
Q5 (Jul – Sept '18)	0	3	6	4	23	36
Q6 (Oct – Dec '18)	0	1	10	10	21	42
Q7 (Jan – Mar '19)	0	0	0	0	19	19
Total	1	21	18	17	101	158

Source: SFDPH PRSPR referral records; HLC-Salvation Army admission records

In Quarter 7, the Salvation Army initiated a new contract with Adult Probation to provide residential treatment beds for direct referrals. The SA Intake Coordinator posited that it was possible that the decrease in referrals from the Offender Treatment Program (OTP) for PRSPR may have been related to this new contractual relationship with Adult Probation. Effectively, PRSPR eligible individuals on mandatory supervision were being referred to the new Probation program at Salvation Army, rather than PRSPR.

There was also an ebb in JBHS referrals, from a high of nine during Quarter 4, to zero in Quarter 7. JBHS staff specifically stated that they were not referring individuals because they were not being admitted to the program. To this point, HTA calculated that individuals referred to PRSPR but did not enroll (n=32) were statistically more likely to be referred by Jail Behavioral Health Services (JBHS)⁴ than any other referral source. That is, 71.4% of JBHS referrals were not admitted compared to 12.4% by other referring agencies. Because partners wanted to understand why JBHS referrals were not admitted, a meeting was held with Salvation Army, SFDPH and HTA on May 23rd. Going through the files one at a time, it was seen that the majority of these referrals had

³ Salvation Army could not make independent referrals to PRSPR during this time period because staff were not yet certified to administer the ASAM, which is part of the referral process. At the time of the writing of this report, Salvation Army's Intake and Network Manager became ASAM certified, and will be able to make independent referrals from here on out.

⁴ Pearson chi-square=55.438, p=.000

actually been assessed in-custody and accepted into the program, but then the individual did not follow through by going to SA HLC upon release from jail, or if they did arrive, they only stayed for one night, checking out the next day. The SA Intake Coordinator speculated that the JBHS referrals were not sincere in their desire to attend residential treatment, perhaps believing that stating such a desire would result in an earlier release from jail.

Residential Substance Use Disorder Treatment

As planned. The SFDPH contracted with Salvation Army's Harbor Light Center (SA HLC) facility to provide 5 social detox and 32 residential SUD treatment beds for eligible participants with a target of a 90% occupancy rate. The average stay in detox would be 4-10 days and include 21 hours of treatment/week. Participants in SA's residential treatment program, which typically lasts up to 6 months, would receive individual and group counseling and therapy, case management, SUD and MH classes, and physical wellness. Their client-centered social model program emphasizes accountability, mutual self-help, and relearning responses to challenges to build positive coping behaviors and social support systems. Participants are part of a healing community based on restorative justice principles; if individuals cause harm or relapse, they are supported to get back on track. SA currently utilizes two evidence-based curricula, including *Living in Balance*, which addresses dependency issues via units specifically for formerly incarcerated, and *Change Company*, which incorporates principles of restorative justice to help participants break the cycle of behavior related to criminal offenses and take corrective action.

Progress to date. In the grant application, the target was to admit 16 individuals per quarter to residential treatment, with a total of 96 enrollments expected by then end of Quarter 7. (No similar targets were set for social detox). **As shown in Table 3, the program goal for residential treatment admits was reached.** The highest number of admits to residential treatment reached was in Quarters 5 and 6, with 25 admits each. However, there was a large drop in Quarter 7 admits, which coincides with the notable decrease in referrals, noted above.

Table 3: HLC Admit Modality by Quarter, Dec 2017- Mar 2019

Quarter	Social Detox	Residential Treatment	Targets (Res. Treatment)
Q1 (Jul – Sept '17)	Planning Period		
Q2 (Oct – Dec '17)	0	1	16
Q3 (Jan – Mar '18)	3	20	16
Q4 (Apr – Jun '18)	6	14	16
Q5 (Jul – Sept '18)	13	25	16
Q6 (Oct – Dec '18)	16	25	16
Q7 (Jan – Mar '19)	10	11	16
Total	48	96	96

Source: HLC-Salvation Army admission records

Some PRSPR clients engaged in both social detox and residential treatment – these clients accounted for 13.6% of unduplicated clients (16 of 118 unduplicated clients) or 12.5% of all admits (18 of 144 admissions) – a relatively small number of the total.

Statistical analyses were conducted to see if there was any statistical variation in the type of individuals who enrolled in PRSPR compared to those who did not. It was found that individuals who were referred to PRSPR but did not enroll (n=32) were statistically more likely to be younger⁵. Non-enrollees were 35 years old, on average, compared to 40 years old for enrollees. There were no statistical differences by gender or race/ethnicity between enrollees and non-enrollees.

For the targeted population of PRSPR clients, waiting time to treatment entry can be a major barrier, as individuals with substance use issues may give up on treatment and continue using at harmful levels or may conclude that the long wait time proves their substance issues are not really that serious⁶. Table 4 shows the average wait times from referral to admit by service modality. On average, PRSPR clients waited 5 days for a social detox bed, and 4 days⁷ for a residential treatment bed at HLC-Salvation Army. The average days to wait increased for social detox beds from same day to 7 days, while the wait for residential treatment beds dropped from a high of 9 days to 0 days over the period studied.

Table 4: Length of Time (in Days) from Referral to Admit by Modality by Quarter, Dec 2017- Mar 2019

Social Detox		Residential Treatment	
Mean	Std. Dev.	Mean	Std. Dev.
5.2	12.6	4.2	12.8

Source: HLC-Salvation Army admission records

Among those individuals who were admitted into programming, there were few demographic differences between detox and residential treatment participants (see Table 5). Approximately three-fourths of all participants were male. It was most common for participants to be White or Black/African American. Participants ranged in age from 19 to 67 years, and averaged 40 years. The percentage of Transitional Age Youth (TAY) participants was somewhat low, representing 8% of all program participants. Program admits, by and large, were sourced through referrals from TAP. Referrals from OTP and LEAD also accounted for a fair amount of program admits, but JBHS and Felton referrals only accounted for a handful of admits.

As of the end of Quarter 7 (i.e., March 30, 2019), 100% of social detox admits and 76% of residential treatment admits had exited from treatment. Among those who had exited, the average length of stay at HLC-Salvation Army was 74 days (or 2.5 months), with an average of 11 days in social detox and/or 101 days (or 3.4 months) in residential treatment (see Table 6). The time in treatment ranged from 1 day to up to 213 days (or 7.1 months), when combining social detox and residential treatment.

Among those who exited social detox, 52.1% successfully completed their recommended detox treatment. Among those who exited residential treatment, 37.0% successfully completed their recommended residential treatment. For both cases, successful treatment is defined by the HLC-Salvation Army Intake Coordinator as “meeting their treatment plan goals.”

⁵ $t=2.184$, $p=.030$

⁶ Redko, C., Rapp, R.C., and Carlson, R.C. 2006 (Sept). Waiting time as a barrier to treatment entry: Perceptions of substance users. *Journal of Drug Issues*. 36(4): 831–852.

⁷ Clients who had been admitted to detox first, were not included in this calculation.

Table 5: Demographics by Admit Modality, Dec 2017- Mar 2019

	All Admits (N=126)	Social Detox (N=48)	Residential Treatment (N=96)
Gender (%)			
Female	25.4%	27.1%	22.9%
Male	73.8%	72.9%	76.0%
Other	0.8%	0.0%	1.0%
Race/Ethnicity (%)			
African-American/Black	33.3%	33.3%	35.4%
Asian	4.0%	6.3%	3.1%
Hispanic/Latinx	13.5%	10.4%	13.5%
Native American	4.0%	2.1%	4.2%
Pacific Islander	0.8%	0.0%	1.0%
Multi-Ethnic	13.5%	12.5%	12.5%
White	29.4%	35.4%	28.1%
Other/Not Stated	1.6%	0.0%	2.1%
Age			
Years (mean)	39.5	39.8	39.6
Years (range)	19 - 67	22 - 64	19 - 67
Transition Age Youth ⁸ (%)	7.9%	2.1%	10.4%
Referring Agency			
Felton-TAY	0.8%	0.0%	1.0%
JBHS	4.8%	2.1%	6.3%
LEAD	9.5%	25.0%	2.1%
OTP	9.5%	6.3%	10.4%
TAP	75.4%	66.7%	80.2%

Source: HLC-Salvation Army admission records

Table 6: Length of Stay (Days) by Modality, Dec 2017- Mar 2019

	Mean	Std. Dev.	Range
All Admits ⁹ (N=108)	70.1	71.1	1 - 213
Social Detox (N=48)	10.7	11.7	1 - 74
Residential Treatment ¹⁰ (N=73)	96.8	66.3	1 - 181

Source: SFDPH Database (Avatar)

⁸ TAY=18-24 years old

⁹ Only admits with an exit date were included in the analysis. 23 admits had not yet exited residential treatment at the time of this report. They are not included in this analysis.

¹⁰ Ibid.

Overall while Salvation Army has made available the detox and residential treatment beds and delivered treatment as planned, **occupancy rates have been lower than the anticipated 90% target for residential treatment, averaging around 61%** between Quarter 3 (Jan – Mar 2018, the first full quarter of service delivery) and Quarter 7 (Jan – Mar 2019). Occupancy rates were calculated by dividing the number of beds that were filled, by the number of beds that were provided each quarter.

Both social detox and residential treatment demonstrated incremental growth in occupancy rates (see Table 7). There was an initial ramping up period during the first few quarters, and by Quarter 4 there were notable gains in occupancy. Since then, social detox and residential treatment have followed slightly different trajectories. Social detox had their highest occupancy rates in Quarter 5 with a decline by 61% at the end of Quarter 7. Residential treatment, on the other hand, continued to progress, almost reaching the 90% target in Quarter 6, followed by a slight decline in Quarter 7. Declines in occupancy rate mirror the declines seen in referrals and admits during this same period.

Table 7: Occupancy Rates by Modality by Quarter, Dec 2017- Mar 2019

Quarter	Social Detox	Residential Treatment
Q2 (Oct – Dec '17)¹¹	0%	3%
Q3 (Jan – Mar '18)	2%	18%
Q4 (Apr – Jun '18)	24%	61%
Q5 (Jul – Sept '18)	41%	74%
Q6 (Oct – Dec '18)	37%	88%
Q7 (Jan – Mar '19)	16%	82%

Source: SFDPH Database (Avatar)

Finally, it should be noted that Salvation Army counselors have participated in many DPH trainings throughout the course of the grant to expand their body of knowledge around evidence-based theory and practice (e.g., Wellness Recovery Action Planning or WRAP, Harm Reduction, Medication-Assisted Treatment, etc.). In addition, through their partnership with Felton Institute, a new curriculum (*Seeking Safety*) will be adopted as part of Harbor Light Center's programming for TAY clients.

Utilization Review

As planned. Participants would remain in residential treatment for as long as treatment is deemed to be of medical necessity. The SFDPH Transitions Division receives all referral data from TAP to provide utilization management services to PRSPR. Salvation Army would work with Transitions to set a monthly meeting to review PRSPR cases receiving treatment at their facility. PRSPR participants would be discussed at the onset of the meeting in a group case conferencing session, and then Salvation Army would provide a private room for Transitions to meet with participants (meetings with each participant will occur on a quarterly basis) to determine if the participant continues to meet necessity for residential treatment. If a participant was determined to no longer meet necessity for residential treatment, Salvation Army and the DPH Project Director would be notified. At that time, Salvation Army could continue to serve the individual through an alternative

¹¹ The first program admissions were in December 2017.

funding source, but their PRSPR case status will be marked as closed. BHS case managers would continue to provide mental health services for as long as they are clinically indicated.

Progress to date. The SFDPH Transitions Division has provided utilization review much as was originally envisioned. Salvation Army worked with Transitions to schedule a monthly meeting to review PRSPR cases receiving treatment at their facility. Utilization Review began in January 2018, shortly after the first clients had been enrolled in treatment. All feedback about the utilization review process has been positive, and it appears as if Salvation Army and Transitions are working very well together.

Community Care Planning

As planned. Prior to completion of residential treatment, each participant would have a collaboratively developed Community Care Plan (CCP) that supports the participant to continue on their path to recovery and wellness by addressing their needs and ensuring connection to community based resources including housing, employment, benefit programs (e.g. medical care, food, AIDS Drug Assistance Program, SSI), and long term behavioral health treatment. It was expected that Salvation Army would drive the completion of the CCP 30 days prior to discharge, working closely with RAMS, Felton, and other community-based treatment providers, as needed.

Progress to date. As of the end of Quarter 7 (i.e., March 30, 2019), a total of 28 community care plans (CCPs)¹² were completed (for 28 unduplicated clients). In the same time period, there were 73 exits from residential treatment (for 69 unduplicated clients), which suggests that most clients are leaving treatment without completing the CCP with their PRSPR peer navigator and counselor. However, **78% of clients who successfully completed programming left with a CCP**, indicating that those exiting programming without a CCP probably exited the program prematurely. (See Table 8.)

Table 8: Community Care Plans by Quarter, Dec 2017- Mar 2019

Quarter	% of All Tx Completers w/CCPs	% of Unsuccessful Tx Completers w/CCPs	% of Successful Tx Completers w/CCPs
Q2 (Oct – Dec '17)	-	-	-
Q3 (Jan – Mar '18)	0% (0 of 5)	0% (0 of 5)	-
Q4 (Apr – Jun '18)	18% (2 of 11)	11% (1 of 9)	50% (1 of 2)
Q5 (Jul – Sept '18)	44% (7 of 16)	0% (0 of 8)	88% (7 of 8)
Q6 (Oct – Dec '18)	26% (6 of 23)	0% (0 of 15)	75% (6 of 8)
Q7 (Jan – Mar '19)	44% (8 of 18)	11% (1 of 9)	78% (7 of 9)
Total	32% (23 of 73)	4% (2 of 46)	78% (21 of 27)

Source: PRSPR CCPs collected by HLC-Salvation Army and RAMS

Most of the CCPs, to date, have been developed just prior to planned program exits. On average, plans were developed 11 days prior to the actual date of discharge, with a range from 39 days prior to 3 days after departure. In an interview with RAMS, it was verified that it is often difficult for Peer Navigators to develop CCPs with their clients one month prior to discharge as planned. Since

¹² Five of the 28 plans are for clients who have not yet exited.

Salvation Army Counselors carry the cases, the Peer Navigators have been relying on them to coordinate CCP completion, and in some cases CCPs are less of a priority than other parts of their work with clients, especially for those who choose to remain in treatment beyond their time in PRSPR. Peer Navigators are also only stationed at Salvation Army two days a week, which limits the amount of time available for scheduling meetings. RAMS agrees that it would be better to have CCPS completed a full 30 days prior to discharge, especially for those clients who do not plan to stay at Harbor Light Center post discharge, and to that end they are trying to establish relationships with clients earlier in the process and explicitly define community care planning as part of their role.

Because Community Care Plans were really meant to help prepare clients for their return to the community after discharge from the program, the forms were designed to facilitate conversations and connect participants to resources around individual housing, employment, medical care, mental health treatment, vocational services, and other resources as needed. **All completed Community Care Plans address each of the aforementioned areas to some degree, and participants are prepared to leave with related goals and action steps for achieving their goals.**

Beyond the Community Care Plans, participants are also prepared for a return to the community through enrollment in public benefits. As part of the first phase of treatment at Harbor Light Center, participants complete a financial assessment with the business department, at which point they are linked to appropriate benefit programs. Enrollment in all benefit programs has not yet been collected, but Medi-Cal enrollment is regularly tracked in Salvation Army participant logs which show that **of the 27 individuals who successfully completed treatment, 24 (89%) were enrolled in Medi-Cal at the time of discharge.**

Along the way, a few challenges with the community care planning were identified and discussed:

- **Understanding of CCP.** There were some difficulties associated with the completion of CCPs and establishing a mutual understanding about its purpose. Because the CCP was really conceptualized for the PRSPR grant, its completion was outside of the normal routine for Salvation Army and RAMS, who have their own exit planning tools for clients. HTA facilitated the development of the CCP tool at implementation team meetings; however, it took a while for partners to agree on the purpose and meaning of it for clients.
- **Longer stays at HLC than expected.** Because it was originally anticipated that PRSPR clients would be returning to the community immediately when their residential treatment was completed, it was assumed that they would need a clear plan for their return in the 30 days prior to their PRSPR exit. However, many PRSPR clients have chosen to remain at Harbor Light Center (HLC) after their discharge from PRSPR. With an extended stay, this has resulted in a lowered sense of urgency around community care planning.
- **Establishing new partnerships and growing pains.** As stated earlier, the CCP was outside of the normal routine for Salvation Army and RAMS, who not only have their own exit planning tools, but also had not worked closely with each before. The collaborative nature of community care planning has been a challenge, as Peer Navigators, who are only present on site at HLC for two days each week, are not always aware when a participant is to be discharged. The Peer Navigators (who by design are meant to take direction from a clinician) were often waiting for the CCP process to be driven by the Salvation Army Counselors, who may have been expecting the Peer Navigators to drive the process. Many meetings and discussions have been held between the two CBOs to further their partnership and improve outcomes for their clients. Also, as documented in the PRSPR Procedures

document, it was established that, one month prior to planned discharge from residential treatment, Salvation Army was to host a case conference with a Peer Navigator from RAMS to develop the detailed Community Care Plan.

Although there have been some stumbling blocks associated with CCP completion, there were some successes in this area as well. The implementation team work group has had several ongoing discussions about what a “good” community care plan should look like. In November 2018, the work group agenda included CCPs and best practices, and early examples of CCPs were reviewed as a team to discuss their utility and ways in which the form could be redesigned to better equip participants with concrete action steps and connections to their Peer Navigator specifically in support of their goals. As a result, the CCP form was revised, and the ongoing discussions have led to more buy-in and commitment to CCP completion. While not every individual has left HLC with a CCP as of yet, the 100% target is seen as attainable.

Peer Navigation

As planned. Peer Navigators from Richmond Area Multi-Services (RAMS), a non-profit mental health agency committed to advocating for and providing community-based, culturally-competent services, would work with identified participants for 60 days following completion of residential treatment to help them navigate the system, support them in attending appointments, and coordinate with existing providers to ensure that the participant is on track with their care plan. One half-time Peer Navigator would be selected to work specifically with TAY participants.

Progress to date. Through the end of Quarter 7, there was a total of 59 new initiations with Peer Navigators (i.e., first contact within each episode), representing 56 unique clients. (See Table 9.) Because Peer Navigators were primarily responsible for offering support to participants after their completion of PRSPR (estimated to be 3-6 months in length), direct service from RAMS did not begin until Quarter 4. However, services quickly ramped up, and 26 new participants were engaged by Quarter 5. After this initial push, engagement with new participants has slowed down (averaging about 16 per quarter), but this is likely because the Peer Navigator caseloads were full. Overall, each session with participants averaged about 38 minutes, with a standard deviation of 24 minutes.

Table 9: Peer Navigation Initiations, Contacts, and Time Spent by Quarter, Dec 2017- Mar 2019

Quarter	New Initiations	Client Sessions	Minutes/Session
Q2 (Oct – Dec '17)	0	0	-
Q3 (Jan – Mar '18)	0	0	-
Q4 (Apr – Jun '18)	2	2	60
Q5 (Jul – Sept '18)	26	49	39
Q6 (Oct – Dec '18)	15	57	31
Q7 (Jan – Mar '19)	16	68	43
Total	59	176	38

Source: RAMS peer navigation logs

As of the end of Quarter 7 (i.e., March 30, 2019), 44% of peer navigation initiations had an exit date, which suggests that the relationship had ended. Of these completed peer navigation relationships, the average engagement was 105.1 days (or 3.5 months) in length with a standard deviation of 48.5

days (or 1.6 months). The length of the relationships ranged from 5 days to 160 days (or 5.3 months).

While RAMS has been a dedicated program partner, and the Peer Navigators are viewed as assets to the program, peer navigation has experienced many challenges during implementation.

- **Impacted by delays in contracting.** Delays in contracting between SFDPH and the CBOs resulted in a delay to the start date of services by 6 months. The delay in services effected all providers, but especially RAMs because they had to wait another 6 months after the start of the program, when the first group of clients were ready to exit residential treatment and peer navigation could kick in. RAMS could not invoice for their time until first client was served. Two navigators were hired in Oct 2017, but because there was no work for them to do under PRSPR, they were transferred to another project. It was not until July 2018, that the first Peer Navigator (newly hired) began serving clients.
- **Longer stays at HLC then expected.** Much of the initial planning around peer navigation was designed around the idea that participants would have a 3 to 6 month stay in residential treatment, followed by transition into the community with help from their Peer Navigator. However, after services began it became clear that this design does not fit with Salvation Army's traditional residential treatment model that is built around 6 months to 2 years of programming. In fact, even though clients were beginning to successfully exit from PRSPR, very few were actually exiting their treatment at Harbor Light Center, opting instead to commit to the full Salvation Army program under alternative funding streams. Although on the face of things, it is good that Salvation Army is retaining clients, it did create a challenge in that peer navigation, as it was originally envisioned, was not really necessary for most clients.
- **Establishing new partnerships and growing pains.** As stated there have been some challenges in integrating the work between RAMS and Salvation Army. To that end, Salvation Army provided a dedicated space for Peer Navigators at Harbor Light Center which has proved very helpful. However, because there is no shared database that flags PRSPR clients and discharge dates, RAMS began working early on with Salvation Army and HTA to establish some kind of process in sharing client data, but it took time. Also as mentioned earlier, the Peer Navigators, are only present on site at HLC for two days each week, and thus are not always aware when a participant is to be discharged. This challenge was discussed at implementation team work group meetings, and eventually it was decided that Peer Navigators should participate in utilization review meetings and through regular check-ins on-site with Salvation Army counselors to remain apprised of client progress.
- **Role confusion by clients.** There has been confusion among some clients regarding the independent roles of Salvation Army staff and RAMS. During a focus group with PRSPR participants, clients had many questions about what exactly the Peer Navigator was for, how they were different from their Counselor or other Salvation Army staff, and who they were supposed to go to with needs and questions. In part, because the role of Peer Navigator has evolved into something other than what was originally intended, it is not unexpected that there was some related confusion among participants. The role will need to be redefined moving forward, and once it is shaped to best fit within the parameters of the program, it is likely that a lot of the confusion will be cleared up.

"It is an awesome partnership! The Peer Navigators are engaged and responsive. They fit in with the culture here. They participate in case conferencing, and they share their opinions, which are taken seriously. They are fully engaged with both clients and counselors. They have been able to build rapport with the clients and provide advocacy for them because they have been able to establish a comfort level with them that they may not have with other people."

-Salvation Army staff

Despite the aforementioned challenges with Peer Navigation, it is not meant to imply that this aspect of programming is not working. Both parties are working together to reshape and redefine

the role as it pertains to this project. Recent suggestions have included the following ways to modify the peer navigation piece:

- **Connecting Peer Navigators to clients early**, so that they can provide support and advocacy for participants who are just beginning to adjust to programming. The fact that Peer Navigators have lived experience (and for one navigator having graduated from HLC) can provide hope and motivation on the front end so that individuals are more empowered to remain in treatment.
- **Having Peer Navigators facilitate PRSPR group meetings at HLC**, so that participants can tap into the extra support of a common cohort, and seek answers to their programming questions.
- **Encouraging Peer Navigators to be more focused on what is happening during treatment** rather than just focusing on the future, by helping participants navigate through complicated situations, experiences, and emotions inherent to being in residential treatment.

The role of the Peer Navigator will ultimately look different than that which was planned, but all partners have remained highly committed to working with one another and allowing the role to take shape in response to what best fits with program and client needs. The tremendous amount of flexibility and openness to reshaping the role has been of benefit to the program in that it has strengthened partnerships and created a more effective system of support for clients.

In a December 2018 focus group, PRSPR participants were asked about the quality of Peer Navigators and the usefulness of their role. Participants who were familiar with the Peer Navigators agreed that they were “really nice,” and loved the idea of having the extra support, but were not sure exactly what they were there for or how to engage with them. Some representative quotes of this sentiment follow:

“Then I did hear something about they can help you in some areas, maybe funding or something, but it was never discussed anymore. I think they’re doing a good job, but I just need some more information”

“They’re really approachable, but people don’t know that you can go up to them and schedule, like ‘hey I’d like to check in with you’...it’s really easy to do that, it’s just I don’t think a lot of people know that.”

“Even though I’m going to be finishing here in a few weeks, I just did my community care plan, and up until then I had no idea that RAMS was a part of this process.”

-Three PRSPR participants

Overall, it was found that the general impression of Peer Navigators is positive, but more information is needed so that participants can have clearer expectations and know how to utilize their services. The information from the focus group was shared with the implementation team work group, and, as a result, a PRSPR participant pamphlet was created to describe the program (and the corresponding role of the Peer Navigator) in clear and concise terms (a copy of which is included in the Appendix). Feedback about the pamphlet so far has been positive, and partners have stated that they are distributing it and using it to better facilitate their communication with clients.

TAY linkage and services.

As planned. Felton Institute (FI) is a social services organization that delivers evidence-based social/mental health services, including intensive clinical case management, outpatient services, and home visits. A Masters-level Clinician from FI would provide additional support to Transitional Age

Youth (TAY) receiving treatment services at Salvation Army as clinically indicated through specific clinical case management, developmentally appropriate treatment groups based in wellness recovery, evidence-based SUD treatment, outreach and linkage to care. To support Salvation Army in the delivery of treatment, FI would assist with the development of a TAY specific curriculum for Substance Use Disorder treatment services. FI would also collaborate with the existing TAY Mental Health Linkage Team to conduct outreach, prevention, and linkage services for TAY in the community struggling with substance use, regardless of whether they enroll in services or not.

Progress to date. One of the biggest challenges to client flow was the delay in hiring the TAY Clinician. The first TAY Clinician was hired in Quarter 3 (Jan – Mar 2018), and then resigned in Quarter 4 (Apr – Jun 2018), due to personal reasons. Then, it was not until Quarter 8 (Apr – Jun 2019) that the second TAY Clinician was hired. This had a negative impact on the work of RAMS Peer Navigators with TAY, as their TAY-focused Peer Navigator could not be hired until there was a Clinician on board long enough to offer them the guidance and supervision that they needed. Collectively, these delays have left long periods of time during which the TAY population were not receiving extra support or promised case management services. The delays have also left long periods of time during which grant funds were not expended. As a result, a no-cost extension (until August 31, 2021) was requested and has already been accepted. It is expected that now that all positions have been filled, TAY linkage and services will quickly fall into place and be implemented much as it was originally envisioned.

During the brief period when the first TAY Clinician was on board, a total of 14 TAY clients were served. As shown in Table 10, approximately three-fourths of TAY served were male, and primarily White (50%) or African American/Black (36%).

Table 10: Demographics of TAY engaged by Felton through PRSPR, Dec 2017- Mar 2019

	All TAY Engaged w/ Felton through PRSPR (N=14)
Gender (%)	
Female	21.4%
Male	78.6%
Race/Ethnicity (%)	
African-American/Black	35.7%
Hispanic/Latinx	14.3%
White	50.0%

Source: Felton Institute case logs

Six of the 14 TAY enrolled in residential treatment at Harbor Light Center (1 of whom had been referred directly by the TAY Clinician), and received extra support from the Felton case manager during their stay. To all TAY clients served, the TAY Clinician provided group psychology, general case management, assessments, and referrals. Overall in that short period, 305 hours of service were provided, that included 145 group psychology contacts, 40 case management contacts, 2 assessments, and 19 referrals during his time with PRSPR. In addition, he initiated five outreach activities (for CASC, the Larkin Street TAY Shelter, Larking St. REUTZ, and the Larkin Street Drop-in Center), through which 12 staff and 42 TAY were engaged. The services provided during

this brief time period suggest that there is a capacity for Felton to make strong contributions to the TAY population as long as a case manager is on board and, ideally, retained.¹³

Flexible “Flex” Funds

As planned. San Francisco Public Health Foundation (SFPHF) is the fiscal sponsor responsible for managing payment for project-related expenses such as office supplies, travel vouchers, document support, and “flex” funds for participants (e.g., bus tokens, clothing, food, ID cards, incentives, etc.), under the direction of DPH. All partners were notified that they must follow the guidelines of the DPH Health and Food Expenditure Policy, seek approval from DPH for any single expenditure over \$250, and seek approval from the Board of State and Community Corrections for any expenditure over \$1,000. Partners were asked to submit detailed, line-item requests for all flex fund expenditures on at least a monthly basis, and all requests must receive approval from both SFDPH and the PHF before reimbursement is granted (which, to date, has always happened in a timely manner). Only BSCC-eligible project expenses can be approved by SFPHF, and all partners requesting funds were expected to maintain documentation of all costs claimed and reimbursed. In general, the purpose of flex funds was defined as providing additional support for meeting an individual’s wellness and recovery goals, at the discretion of the counselor, clinician, or peer navigator.

“PRSPR has helped me a lot. With my leg I have to have it elevated at night, and here we are short on pillows, and if it wasn’t for PRSPR I wouldn’t have been able to get extra pillows at Ross.”

-PRSPR participant

Progress to date. Funds have been requested from all three direct service providers for PRSPR (Felton Institute, RAMS and Salvation Army). However, Salvation Army, who has the longest relationship with clients, has likewise, been the highest utilizer of flex funds. Based on PHF expense records dated through Quarter 7, a rough estimate of the money spent per PRSPR client averaged about \$177. (See Table 11.) By order of predominance, clothing (socks, underwear and possibly work clothes), transportation (BART, Muni), and snacks (at Salvation Army’s Canteen) have been the biggest needs filled for clients through flex funds.

Table 11: Flex Fund Expenditures by Type of Expense, Dec 2017- Mar 2019

Expense Type	\$ Expended	\$ per Admit ¹⁴
Clothing	\$8,514	\$68
Public Transportation	\$6,898	\$55
Snacks	\$4,026	\$32
Misc.	\$1,911	\$15
Medical Supplies & Services	\$447	\$4
Fees for IDs, birth certs	\$255	\$2
Toiletries	\$188	\$1
Total	\$22,240	\$177

Source: PHF Expense records

¹³ At the time of writing this report, a new case manager had been hired and was starting to engage with clients.

¹⁴ 126 admits (social detox and/or residential treatment) from Dec 2017 thru March 2019

By design, parameters around flex fund spending were kept somewhat loose to allow for funding to address individual client needs, especially in support of their program goals. However, the parameters of flex funds have been an ongoing source of confusion for the partners, especially Salvation Army, as well as PRSPR clients.

- **Flex fund priorities.** Discussions about flex funds were built into implementation team work group meeting agendas, and while it was generally agreed that priorities should be given to transportation (muni cards), basic needs (not already provided by Salvation Army), and hospitality (e.g., a cup of coffee during meetings with clients), the group also suggested other possibilities (i.e., dental work, DUI classes, tuition fees, etc.), which would need to be determined on a case-by-case basis. However, SFDPH pointed out that if flex funds were directed to more expensive priorities, then there would be less available for basic needs.
- **Fair and equal use of flex funds.** It can be challenging to distribute funds fairly to clients. As program participants have begun to hear about different ways in which their peers have been supported, they have expressed some suspicions about the ways in which funds are allocated. During a focus group with the program evaluator, participants had many questions about how much in flex funds they were “owed,” or they expressed suspicion that HLC staff were “playing favorites” on who got more expensive expenses covered (i.e., DUI classes, dental work). Clients had been told that “additional support for meeting your individual wellness and recovery goals may be available, as determined with your counselor¹⁵,” but this still leaves some room for misconceptions and confusion. Many stated the desire for a hard number.

The San Francisco Public Health Foundation (PHF), who is the fiscal agent in charge of flex funds, did not attend quarterly implementation team work group meetings, and did not provide input about how the flex fund money should be spent. However, they did provide guidance on how to track expenditures and what was an exclusionary expense item. Partners have submitted all documentation as required for reimbursement, and have expressed satisfaction with the pace at which reimbursements have been made.

Evaluation Findings: Outcomes

Preliminary Recidivism Outcomes

Of 69 unduplicated individuals who exited residential treatment by March 30, 2019, there were a total of 28 individuals with arrest data in the San Francisco City and County District Attorney’s records spanning from October 2014 through December 2018. These arrest records are only of arrests occurring in San Francisco City and County, and do not include warrants for arrests in other cities or counties. Ostensibly if an individual’s data was not in the arrest records file, then they had not been arrested in San Francisco during the time period studied.

Among the 28 unique clients with arrest data, 25 clients had an average of 2 arrests before enrolling in residential treatment, with a range of 1 to 7 arrests, and 4 clients had at least 1 arrest after their treatment exit date, with a range of 1 to 3 arrests. For these 4 clients, the length of time from discharge from residential treatment to arrest, on average, was 120 days (or 4 months). Only 1 had been convicted and sent to County Jail; the remainder has their charges dismissed (n=2) or the case was still open (n=1) at the time of the analysis.

¹⁵ Promoting Recovery and Services for the Prevention of Recidivism (PRSPR) program brochure (2019).

None of the clients with records of arrest and/or conviction after exit from residential treatment had completed the program successfully. Among successful completers there have been 0 arrests and 0 convictions to date. However, because many of the successful completers remained at Harbor Light Center following their time with PRSPR, they are still receiving support services and have not yet had enough time back in the community to contribute to a fair measure for recidivism. Recidivism data will be revisited at the end of the grant-funded period, at which point more participants will have been out in the community for longer periods of time.

Preliminary Client Quality of Life Outcomes

As specified in the logic model, it was anticipated that an improvement in the client's quality of life outcomes, such as, changes in sense of well-being and criminal mindset as a result of a treatment, as well as the client's overall satisfaction with program services would have an impact on more distal client outcomes, such as reduced recidivism. To this end, the evaluation has also included the implementation of pre-/post- surveys and focus groups to help measure change in these particular areas over time.

Sense of Wellbeing

To measure client's change in sense of wellbeing from the start of the program to the finish, HTA designed a pre-/post- Wellbeing Survey to be completed by program participants at program intake, and at exit (whether successful or not). The instrument includes:

- 5 items measuring **satisfaction and confidence** about various aspects of life: finances, housing, substance use, happiness, and general satisfaction (each of which used a Likert scale, with 1= strongly disagree and 5= strongly agree);
- 1 item in which clients ranked the **perceived quality of their lives** on a Likert scale with 1= worst possible life to 6= best possible life); and
- 20 items on **positive and negative affect** from the Positive and Negative Affect Schedule (PANAS) questionnaire¹⁶, designed to measure positive affect and negative affect¹⁷. The scores from each item is summed into a positive affect scale and negative affect scale, which range from 10-50. Positive affectivity refers to positive emotions and expression (i.e., cheerfulness, pride, enthusiasm), whereas negative affectivity refers to negative emotions and expression (i.e., sadness, disgust, fear).

As of the end of Quarter 7, only 10 participants completed both the pre- and post- Wellbeing Surveys. Paired sample t-tests were conducted for each scale item and the results are presented in Table 12.

For the first five items on the survey (meant to measure satisfaction and confidence), a higher mean is more desirable. Among the ten respondents, there was an overall increase on all satisfaction and confidence items, one of which (housing situation) was significant. There was also an increase in perceived quality of life ranking, although it was not significant. For affectivity, there was an increase in positive affect and emotions (not significant), and a statistically significant decrease in negative affect and emotions (which is more desirable). Although only completed by a small sample of

¹⁶ Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: the PANAS scales. *Journal of personality and social psychology*, 54(6), 1063.

¹⁷ Positive and negative affect scales can range from 10 to 50.

program completers at this time, these preliminary results suggest that participation in PRSPR is leading to an improved sense of wellbeing for clients.

Table 12: Pre-/Post- Wellbeing Results, Dec 2017- Mar 2019 (n=10)

Item	Pre (Mean)	Post (Mean)	Change Score	p-value
Satisfaction & Confident with Life (Scale: 1-5)				
I am satisfied with my current financial situation.	1.90	2.10	+0.2	.726
I am satisfied with my current housing situation.	2.30	3.60	+1.3	.039*
I am confident that I can maintain sobriety.	4.00	4.20	+0.2	.343
All things considered; I am happy.	3.90	4.10	+0.2	.678
Overall, I am satisfied with my life as it is right now.	2.40	3.40	+1.0	.063
Perceived Quality of Life (Scale: 1-6)				
Life Ranking	2.70	3.60	+0.9	.185
Affectivity Score (Scale: 10-50)				
Positive Affect Sum Score	31.40	35.90	+4.50	.175
Negative Affect Sum Score	26.20	18.60	-7.60	.029*

Source: HTA Wellbeing surveys

*Statistically significant at the .05 level.

Criminal Mindset

To measure criminal mindset, a modified version of the Criminal Thinking Scale (CTS)¹⁸ was utilized. The CTS was designed by researchers at Texas Christian University to measure concepts of special significance in treatment settings for correctional populations: entitlement, justification, personal irresponsibility, power orientation, cold heartedness, and criminal rationalization. Because the target population served by PRSPR has had contact with the corrections system at some point in their lives, it was determined that this instrument could be an effective tool to help measure any possible change in criminal mindset of program participants. Based on feedback from the CBOs and SFDPH, only four of the six scales were selected for the evaluation. All items were used for the following three scales: cold heartedness, power orientation, entitlement. Only 3 of 6 items were used for the fourth component: justification.

Table 13: Pre-/Post- Criminal Mindset Results, Dec 2017- Mar 2019 (n=8)

Scale Scores (Scale: 10-50)	Pre (Mean)	Post (Mean)	Change Score	p-value
Cold Heartedness	23.00	21.25	-1.75	.514
Power Orientation	23.57	18.21	-5.36	.078
Entitlement	16.04	14.79	-1.25	.510
Justification	19.58	15.42	-4.17	.049*

Source: Texas Christian University Criminal Thinking Scale (CTS) - adapted

*Statistically significant at the .05 level.

¹⁸ Institute of Behavioral Research. (2007). *TCU Criminal Thinking Scales (TCU CTS Form)*. Fort Worth: Texas Christian University, Institute of Behavioral Research. Available at ibr.tcu.edu

To date, eight participants completed both pre and post CTS surveys. Paired sample t-tests were conducted for each scale item and the results are presented in Table 13.

A decrease in the mean scale scores is more desirable as it indicates a reduction in criminal thinking for the particular component. Overall, means decreased for each of the four scales from pre- to post-. However, only the change in justification was statistically significant, and this scale was not used in its entirety. Although trending in the right direction, much of the change at this time can really only be attributed to chance as much as anything else at this time.

Satisfaction with Program Services

Finally, to measure overall client satisfaction, HTA conducted a focus group with 24 PRSPR participants at Harbor Light Center on December 3, 2018 (Quarter 6). Questions were crafted around different components of the program (e.g., the enrollment process, Peer Navigators, Community Care Plans, etc.) with a focus on identifying program strengths and weaknesses, and levels of satisfaction.

Participants were universally appreciative of the PRSPR program and the services that were being provided for them.

"It takes a whole lot of load off me personally knowing that PRSPR is actually assisting me in being here for my first six months. That's a bit weight off my shoulders."

-PRSPR Participant

Of course, there were some frustrations. Among those that were most commonly cited, participants mentioned that they were often bored, and felt that classes were sometimes "mundane" and "repetitive." Some expressed a desire for more relevant, in-depth classes covering topics such as:

"...[The] outcomes of drug use, health aspects, we need clear info – being confronted with the reality of use and where things could go – understanding the impact on both body and brain."

-PRSPR participant

Among other common weaknesses cited, nearly all participants wanted to address aspects of their return to the community (e.g. housing, employment, etc.) earlier in the program; and several were frustrated with some of the program rules (although there were none that they could not live with). However, the biggest weakness cited was a lack of clarity about what it really meant for someone to "be in PRSPR." Participants all knew that they were a part of something special, but were not clear about the details and the benefits. They suggested having a "PRSPR Liaison" or "PRSPR-specific meetings," to help them navigate through programming and not have to search independently for answers to their questions.

"I would like to have a clear understanding of what PRSPR is providing me that I may not know about."

-PRSPR participant

Despite some frustrations and some confusion about programming, by far comments from focus group participants were positive, and expressed high levels of satisfaction with PRSPR. Although

there was agreement that the program might not be a good fit for everyone, for those who felt well-matched and had stayed with the program, the benefits that they received from the program were multifaceted and frequently powerful.

"I love the part that I can still live in the city that I love and actually not be on the streets and not have to be placed in dangerous situations, just to stay where I want to."

"All around, getting the time to work on one's personality is a big thing because if you are outside working or if you are homeless, either/or, you are too busy to work on yourself. And so being able to sit down and really get to your priorities...because it is a constant struggle, so you don't know what you really want, you are basically just surviving...so knowing what you want and how you want to accomplish things is a very good way to learn how to live, and this gives you the time to learn that."

"I think what I like most about this program is the fact that I have hope back in my life. It's kind of like a fresh start, but I get to utilize everything that I have learned here and just to boost myself into the direction I want to go, and I can feel it actually starting to happen, like pieces falling into place. And like how to act and how to carry myself, and that is due to this program and the stuff that I learned here. It is definitely a lot better, and I would never have had that opportunity if I wasn't here."

-Three PRSPR participants

Some participants received unexpected benefits from the program, and were changed in ways that they would have never imagined.

"It's a safe place here. I've never felt safe before in my life."

"And I have learned to love to read, I have read many books, and I haven't read a book since high school, maybe actually middle school. I have read many books since I have been here...I never thought I would enjoy reading."

"I would say for me it is spirituality, establishing a connection with my higher power, the good food, that definitely helps a lot. Everything is provided for us to succeed. They give us everything that we need to succeed. I have never done cardio in my life, I used to look at people that do cardio as like freaks and lames and weird people, and now I am doing cardio, so that is something I have never done. I have never jogged before!"

-Three PRSPR participants

And for many, the program has been empowering.

"I think for me, my biggest support is me, myself. I definitely have help along the way, but the bulk of it rests on me, to make the right decisions, to persevere, to stay confident, to keep my morale up. Plus a higher power, there is something helping me out along the way, definitely, but the bulk of it is on me. Like 90%, maybe more than 90%, is on me to do the right thing. The help I get is like, 'maybe you should try this.' Something like that, like real subtle, and then I do it and it becomes very beneficial."

"The goals that I have set are obtainable; they are not dreams, they are not fantasies. And the reason I think I will be able to obtain those goals is because I have become brutally honest with myself, with my sponsor, I have worked my fourth and fifth step, and what that is I have taken my

own inventory and I have been honest with him about my triggers and about things that have come up, and a huge part, the reason I have been able to be honest, is because I have forgiven myself. Because the person that was using, drinking, and drugging, that is not who my higher power intended me to be, and I have come to forgive myself.”

-Two PRSPR participants

HTA will try to reconnect with these PRSPR participants at later points in their journeys to see if the optimism remains, but at this point in their journey, they had some compelling statements to make, and there was no doubt that their experience with PRSPR had left most of them in a better place.

Conclusion and Next Steps

Is the project working as intended?

Despite some challenges and growing pains, the PRSPR program is, to a large degree, working as intended. Of the eight project objectives, five have been met, and three are close to being met. Some slight adjustments to programming have been made in response to on-the-ground experience, including revisions to the referral process, adaptations to service delivery in response to participants remaining in treatment beyond their time in PRSPR, and the corresponding reinvention of some roles such as that of the peer navigator. However, despite these changes, the fundamental program model remains intact and program partners are driven to deliver services as promised as part of a coordinated system of care.

Next Steps

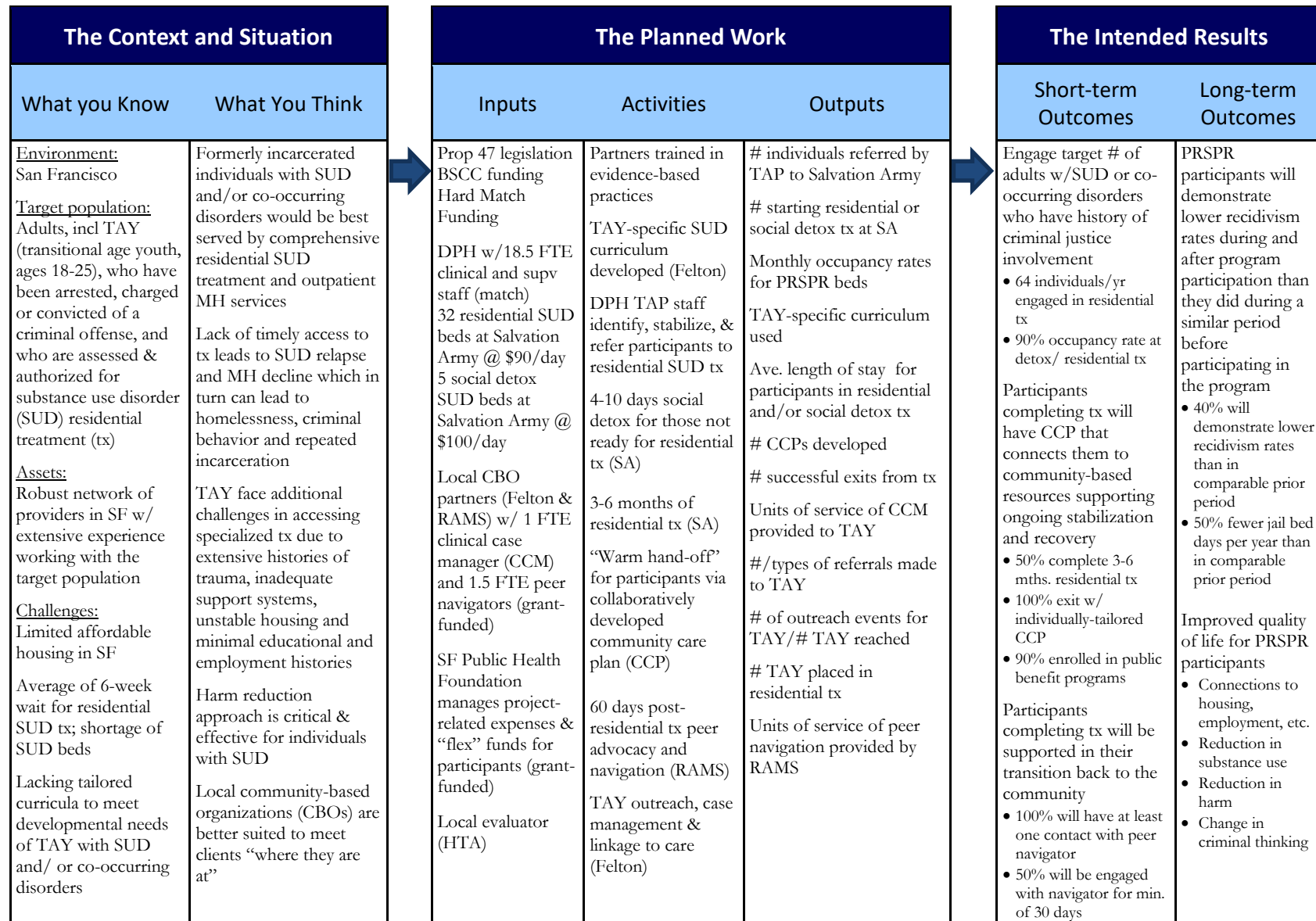
Because of the delays in programming (and, thus, the expenditure of funds), a no-cost extension (until August 31, 2021) was requested and has already been accepted. At this point in time many of the pieces of the PRSPR program seem to have fallen into place, and partners are well-positioned to deliver services with fewer delays and challenges.

In addition, lessons learned from this first cohort of Prop 47 funding were applied to a new program model (Supporting Treatment and Reducing Recidivism or STARR) that was written into a grant application for the second cohort of Prop 47 funding. This new model builds upon many of the services that are already being delivered under PRSPR, and enhances them through the integration of drop-in and outpatient services. The grant for the second cohort of funding was awarded to SFDPH and STARR programming will run concurrently to PRSPR until the end of the no-cost extension period, at which point some services (e.g., TAY-specific support, peer navigation) will come to a conclusion and others (e.g., detox, residential treatment) will be sustained through 2022.

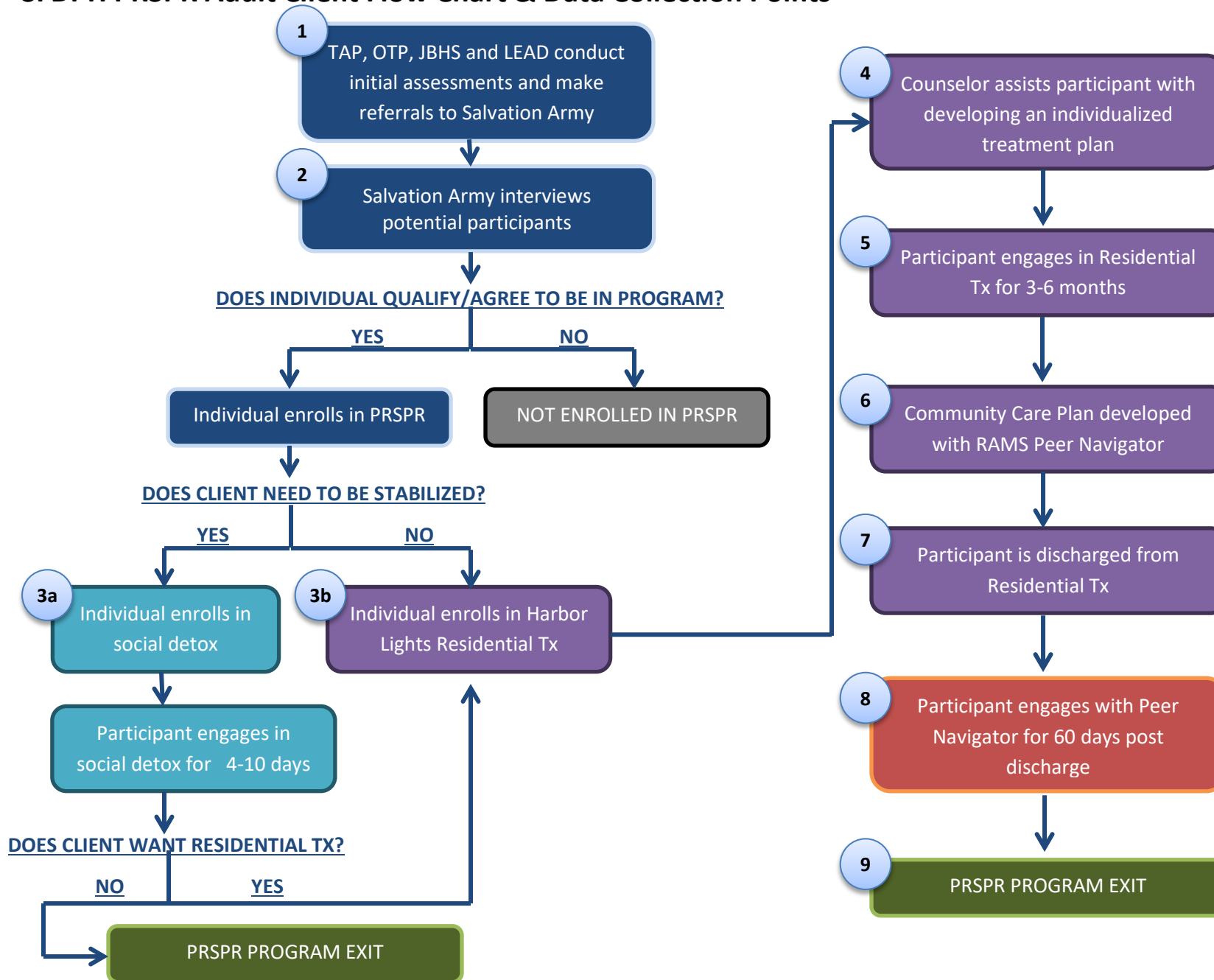
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PRSPR Logic Model (10/04/17)



SFDPH PRSPR Adult Client Flow Chart & Data Collection Points



SFDPH PRSPR Adult Client Flow Chart & Data Collection Summary

Phase 1/2 –Referral and Intake	
SFDPH Programs: <ul style="list-style-type: none"> • TAP¹ • OTP² • JBHS³ • LEAD⁴ 	<ul style="list-style-type: none"> • Avatar (pre-admit) • ASAM assessment • Consent and authorization forms • Salvation Army Application (p1) and Health Questionnaire • Salvation Army Referral Coversheet • PRSPR SFDPH Case Log
Salvation Army	<ul style="list-style-type: none"> • Salvation Army Intake Interview
Phase 3 – Enrollment	
Salvation Army Social Detox	<ul style="list-style-type: none"> • Avatar (for enrollment numbers & daily census) • Salvation Army Case Log
Salvation Army Harbor Lights Residential Treatment	<ul style="list-style-type: none"> • Avatar (for enrollment numbers) • Salvation Army Case Log • PRSPR Intake Packet <ul style="list-style-type: none"> a. PRSPR Intake Form b. Wellbeing Survey c. Criminal Thinking Scales Survey
Phase 4 – Individualized Case Planning	
Salvation Army Harbor Lights Residential Treatment	<ul style="list-style-type: none"> • Salvation Army Treatment Plan
Phase 5 – Residential Treatment Services	
Salvation Army Harbor Lights Residential Treatment	<ul style="list-style-type: none"> • Avatar (for daily census) • Salvation Army Case Log

¹ Treatment Access Program

² Offender Treatment Program

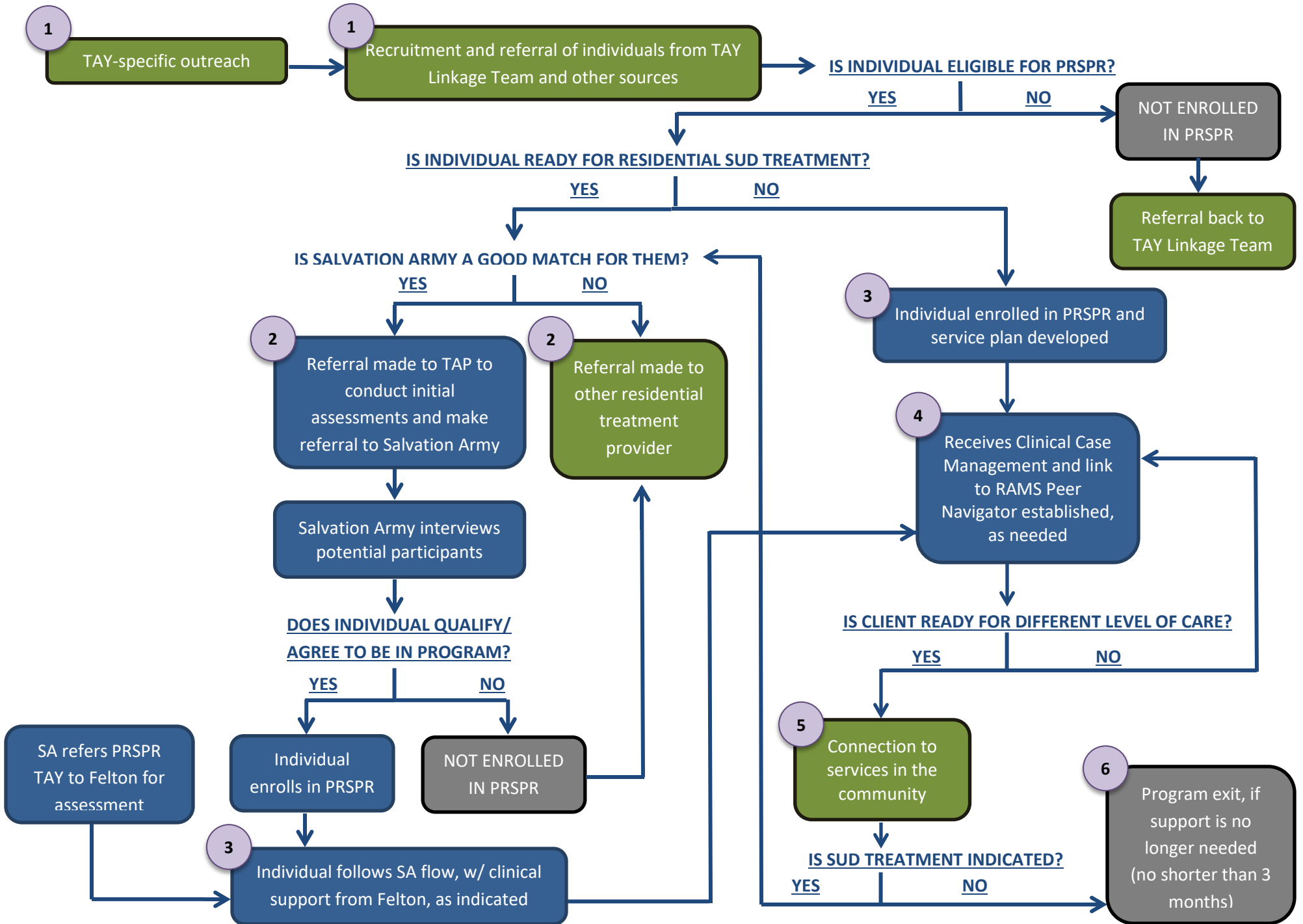
³ Jail Behavioral Health Services

⁴ Law Enforcement Assisted Diversion

SFDPH PRSPR Adult Client Flow Chart & Data Collection Summary

Phase 6 – Community Care Planning/Planned Exit	
<ul style="list-style-type: none"> • Salvation Army Harbor Lights Residential Treatment • Richmond Area Multi-Services (RAMS) 	<ul style="list-style-type: none"> • Community Care Plan
Phase 7 – Exit from Residential Treatment	
Salvation Army Harbor Lights Residential Treatment	<ul style="list-style-type: none"> • Salvation Army Case Log • PRSPR Discharge Packet <ul style="list-style-type: none"> a. PRSPR Outcomes Form b. Wellbeing Survey c. Criminal Thinking Scales Survey
Phase 8 – Peer Navigation Support	
Richmond Area Multi-Services (RAMS)	<ul style="list-style-type: none"> • RAMS Case Log • RAMS Peer Service Logs • Empowerment Service Plan • PRSPR Member/Navigator Surveys
Phase 9 – Program Exit/ Follow-up	
Hatchuel Tabernik & Associates (HTA)	<ul style="list-style-type: none"> • PRSPR Follow-up Packet <ul style="list-style-type: none"> a. PRSPR Outcomes Form b. Wellbeing Survey c. Criminal Thinking Scales Survey • Recidivism Data (collected every six months post-exit)

SFDPH PRSPR Alternative TAY Client Flow Chart & Data Collection Points



SFDPH PRSPR Alternative TAY Client Flow Chart & Data Collection Summary

Phase 1 - Outreach	
Felton	<ul style="list-style-type: none"> • # of Outreach activities • Description of outreach activity (i.e event, organizational support, education, street outreach, etc...) • Approximate TAY reached, when applicable • Organizations reached, when applicable • # of referrals from TAY Linkage Team and other sources
TAY Linkage Team	<ul style="list-style-type: none"> • Referral to Felton – form/packet?
Phase 2 – Referrals to Residential Treatment	
Felton	<ul style="list-style-type: none"> • # of referrals made to Residential Tx providers • Names of provider receiving referral • If other than Salvation Army, why? • Treatment recommendation (i.e. level of care, services needed, etc...) – from TAP?
Salvation Army	See flow for SA residential treatment
Phase 3 – Clinical Case Management	
Felton	<ul style="list-style-type: none"> • Assessment for clinical needs • # served • Demographics • Service Log: <ul style="list-style-type: none"> ○ Service type (e.g., service plan development, care coordination, referrals, etc.) ○ Time spent with client (minutes and contacts) • Client Status • Medi-Cal enrollments • Items from SA Outcomes (benefits, housing, employment, etc...)
Phase 4 – Care Plan	
Felton	<ul style="list-style-type: none"> • Service Plan developed (copies shared) • Date Service Plan developed
RAMS	<ul style="list-style-type: none"> • Service logs
Phase 5 – Connection to Services	
Felton	<ul style="list-style-type: none"> • Referrals made
Phase 6 – Program Exit	
Felton	<ul style="list-style-type: none"> • # of successful and unsuccessful exits



PRSPR- Prop 47

Promoting Recovery and Services for the Prevention of Recidivism (PRSPR) PROCEDURES | MAY 2019

San Francisco has been chosen as a recipient of a Board of State and Community Corrections (BSCC) grant to implement a Prop 47 program. This grant is funded for 6 million dollars for 38 months (June 16, 2017-August 15, 2020).

This program is designed to provide additional Substance Use Disorder (SUD) Treatment services for individuals who have been arrested for, charged with, or convicted of a criminal offense. This grant will fund 32 residential SUD treatment beds (3-6 month stay), as well as 5 social detox beds, at Salvation Army Harbor Light. Peer navigators will also support participants who successfully complete the program for 60 days after discharge. Additionally, in order to better meet the SUD treatment needs of Transitional Age Youth (18-25 year olds) in our system of care, this program will provide increased clinical support to TAY participants, as well as supporting the development of TAY specific curriculum at the residential treatment program.

I. Goals

- a. Engaging adults with a Substance Use Disorder or co-occurring disorders who have a history of involvement with the criminal justice system
- b. Developing a community plan of care that connects participants to community based resources for all participants who have a planned exit from the program
- c. Demonstrating lower recidivism rates during and after program participation

II. PRSPR Partners

- a. Department of Public Health
 - i. Responsible for administering the grant
 - ii. Responsible for assessing appropriateness for services under the grant
 - iii. Responsible for Utilization Management through Transitions
- b. Salvation Army
 - i. Responsible for providing SUD residential and social detox services for grant participants
- c. Richmond Area Multi Services (RAMS)
 - i. Responsible for providing peer navigation and support for participants who successfully complete the program
 - ii. Will support participants to connect with the evaluation team after discharge to complete program instruments
- d. Felton Institute
 - i. Responsible for providing TAY specific services for participants enrolled in Salvation Army



PRSPR- Prop 47

- ii. Responsible for providing support to Salvation Army to develop a TAY specific curriculum
 - iii. Responsible for outreach and prevention services for the TAY population regardless of their enrollment in services
 - iv. Responsible for providing linkage support for the TAY population to ongoing care
- III. Referrals for SUD Residential Treatment or Detox
 - a. Treatment Access Program (TAP)
 - i. TAP will assess individuals for appropriateness to enter the program by
 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 2. Completing the DSM-5 Checklist and Diagnosis
 3. Reviewing and documenting the presence of contact with the San Francisco County Jail via the Coordinated Case Management System (CCMS)
 4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
 6. Providing a current medication list and TB Clearance
 7. Reviewing the consent and authorization forms for the program
 8. Supporting enrollment for MediCal or Healthy San Francisco (individuals do not need MediCal to participate in the program, but should be encouraged to meet with an eligibility specialist if available)
 - ii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax and follow up with an email to ensure receipt by the intake coordinator) to the Salvation Army Intake Coordinator (Angel Carter, Angel.Carter@usw.salvationarmy.org, Fax 415-861-4261) and PRSPR@sfdph.org for processing
 - iii. Each referral source will be responsible for coordinating with the Salvation Army Intake Coordinator via email (Angel.Carter@usw.salvationarmy.org, 415-503-3054) to schedule an assessment to determine appropriateness for admission
 - iv. The staff member who will be the contact person at TAP will be **Angel Cassidy** (415-503-4738, angel.cassidy@sfdph.org)
 - b. Offender Treatment Program (OTP)
 - i. OTP will assess individuals for appropriateness to enter the program by
 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 2. Completing the DSM-5 Checklist and Diagnosis



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3. Reviewing and documenting the presence of contact with the San Francisco County Jail via the Coordinated Case Management System (CCMS)
4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
6. Providing a current medication list and TB Clearance
7. Reviewing the consent and authorization forms for the program
- ii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax and follow up with an email to ensure receipt by the intake coordinator) to the Salvation Army Intake Coordinator (Angel Carter, Angel.Carter@usw.salvationarmy.org, Fax 415-861-4261) and PRSPR@sfdph.org for processing
- iii. Each referral source will be responsible for coordinating with the Salvation Army Intake Coordinator via email (Angel.Carter@usw.salvationarmy.org, 415-503-3054) to schedule an assessment to determine appropriateness for admission
- iv. The staff member who will be the contact person at OTP will be **Jimmy Vi (415-241-4270, jimmy.vi@sfdph.org)**
- c. Jail Behavioral Health Services (JBHS)
 - i. JBHS will assess individuals for appropriateness to enter the program by
 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 2. Completing the DSM-5 Checklist and Diagnosis
 3. Reviewing and documenting the presence of contact with the San Francisco County Jail via the Coordinated Case Management System (CCMS)
 4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
 6. Providing a current medication list and TB Clearance
 7. Reviewing the consent and authorization forms for the program
 - ii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax and follow up with an email to ensure receipt by the intake coordinator) to the Salvation Army Intake Coordinator (Angel Carter, Angel.Carter@usw.salvationarmy.org, Fax 415-861-4261) and PRSPR@sfdph.org for processing



PRSPR- Prop 47

- iii. Each referral source will be responsible for coordinating with the Salvation Army Intake Coordinator via email (Angel.Carter@usw.salvationarmy.org, 415-503-3054) to schedule an assessment to determine appropriateness for admission
- iv. The staff member who will be the contact person at JBHS will be **Rachel Bartel** (415-734-3261, rachel.bartel@sfdph.org)
- d. Law Enforcement Assisted Diversion (LEAD)
 - i. The LEAD DPH Intake clinician will assess individuals for appropriateness to enter the program by:
 - 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 - 2. Completing the DSM-5 Checklist and Diagnosis
 - 3. Reviewing and documenting the presence of contact with the San Francisco County Jail via the Coordinated Case Management System (CCMS)
 - 4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 - 5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
 - 6. Providing a current medication list and TB Clearance
 - 7. Reviewing the consent and authorization forms for the program
 - ii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax and follow up with an email to ensure receipt by the intake coordinator) to the Salvation Army Intake Coordinator (Angel Carter, Angel.Carter@usw.salvationarmy.org, Fax 415-861-4261) and PRSPR@sfdph.org for processing
 - iii. Each referral source will be responsible for coordinating with the Salvation Army Intake Coordinator via email (Angel.Carter@usw.salvationarmy.org, 415-503-3054) to schedule an assessment to determine appropriateness for admission
 - iv. The staff member who will be the contact person at LEAD will be **Nicole Brooks** (415-489-7314, nicole.brooks@sfdph.org)
- e. Felton PRSPR Transitional Age Youth Case Manager
 - i. The Felton PRSPR Transitional Age Youth Case Manager will assess individuals for appropriateness to enter the program by:
 - 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 - 2. Completing the DSM-5 Checklist and Diagnosis
 - 3. Reviewing and documenting the presence of contact with the San Francisco County Jail via the Coordinated Case Management System (CCMS)



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4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
 6. Providing a current medication list and TB Clearance
 7. Reviewing the consent and authorization forms for the program
 - ii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax and follow up with an email to ensure receipt by the intake coordinator) to the Salvation Army Intake Coordinator (Angel Carter, Angel.Carter@usw.salvationarmy.org, Fax 415-861-4261) and PRSPR@sfdph.org for processing
 - iii. Each referral source will be responsible for coordinating with the Salvation Army Intake Coordinator via email (Angel.Carter@usw.salvationarmy.org, 415-503-3054) to schedule an assessment to determine appropriateness for admission
 - iv. The staff member who will be the contact person at Felton PRSPR Transitional Age Youth Case Manager will be **PENDING**.
- f. Community Justice Service Center
- i. A DPH Team Member from Drug Court or the Community Justice Center Collaborative Courts will assess individuals for appropriateness to enter the program by:
 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 2. Completing the DSM-5 Checklist and Diagnosis
 3. Reviewing and documenting the presence of contact with the San Francisco County Jail via the Coordinated Case Management System (CCMS)
 4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
 6. Providing a current medication list and TB Clearance
 7. Reviewing the consent and authorization forms for the program
 - ii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax and follow up with an email to ensure receipt by the intake coordinator) to the Salvation Army Intake Coordinator (Angel Carter, Angel.Carter@usw.salvationarmy.org, Fax 415-861-4261) and PRSPR@sfdph.org for processing
 - iii. Each referral source will be responsible for coordinating with the Salvation Army Intake Coordinator via email (Angel.Carter@usw.salvationarmy.org, 415-503-3054) to schedule an assessment to determine appropriateness for admission



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- iv. The staff member who will be the contact person at CJSC will be **Jeannie Killmer (415-202-2816, jeannie.killmer@sfdph.org)**
- g. Salvation Army
 - i. In situations where Salvation Army is sending an individual to another referral agency (e.g., TAP, OTP, LEAD) for authorization (Salvation Army will inform the referral agency if Health Screening, medication list, and TB Clearance have been completed), the authorizing agency will assess individuals for appropriateness to enter the program by:
 - 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 - 2. Completing the DSM-5 Checklist and Diagnosis
 - 3. Reviewing and documenting the presence of contact with the San Francisco County Jail
 - 4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 - 5. Reviewing the consent and authorization forms for the program
 - ii. The Salvation Army Intake Coordinator will determine appropriateness to enter the program by:
 - 1. Completing the DPH Level of Care/ASAM Screening indicating the need for social detox or residential treatment within the last 60 days
 - 2. Completing the DSM-5 Checklist and Diagnosis
 - 3. Reviewing and documenting the presence of contact with the San Francisco County Jail
 - 4. Supporting individuals in completing the PRSPR Referral Form for Detox or Residential Treatment
 - 5. Supporting individuals in completing the Salvation Army Application-Health Screening for Residential Treatment
 - 6. Providing a current medication list and TB Clearance
 - 7. Reviewing the consent and authorization forms for the program
 - iii. These referral documents will be sent via secure email (if secure email is not available, you can send documents by secure fax) to the Treatment Access Program and PRSPR@sfdph.org for authorization and processing
- h. Additional Referral Sources
 - i. Given current programmatic structure, direct referrals will only be accepted by the aforementioned referral sources at this time
 - ii. In the event that there is a potential PRSPR candidate who is eligible to be released to residential treatment (e.g., there is a legal disposition allowing for placement, individual is sentenced to time serveable in a program, individual is a participant in a collaborative court) an email requesting evaluation, including



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information related to an individual's eligibility for placement, should be sent to PRSPR@sfdph.org

- i. If participant is determined to be appropriate and eligible for residential services through PRSPR, the following will occur
 - i. **All referral packets will be sent via secure email to Salvation Army intake coordinator, as well as PRSPR@sfdph.org for data collection purposes**
 - ii. Salvation Army will notify referral party and PRSPR@sfdph.org of a move in date
 - iii. Salvation Army Responsibilities
 1. Salvation Army will conduct a Background Check immediately upon receiving the referral packet
 2. Salvation Army Intake Coordinator will inform the referral source that they received the referral within 2 business days
 3. Salvation Army Intake Coordinator will review the application and attempt to complete all interviews with participants for admission to services within 5 business days. If there will be a delay, the referral source will be notified
 4. Salvation Army Intake Coordinator will inform the referral source of the outcome of the interview within 2 business days
 5. Salvation Army Intake Coordinator will send a weekly update to the designated contact from each referring agency to provide updates on referrals and timeline for placement. It will be the responsibility of that individual to disseminate the information to the remainder of their staff
- j. Exclusions for Acceptance
 - i. Salvation Army may exclude some participants due to types of charges in their history. These charges are listed in the "Salvation Army Precluded Offenses" document
 - ii. Salvation Army is not able to accept participants who are on the Sex Offender and/or Arson Registry
 - iii. Salvation Army is not currently able to accept participants who are on narcotic medications and/or Medication Assisted Treatment (e.g., Antabuse, Buprenorphine, Methadone)
- k. Additional/Updated Information Needed by Salvation Army Prior to Admission
 - i. Current Medication List
 - ii. Medical Screening/Physician's Report (as requested by Salvation Army Intake Coordinator)
 - iii. Supply of Medications (Up to 30-45 days)
 - iv. TB Clearance within 6 months (PPD placed prior to admission) or chest x-ray within the last year
 - v. Contact information for current treatment providers



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- vi. Information for future medical, psychiatric, or court related appointments
- IV. Treatment at Salvation Army
 - a. Detox
 - i. It is the goal of PRSPR to enroll participants in the Salvation Army Detox program who may successfully transition to the Harbor Light Residential Treatment once stable
 - ii. Participants who need additional stabilization prior to entry at Harbor Lights may be placed in the detox program
 - b. Harbor Light
 - i. Placement for 3-6 months
 - ii. Participant will receive individual and group support while at the program
 - iii. If a participant relapses and returns to the program, they may be placed in detox for stabilization prior to returning to Harbor Lights Treatment
 - iv. Salvation Army will support the participant with the following services
 - 1. Enrollment in public benefits
 - a. A list of participants who successfully complete the program must be provided to BOCC quarterly to access data regarding active MediCal
 - 2. Developing a Treatment Plan of Care
 - 3. Developing a discharge plan
 - c. Transitional Age Youth (TAY)
 - i. Felton Institute will provide additional support to TAY youth receiving treatment services at Salvation Army as clinically indicated
 - ii. Felton Institute will support Salvation Army to develop a TAY specific curriculum for Substance Use Disorder treatment services
 - d. Discharge
 - i. Planned Discharge
 - 1. One month prior to planned discharge Salvation Army will host a case conference with peer navigator from RAMS and community provider to develop a detailed Community Care Plan
 - 2. Salvation Army will work with the Department of Public Health to ensure referral to ongoing behavioral health services as clinically indicated
 - 3. Participants will be connected to a peer navigator who will support them post discharge for up to 60 days
 - a. If a participant has a community based case manager/care coordinator the peer navigator will work with that individual to maximize support for the participant
 - b. If a participant does not have a community based case manager/care coordinator, and one is not indicated, the peer



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- navigator will coordinate with Salvation Army Aftercare (when indicated) to maximize support for the participant
- ii. Salvation Army is responsible for notifying PRSPR@sfdph.org within 24 hours of a bed being vacated either by planned or unplanned discharge
 - e. Documentation
 - i. Salvation Army
 - 1. Salvation Army will enter data into Avatar within three business days
 - 2. Salvation Army will complete a daily census in Avatar for both social detox and Harbor Lights Program
 - 3. Salvation Army will complete CalOMS for all PRSPR participants in Avatar
 - 4. Salvation Army will maintain the PRSPR Log for all participants
 - 5. Salvation Army will place all referral paperwork from referral source in their chart on site and maintain these records
 - 6. Salvation Army will send information on all participants to the DPH Business Office of Contract Compliance on a quarterly basis to measure enrollment in MediCal services
 - 7. Intake
 - a. Salvation Army will enroll all PRSPR participants in Avatar for both social detox and Harbor Lights Program
 - b. Salvation Army will complete the following forms with all PRSPR participants upon enrollment in services:
 - i. Data Collection Referral Form
 - ii. Intake Outcomes
 - iii. Criminal Thinking Scales
 - iv. Wellbeing Survey
 - 8. Discharge
 - a. Salvation Army will discharge all PRSPR participants in Avatar for both social detox and Harbor Lights Program
 - b. Salvation Army will complete the following forms with all PRSPR participants prior to discharge from the program:
 - i. Community Care Plan
 - ii. Discharge Outcomes
 - iii. Criminal Thinking Scales
 - iv. Wellbeing Survey
 - ii. RAMS
 - 1. RAMS will complete documentation for their contacts with participants via progress notes and peer service log
 - iii. Felton Institute



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1. Felton will complete documentation for their contacts with participants in the Felton database (CIRCE)
- f. Utilization Management at Salvation Army
 - i. Transitions will run data in Avatar to determine individuals who are enrolled in the PRSPR program
 - ii. Salvation Army will work with Transitions to set a regular meeting (this can be a regularly scheduled case conference with staff) to review PRSPR cases receiving treatment at the facility
 - iii. PRSPR participants will be discussed at the onset of the meeting
 - iv. Salvation Army will provide a private room for Transitions to meet with participants (meetings with each participant will occur on a quarterly basis) to determine if the participant continues to meet necessity for residential treatment by utilizing the Level of Care Utilization System (LOCUS) assessment
 - v. If a participant is determined to no longer meet necessity for residential treatment, Salvation Army and DPH Project Director will be notified. At that time Salvation Army may continue to serve the individual through an alternative funding source and will close their case in Avatar with the PRSPR program code.
- V. Photos
 - a. DPH contractors may take pictures of participants (with the participant's consent) on a work-issued cell phone or camera
 - b. Taking pictures on a personal phone is strictly prohibited
 - c. Photos must be transferred to a work computer on a secure network the same day, and then must be deleted from the cell phone
 - d. Failure to comply with the above leading to a security breach will lead to a termination of access to DPH resources and data systems
- VI. Flexible Funds
 - a. Grant funds have been dedicated to flexible funds to support participant needs through the Public Health Foundation (e.g., transportation, clothing, food, client paperwork, ID cards, incentives)
 - i. All contracted organizations have received the Department of Public Health's Health Food and Food Expenditure Policy and will not use flex funds to purchase sugary drinks as laid out in this policy
 - ii. All contracted organizations will track how resources are utilized by creating a tracking system to document the amount of funds used by each participant (e.g., tokens given, gift card, cost of food)
 - iii. Each expense, with a client identifier or client name, needs to be logged, and the receipts should be kept
 - iv. Funds can not be used for any staff related expenses and as such the only items on any receipt should be directly tied to a client
 - v. Funds can not be used to purchase a tent or camping equipment



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- vi. Any single expenditure over \$250 requires approval from the Department of Public Health Project Director or designee and may be brought to the Implementation Committee for further discussion (e.g., bills, legal services)
 - vii. Any single expenditure over \$1,000 requires Board of State and Community Corrections approval
- b. Contracted organizations will submit a request to purchase of items or receive reimbursement for participant related expenses at least monthly
 - i. This request will provide details for line items and associated receipts for purchases
 - ii. The Department of Public Health Project Director or designee will review and approve the request and submit to the Public Health Foundation
 - iii. The Public Health Foundation will review the request and provide a reimbursement check to the agency
 - iv. The Public Health Foundation will review the request and provide purchase requested items
 - v.
- c. Participant Level Tracking
 - i. Contracted organizations will be responsible for tracking participant level details regarding funds/resources that are utilized for BSCC audit purposes
 - ii. In the event that a disbursement is disallowed, the aforementioned agencies will be responsible for the amount
 - iii.

What is PRSPR?

PRSPR is a collaborative program offering wellness and recovery for individuals who have a history of criminal justice involvement in San Francisco.

The Salvation Army Harbor Light Program, in collaboration with the Department of Public Health (DPH), is offering 3-6 months of residential substance use disorder treatment services to individuals with a criminal justice history. After an individual has completed 3-6 months in the program, they will also be able to work with a peer navigator to support their recovery in the community through Richmond Area Multi Services (RAMS), regardless of whether they stay in residential treatment at Salvation Army or not.

Who is eligible?

You must...

- ✓ be 18 years of age or older
- ✓ have a substance use disorder
- ✓ have a history of criminal justice system involvement

You must have a referral from an approved partner organization to enter this program.

The PRSPR Goal

Through engaging with eligible participants, supporting them with Community Care Plans, and reducing recidivism rates, PRSPR aims to interrupt the cycle of substance abuse, unaddressed behavioral health issues, homelessness, and incarceration.

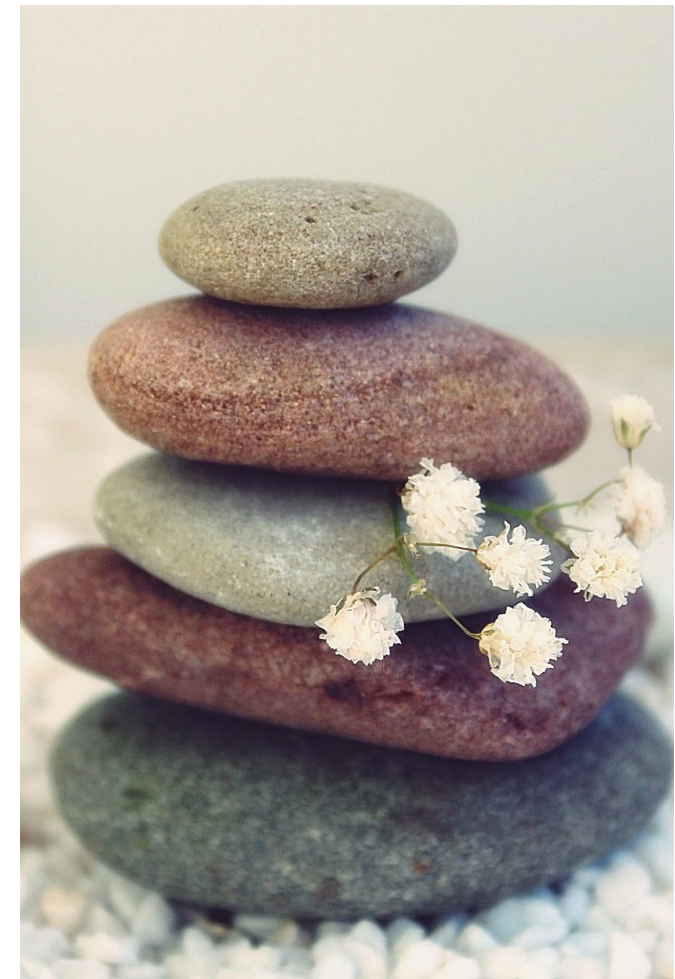
If you have any concerns during your time in the PRSPR program, your Salvation Army counselor is always available to you.

You will also find grievance procedures in your intake packet, which will include contact information for staff at the San Francisco Department of Public Health. You may file an official complaint using this information.



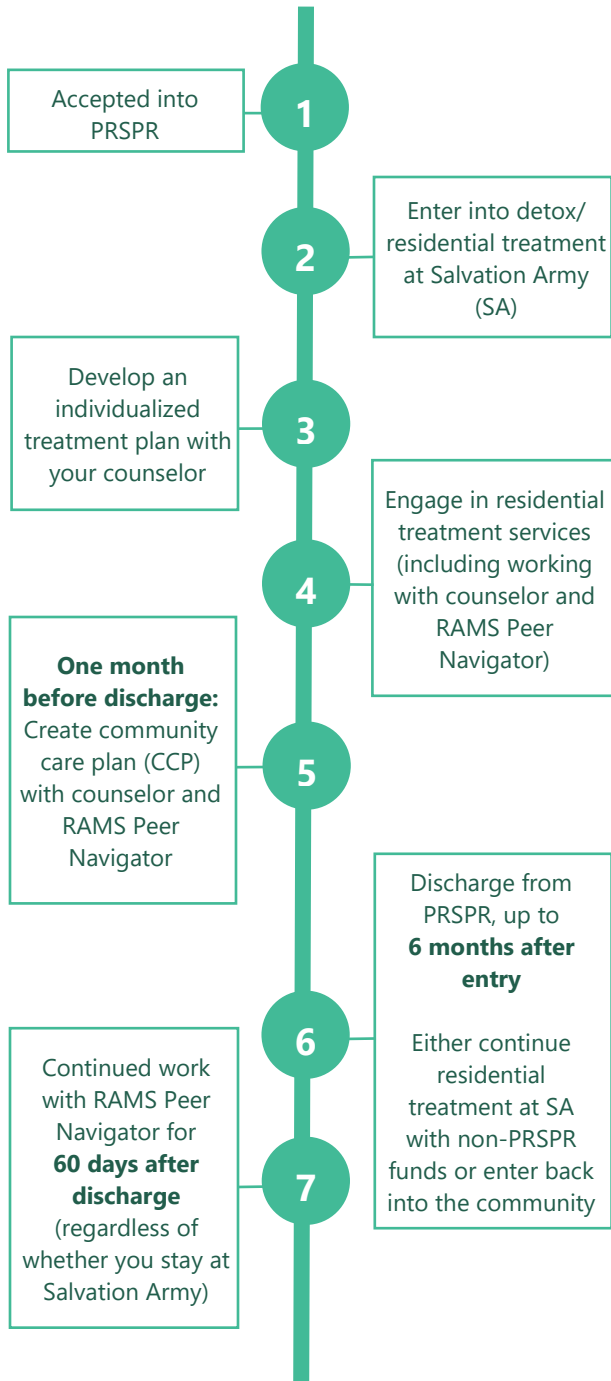
San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH



**Promoting Recovery
and Services for the
Prevention of
Recidivism
(PRSPR)**

Your time in PRSPR



Salvation Army Services

- Residential sober support system as a foundation to community reentry
- Therapeutic educational classes
- Process groups
- AA/NA meetings
- Individual counseling sessions
- Social gatherings & group activities
- Meal and laundry services
- Recreational room and gym
- Resource center and library
- Connection to sober living in the community upon completion

RAMS Peer Navigator Services

Peer-to-peer support services, such as accompaniment to appointments and shopping trips, or assistance with completing forms, are available to you.

Basic Needs Assistance

Additional support for meeting your individual wellness and recovery goals may be available, as determined with your counselor. This may include such things as: interview attire, eyeglasses, dentures, or DMV fees.

TAY-Specific Services (18-25 year old participants)

- TAY groups
- Case management
- Long-term planning and services

"It's a safe place here. I've never felt safe before in my life."

– PRSPR Participant

What happens after my time in PRSPR is over?

One month before you are due to discharge from the PRSPR program, you, your Salvation Army Counselor, and a RAMS peer navigator will sit down to create a community care plan (CCP) together. This plan will serve as a roadmap to connect you to needed resources like housing, employment, benefit programs, and long-term behavioral health treatment.

After up to 6 months in the program, PRSPR will no longer fund residential treatment at Salvation Army, but it may be possible to extend your stay using alternative funds. You can discuss continuing your stay and treatment plan with your Salvation Army Counselor.

Regardless of whether you stay at Salvation Army or not when you are discharged from PRSPR, the RAMS Peer Navigator will continue to work with you for 60 days to support you in completing your CCP.

If you are 25 years old or younger, you may also receive ongoing support through the Felton Institute.