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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 was funded for $6 million dollars across 38 months (June 16, 2017-August 15, 2020). A no cost extension was later approved, extending the program for an additional year (through August 15, 2021). PRSPR was designed to provide substance use disorder (SUD) treatment services for individuals with a history of arrests, charges, or convictions for criminal offense(s). The grant funded 5 social detox beds and 32 residential SUD treatment beds (for a 3-6 month stay) at Salvation Army Harbor Light Center. Peer Counselors from Richmond Area Multi-Services (RAMS) were included in the grant to support participants who successfully completed 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 was available to provide increased clinical support to TAY participants, as well as the development of TAY-specific curriculum for the residential treatment program.

Progress toward Intended Goals: December 2017 through June 2021

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.

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>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).</td>
</tr>
<tr>
<td>1.2: The residential program will maintain at least a 90% occupancy rate.</td>
</tr>
</tbody>
</table>

**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.
<table>
<thead>
<tr>
<th>Objective</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1: 100% of participants who complete the residential program will leave with a community care plan.</td>
<td>Target not met. 44% of those who successfully completed the residential treatment program left with documentation of a community care plan.</td>
</tr>
<tr>
<td>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.</td>
<td>Target met. 100% of community care plans were 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 was designed to ensure that each topic was addressed and that actionable goals were developed.</td>
</tr>
<tr>
<td>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.).</td>
<td>Target met. According to the Salvation Army log, 93% of those who successfully completed the residential program were enrolled in Medi-Cal. Enrollment in other public benefit programs was not collected. However, Medi-Cal alone demonstrates that the target was achieved.</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1: At least 50% of participants will complete 3-6 months of residential treatment.</td>
<td>Target almost met. As of June 2021, 243 participants had completed residential treatment. Of those, 103 (42%) successfully completed the program (i.e., no longer meet medical necessity for enrollment in the program after 3-6 months and met all of their treatment plan goals).</td>
</tr>
<tr>
<td>3.2: As a cohort, 40% of participants will demonstrate lower recidivism rates than in a comparable period prior to admission.</td>
<td>Target met¹. There were very few convictions on record for PRSPR participants. There were only six convictions up to 6 months prior to program admission, and only four convictions up to 6 months after program discharge. Of the six individuals who had convictions prior to admission, none recidivated within a comparable time period after discharge. Looking at arrest data (regardless of conviction), there was a statistically significant decrease in arrests for successful program completers. Because the sample with conviction data is so small it is difficult to say with certainty what the full impact of the program was on recidivism, but the available results were encouraging.</td>
</tr>
<tr>
<td>3.3: As a cohort, participants will utilize 50% fewer jail bed days per year than they did prior to program participation.</td>
<td>Data to calculate jail bed days was not available.</td>
</tr>
</tbody>
</table>

¹ The number of individuals with convictions was very low. Results should be interpreted accordingly.
Project Accomplishments
In addition to meeting or coming close to meeting most of its intended objectives for program participants, other project accomplishments have included:

- **A new, coordinated system of care was 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 remained unflappable to the end. In addition, over time the pool of referring agencies to the program was expanded to include a much wider network, helping to ensure that all those who were ready to be connected to treatment could find it. The relationships and systems that were built and will be sustained by program partners long after the PRPSR grant concludes can be held up as a significant program success.

- **Participants were very satisfied with programming.** Throughout the course of the PRSPR grant, three focus groups were held to gather program feedback directly from the participants. Participants in each of the three focus groups were universally satisfied with programming, but the last group was especially positive and spoke for the first time about the strong reputation of the program in the community. The fact that the PRSPR program was being recommended by peers and professionals in the community alike is a clear indication that something good is happening.

- **Partners have demonstrated adaptability, flexibility, and responsivity to program challenges.** The PRSPR program experienced its share of growing pains and challenges, and had to adapt to the additional strain of a pandemic. However, partners remained committed to the work and responded to each challenge with creativity and a can-do spirit. Thanks to the strong relationships and systems that were developed as part of the coordinated system of care, challenges did not derail programming. Rather, programming and partnerships were strengthened as challenges were overcome.

Project Challenges
Among the challenges that surfaced and were resolved along the way:

- **Delays were an early 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 were also 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 continuously had to be revisited.** Issues included misconceptions among referral partners about program requirements and policies; resistance to referral-related paperwork and duplicative assessments; unpredictable fluctuations in referral numbers over time; and an abstinence-based program model that did not originally embrace approaches like harm reduction and medication-assisted treatment that have been embraced by the city.

- **It took time to understand and implement 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, but there were many barriers to the process including competing demands for time, difficulties coordinating schedules, a lack of clarity around which clients were ready for planning, and a program model that allowed participants to remain at Harbor Light Center after their time in PRSPR came to an end, making community care planning less of a necessity. Despite great effort and the best of intentions, this aspect of programming never really took off.

- **Most participants have remained in residential treatment after their exit from PRSPR.** As mentioned above, the complete Salvation Army treatment model allows for engagement beyond that which is deemed medically necessary by the DPH. Participants were allowed to remain in treatment under alternative funding sources after their time with PRSPR came to an end, and many did. 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 Counselor, had to be redefined to better fit with longer term engagement in treatment.

- **Staff turnover and fluctuations occasionally impeded programming.** The biggest gaps in staffing were with Felton Institute (FI). Their clinician was meant to play a pivotal role in serving the TAY population. It took several quarters to hire the first clinician, and he only remained in his position for a brief period of time. Work with TAY was mostly put on hold while FI attempted to fill the position, but ramped up quickly with a strong new hire about mid-way through the grant. This individual worked closely with RAMS, co-facilitating many popular support group sessions at Harbor Light Center. They also continued with individual work with TAY in the community. However, this individual also left the position before the grant ended, and was not replaced, resulting in impediments to RAMS fulfilling parts of their work that required clinical supervision. There was also staff turnover with some of the Peer Counselors and referring partner agencies, and a devastating loss of Salvation Army’s Project Director during the COVID-19 pandemic, all of which put an occasional strain on program implementation.

- **COVID-19 impacted everything.** Not to use a pandemic as an excuse for anything, but COVID-19 did prove to be a challenge, especially with regard to limiting access to program partners on the Harbor Light campus, and forcing a temporary halt in programming during an outbreak of the virus. Program partners were resourceful and resilient, but the pandemic happened just as PRSPR was really settling in to a nice flow, and numbers were steadily improving. Although programming persevered and outcomes remained mostly positive, it is disappointing to think about what could have been had the pandemic not happened.

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

Despite some challenges and growing pains, the PRSPR program, to a large degree, worked exactly as intended. At least four of the project objectives were met and one was almost met. Only two, community care planning and the program occupancy rate, fell short of expectations, and to some extent it was attributable to circumstances beyond the control of the program (e.g., COVID-19). Slight adjustments to programming were continuously 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 Counselor. However, despite these changes, the fundamental program model remained intact and program partners were driven to deliver services as promised as part of a coordinated system of care.
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 was funded for $6 million dollars across 38 months (June 16, 2017-August 15, 2020). A no cost extension was later approved, extending the program for an additional year (through August 15, 2021). PRSPR was designed to provide substance use disorder (SUD) treatment services for individuals with a history of arrests, charges, or convictions for criminal offense(s). The grant funded 5 social detox beds and 32 residential SUD treatment beds (for a 3-6 month stay) at Salvation Army Harbor Light Center. Peer Counselors from Richmond Area Multi-Services (RAMS) were included in the grant to support participants who successfully completed 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 was available to provide increased clinical support to TAY participants, as well as the development of TAY-specific curriculum for the residential treatment program.

In accordance with grant requirements, only the following individuals were 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 included 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 ensured that all individuals referred to the program were eligible. Only those who met both criteria could be referred/accepted into the program. Cover sheets were distributed to all referring agencies, and shared with multiple partners (Salvation Army, HTA, SFDPH) upon completion to allow for several opportunities to verify that services were 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 activities were 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) was engaged to conduct an independent evaluation of the Promoting Recovery & Services for the Prevention of Recidivism (PRSPR) program. HTA used a utilization-focused approach combining mixed methods of program data, meeting minutes, interviews, focus groups, 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. Additionally, the evaluation focused on both process and outcome elements. The goal of the process evaluation was to document program implementation throughout and provide information on how to continuously revise and improve programming, as needed. The outcome evaluation was focused on describing the program’s outcomes cumulatively over the three-year period.

Given the pilot, developmental nature of the implementation, a comparison group was not identified for this evaluation to assess impact. Rather, impact will be assessed by within-group change from baseline to follow-up for PRSPR participants. This can still provide clear evidence as to the impact of the program.

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Only PRSPR participants who consented to the evaluation (signed at referral) were included in the study.

Process Evaluation. The process evaluation used a continuous improvement model to address fidelity to the program plan and the monitoring of specific program goals (i.e., number engaged, criminal history, substance use history, program occupancy, length of stay, etc.). Process data included various service utilization records including referral forms, case logs, assessments, treatment/care plans, services, referrals, and exit forms. Data was 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 participated 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 meeting agendas and discussion included 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 was the first time these partners came together to collectively serve this population under the auspices of Prop 47 funding, this evaluation was largely process-oriented to help document and learn from program implementation and collaboration.

The following evaluation questions were designed to guide the 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 Counselors 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 was 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 utilized a pre-post design to study whether the program achieved its stated outcomes (i.e., completion of treatment, enrollment in public benefits, lower recidivism rates, etc.). Baseline indicators were compared with post-treatment outcomes to see if changes in individual-level outcomes were not only accomplished but maintained over time. Data sources included 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 included 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 the 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?
   o If so, what type and severity of crimes?
   o 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.

**As delivered.** As of the end of Quarter 16 (Apr – Jun 2021), this group, along with the external program evaluators, and other DPH staff as needed, met a total of nineteen 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. There was at least one meeting every quarter with the exception of Quarter 15 (Jan-Mar 2021) when staff were stretched thin due to COVID deployment and related stresses. However, in lieu of this meeting, HTA conducted a survey to gather feedback and updates from the team. All program partners had representatives at each meeting, and meeting minutes clearly demonstrate that individuals always came to the table prepared.
to share ideas and address challenges head on. It was also very common for partners to schedule smaller meetings outside of the regularly scheduled work group meetings. The relationships that were built as part of the PRSPR program will be sustained, and this is one area that 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.

As delivered. A lot of attention was placed on establishing a clear referral process, as it was the primary channel by which participants were connected to services. From the first referral (November 30, 2017) through the end of Quarter 16 (June 30, 2021), there were a total of 505 referrals (445 unduplicated individuals) to Salvation Army (see Figure 1).

Figure 1: Cumulative PRSPR Referrals, Oct 2017 - June 2021

Source: SFDPH PRSPR referral records; HLC-Salvation Army admission records
Over the four years of the program, the rate of referrals ebbed and flowed, ranging from 2 to 53 and averaging 34 referrals per quarter. Many factors contributed to the fluctuations in referrals, including:

- As with any new program, referrals took a while to ramp up, but increased steadily between Quarter 3 and Quarter 6.
- In Quarter 7, Salvation Army initiated a new contract with Adult Probation to provide residential treatment beds for direct referrals. This coincided with an end of referrals coming in from the Offender Treatment Program (OTP). Effectively, PRSPR eligible individuals on mandatory supervision were being referred to the new Probation program at Salvation Army, rather than PRSPR.
- After JBHS got into the swing of making referrals to PRSPR, there was a brief period of time around Quarter 7 when their referrals began to wane. This turned out to be due to a perception held by JBHS staff that their referrals were not being accepted into the program. PRSPR program leadership addressed this concern directly with JBHS, leading to a restoration of the referral process. However, this helps to explain a temporary drop in referrals during this time.
- In Quarter 10 program partners began fervently addressing some of the city-wide challenges with referrals. Growth in referrals during the coinciding quarters demonstrated that these efforts were bearing fruit.
- There was a slight decline in referrals in Quarter 12. This marked the first full quarter of operations during the COVID-19 pandemic. The city prioritized placement in shelter in place or isolation/quarantine settings, as opposed to congregate settings like Salvation Army’s Harbor Light Center. The impact of COVID-19 will be discussed in more detail in a later section of this report.
- Despite being in the middle of a pandemic, referrals in Quarter 13 held steady. In fact, all of the available 32 residential treatment beds were filled by early September. The increased demand was likely a result of a combination of things including increased needs during this pandemic, and a dependable influx of referrals, demonstrating strengthened relationships with referral partners. There were not enough beds to accommodate this surge in demand, and because there were cost savings from the beginning of the grant BSCC gave approval to fund up to 40 beds as of October 13, 2020.
- In Quarter 15 there was an unfortunate outbreak of COVID-19 at the Harbor Light Center facility. No intakes were allowed between January 27 and March 16 while staff were addressing these issues. Therefore, the number of referrals dropped considerable this quarter.
- Finally, in Quarter 16 there was another surge of referrals. This indicated that the dip was truly COVID-related and not indicative of any decrease in need or interest.

Another factor contributing to fluctuations in referrals has to do with changes within the referring agencies themselves. For example, as mentioned previously, a new contract between Salvation Army and Probation resulted in the Offender Treatment Program (OTP) diverting their referrals away from PRSPR and to the new contract instead. The LEAD grant ended in June 2020, so LEAD was no longer a viable source for referrals after Quarter 13. In addition, at various points in time there was also staff turnover and some leaves of absence within referral partner agencies. These changes coincided with quarters when the number of referrals decreased.
As initially planned, the four primary sources for referrals were TAP, JBHS, LEAD, and OTP. During the first year of programming these remained the primary referral sources, the only exception being one referral that came directly from Felton Institute, the program partner specializing in TAY outreach and case management. To help address the impact of changes within partner agencies and other extenuating circumstances, the pool of referring agencies for PRSPR was intentionally expanded throughout the life of the PRSPR grant to ensure that there was always an active pool available to facilitate placement into the program. Eventually, the list of referring agencies officially included Salvation Army, Felton Institute (for TAY), the Public Defender’s Social Worker, the Collaborative Courts (Drug Court and Community Justice Center), Behavioral Health Court, Young Adult Court, Veterans Justice Court, the Citywide Community Response Team (CCRT), and Behavioral Health Homeless Teams.

As shown in Table 1, the vast majority of referrals came through TAP, in part because Salvation Army partnered with them when they sourced their own referrals to the program. Although TAP was the primary referral partner, there was a gradual ramp up of referrals coming from the other partners and by the third year JBHS and Collaborative Court were the most productive referring agencies.

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Year 1 (Q2-4)</th>
<th>Year 2 (Q5-8)</th>
<th>Year 3 (Q9-12)</th>
<th>Year 4 (Q13-16)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAP</td>
<td>38</td>
<td>78</td>
<td>26</td>
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<td>180</td>
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<td>64</td>
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<td>0</td>
<td>1</td>
<td>0</td>
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<td>26</td>
<td>5</td>
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<td>0</td>
<td>0</td>
<td>14</td>
<td>11</td>
<td>25</td>
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<td>PD Social Worker</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>MHD</td>
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<td>0</td>
<td>1</td>
<td>1</td>
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<td>0</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>61</td>
<td>121</td>
<td>174</td>
<td>149</td>
<td>505</td>
</tr>
</tbody>
</table>

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

Despite the best of intentions, 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.).

- Misconceptions about program acceptance criteria. As mentioned previously, JBHS expressed some concerns about program admissions. They stopped making referrals for a brief period of time because they were under the impression that the individuals they were referring to the program were

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3 Salvation Army could not make independent referrals to PRSPR during the first two years of the project because staff were not yet certified to administer the ASAM, which was part of the referral process. By the third year of the program, Salvation Army’s Intake and Network Manager became ASAM certified, and was able to make independent referrals.
not being accepted. This led to frustrations that temporarily shut down this stream of referrals until it was addressed.

- **Background checks & eligibility requirements.** Salvation Army conducts background checks on all prospective clients and bars entry to individuals who have certain criminal histories. Originally, this involved the completion of quite a bit of paperwork upon referral to help facilitate the background check process.

- **Duplicative assessment forms.** Initially, Salvation Army had their own assessment form separate from DPH's assessment form, which could contribute to a delay in enrollment as duplicative data was captured by separate agencies.

- **Lack of MAT services.** Salvation Army operated primarily from an abstinence-oriented model for treatment, and did 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.

None of these barriers were insurmountable, but had to be addressed to keep the PRSPR program running at full capacity. To this end, the following solutions or modifications related to the referral/admission process were added to the PRSPR program as it was being 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 Background Checks and Paperwork.** To overcome barriers related to background checks, the program partners 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. 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. All forms were designed to be as purposeful and short as possible so that referrals could be completed quickly, thereby reducing the burden on partner agencies.

- **Streamlining the 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 form 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 referring agencies for the PRSPR program was continuously expanded, and eventually included Salvation Army, Felton Institute (for TAY), the Public Defender’s Social Worker, the Collaborative Courts (Drug Court and Community Justice

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4 A modified version of the American Society of Addiction Medicine (ASAM) used by SFDPH.
Center), Behavioral Health Court, Young Adult Court, Veterans Justice Court, the Citywide Community Response Team (CCRT), and Behavioral Health Homeless Teams. The PRSPR Project This expansion helped to facilitate additional placement in the program.

- **Addressing city-wide challenges.** Challenges with referrals were not exclusive to Salvation Army. As PRSPR partners had discussions about the issues they noted that similar problems were surfacing with other treatment programs in the city. To this end, in Quarter 10, Salvation Army started conversations with other organizations in the community to address challenges with referrals in general. In addition, SFDPH developed a public webpage showing the availability of vacant treatment beds in the city (findtreatmentsf.org). The webpage summarizes residential treatment capacity and beds available, as a whole and by provider, along with contact information. This is a way for the system to better support both providers and consumers regarding access to care.

- **Opening up communication with referring agencies about Salvation Army’s Approach to Admission.** Because JBHS staff expressed concern that the individuals they were referring were not being admitted to the program HTA analyzed admission data for review. This showed that individuals referred to PRSPR but did not enroll (n=32) were statistically more likely to be referred by Jail Behavioral Health Services (JBHS) 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 in Quarter 8 (May 23, 2019). Looking at the data, it was seen that the majority JBHS referrals had been assessed in-custody, 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. This review of data cleared the air of any misunderstandings and allowed JBHS and Salvation Army to work closer together to carefully select individuals for referral who were more serious about wanting to participate in the program, and therefore more likely to show up.

- **Opening up communication with referring agencies about Salvation Army’s Approach to Treatment.** To address any misconceptions among referral partners the PRSPR Project Director and the Salvation Army Intake Coordinator regularly conducted in-person outreach with prospective referral partners to explain the program. Known misconceptions were also addressed in an email to referral partners from the PRSPR Program Director, and there were ongoing opportunities for partners to tour Salvation Army’s Harbor Light Center facilities to see for themselves what the program was like. In Quarter 8, a pamphlet that described the program (qualifications, benefits, contacts, etc.) was designed for partners to use during outreach.

- **Opening Up Programming to Provide MAT Services.** 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. As of Quarter 8, Salvation Army began the process of onboarding MAT to their programming. This allowed for better alignment with other City programs and opened access to a larger body of potential detox and residential treatment clients.

**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

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5 Pearson chi-square=55.438, p=.000
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.

**As delivered.** In the grant application, the target was to admit 16 individuals per quarter to residential treatment, which would amount to 64 enrollments annually and 256 enrollments within the by Quarter 16. (No similar targets were set for social detox). **As shown in Table 2, the program goal for residential treatment admits was reached.** The number of new admissions fluctuated over time. There was a large drop in Quarter 7 admits, which coincided with a temporary decrease in referrals, noted earlier. There was also a large drop in Quarter 12, coinciding with the start of the COVID-19 pandemic. Amazingly, there was a rebound in Quarter 13, when residential treatment enrollments hit a peak of 30, but this number was not sustained after subsequent outbreaks of COVID-19 on the HLC campus. Of the 505 referrals to the program there were 390 admits (77%) into social detox and/or residential treatment. This encompassed 348 unduplicated individuals. Some PRSPR clients engaged in both social detox and residential treatment – these clients accounted for 34.8% of unduplicated clients (121 of 348 unduplicated clients).

**Table 2: HLC Admit Modality by Quarter, July 2017- June 2021**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Social Detox</th>
<th>Residential Treatment</th>
<th>Targets (Res. Treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (Jul-Sep ’17)</td>
<td>Planning Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 (Oct-Dec ’17)</td>
<td>0</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Q3 (Jan-Mar ’18)</td>
<td>3</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Q4 (Apr-Jun ’18)</td>
<td>6</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Q5 (Jul-Sep ’18)</td>
<td>13</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Q6 (Oct-Dec ’18)</td>
<td>16</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Q7 (Jan-Mar ’19)</td>
<td>10</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Q8 (Apr-Jun ’19)</td>
<td>6</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Q9 (Jul-Sep ’19)</td>
<td>22</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Q10 (Oct-Dec ’19)</td>
<td>26</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Q11 (Jan-Mar ’20)</td>
<td>33</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Q12 (Apr-Jun ’20)</td>
<td>20</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Q13 (Jul-Sep ’20)</td>
<td>29</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Q14 (Oct-Dec ’20)</td>
<td>24</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Q15 (Jan-Mar ’21)</td>
<td>13</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Q16 (Apr-Jun ’21)</td>
<td>34</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>255</strong></td>
<td><strong>259</strong></td>
<td><strong>256</strong></td>
</tr>
</tbody>
</table>

*Source: HLC-Salvation Army admission records*
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=115) were significantly more likely to be younger.\(^6\) Non-enrollees were 35 years old, on average, compared to 40 years old for enrollees. There were no significant differences by gender or race/ethnicity between enrollees and non-enrollees.

Among those individuals who were admitted into programming, there were few demographic differences between detox and residential treatment participants (see Table 3). The vast majority of all participants were male (81%). It was most common for participants to be White or Black/African American; together accounting for 69% of program enrollments. Participants ranged in age from 19 to 71 years, and averaged 40 years. The percentage of Transitional Age Youth (TAY) participants was somewhat low, representing just 6% of all program participants.

### Table 3: Demographics by Admit Modality, Oct 2017- Jun 2021

<table>
<thead>
<tr>
<th></th>
<th>All Admits (N=390)</th>
<th>Social Detox (N=255)</th>
<th>Residential Treatment (N=259)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>16.9%</td>
<td>13.3%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Male</td>
<td>81.3%</td>
<td>84.3%</td>
<td>79.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1.8%</td>
<td>2.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Race/Ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American/Black</td>
<td>34.9%</td>
<td>33.3%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.3%</td>
<td>3.5%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>13.8%</td>
<td>11.4%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Native American</td>
<td>2.3%</td>
<td>2.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Multi-Ethnic</td>
<td>9.0%</td>
<td>9.4%</td>
<td>7.7%</td>
</tr>
<tr>
<td>White</td>
<td>33.8%</td>
<td>37.3%</td>
<td>30.9%</td>
</tr>
<tr>
<td>Other/Not Stated</td>
<td>2.3%</td>
<td>2.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years (mean)</td>
<td>40.5</td>
<td>40.1</td>
<td>40.7</td>
</tr>
<tr>
<td>Years (range)</td>
<td>19-71</td>
<td>20-71</td>
<td>19-71</td>
</tr>
<tr>
<td>Transition Age Youth(^7) (%)</td>
<td>5.6%</td>
<td>3.9%</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

**Source:** HLC-Salvation Army admission records

As of Quarter 16 there had been 255 social detox admits and 259 residential treatment admits. Among all admits, the average length of stay at HLC-Salvation Army was 77 days (or 2.6 months), with an average of 12 days in social detox and/or 105 days (or 3.5 months) in residential treatment (see Table 4). The time in treatment ranged from 1 day to up to 291 days (or 9.7 months), when combining social detox and residential treatment.

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\(^6\) t=4.656, p<.001

\(^7\) TAY=18-24 years old
Among the 252 participants who exited social detox by June 30, 2021, 63.5% successfully completed their recommended detox treatment; 49.2% also enrolled in residential treatment. Among the 243 participants who exited residential treatment by June 30, 2021, 42.4% successfully completed their recommended residential treatment (see Table 5). For both modalities, successful treatment was defined by the HLC-Salvation Army Intake Coordinator as “meeting their treatment plan goals.”

### Table 4: Length of Stay (Days) by Modality, Oct 2017- June 2021

<table>
<thead>
<tr>
<th>Modality</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Admits (N=390)</td>
<td>77.3</td>
<td>72.7</td>
<td>1 - 291</td>
</tr>
<tr>
<td>Social Detox (N=255)</td>
<td>12.2</td>
<td>9.8</td>
<td>1 - 74</td>
</tr>
<tr>
<td>Residential Treatment (N=259)</td>
<td>104.5</td>
<td>66.2</td>
<td>1 - 270</td>
</tr>
</tbody>
</table>

Sources: Salvation Army Case Logs; SFDPH Database (Avatar)

### Table 5: Successful Completions by Modality, Oct 2017- June 2021

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Detox Completions</th>
<th>Successful Detox</th>
<th>Total Residential Tx Completions</th>
<th>Successful Residential Tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (Jul-Sep ‘17)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q2 (Oct-Dec ‘17)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q3 (Jan-Mar ‘18)</td>
<td>2</td>
<td>50% (1 of 2)</td>
<td>5</td>
<td>0% (0 of 5)</td>
</tr>
<tr>
<td>Q4 (Apr-Jun ‘18)</td>
<td>6</td>
<td>67% (4 of 6)</td>
<td>11</td>
<td>18% (2 of 11)</td>
</tr>
<tr>
<td>Q5 (Jul-Sep ‘18)</td>
<td>14</td>
<td>50% (7 of 14)</td>
<td>16</td>
<td>50% (8 of 16)</td>
</tr>
<tr>
<td>Q6 (Oct-Dec ‘18)</td>
<td>16</td>
<td>56% (9 of 16)</td>
<td>23</td>
<td>35% (8 of 23)</td>
</tr>
<tr>
<td>Q7 (Jan-Mar ‘19)</td>
<td>10</td>
<td>40% (4 of 10)</td>
<td>18</td>
<td>50% (9 of 18)</td>
</tr>
<tr>
<td>Q8 (Apr-Jun ‘19)</td>
<td>5</td>
<td>80% (4 of 5)</td>
<td>20</td>
<td>70% (14 of 20)</td>
</tr>
<tr>
<td>Q9 (Jul-Sep ‘19)</td>
<td>21</td>
<td>57% (12 of 21)</td>
<td>12</td>
<td>25% (3 of 12)</td>
</tr>
<tr>
<td>Q10 (Oct-Dec ‘19)</td>
<td>23</td>
<td>70% (16 of 23)</td>
<td>18</td>
<td>44% (8 of 18)</td>
</tr>
<tr>
<td>Q11 (Jan-Mar ‘20)</td>
<td>35</td>
<td>74% (26 of 35)</td>
<td>23</td>
<td>39% (9 of 23)</td>
</tr>
<tr>
<td>Q12 (Apr-Jun ‘20)</td>
<td>20</td>
<td>60% (12 of 20)</td>
<td>21</td>
<td>48% (10 of 21)</td>
</tr>
<tr>
<td>Q13 (Jul-Sep ‘20)</td>
<td>31</td>
<td>84% (26 of 31)</td>
<td>17</td>
<td>47% (8 of 17)</td>
</tr>
<tr>
<td>Q14 (Oct-Dec ‘20)</td>
<td>23</td>
<td>48% (11 of 23)</td>
<td>15</td>
<td>40% (6 of 15)</td>
</tr>
<tr>
<td>Q15 (Jan-Mar ‘21)</td>
<td>9</td>
<td>89% (8 of 9)</td>
<td>31</td>
<td>48% (15 of 31)</td>
</tr>
<tr>
<td>Q16 (Apr-Jun ‘21)</td>
<td>37</td>
<td>54% (20 of 37)</td>
<td>13</td>
<td>23% (3 of 13)</td>
</tr>
<tr>
<td>Total</td>
<td>252</td>
<td>63% (160 of 252)</td>
<td>243</td>
<td>42% (103 of 243)</td>
</tr>
</tbody>
</table>

Source: Salvation Army Case Logs

Overall while Salvation Army has made available the detox and residential treatment beds and delivered treatment as planned, occupancy rates were mostly lower than the anticipated 90% target for residential treatment, averaging around 66% between Quarter 3 (Jan – Mar 2018, the first full quarter of service delivery) and Quarter 16 (Apr – Jun 2021). 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 6). There was an initial ramping up period during the first few quarters, and by Quarter 4 there were notable gains in occupancy. Fluctuations in occupancy rates mirrored fluctuations in referrals and admits during the same time periods. Social detox and residential treatment have followed slightly different trajectories. Social detox had their highest occupancy rates in the final quarter (Quarter 16), reaching an all-time high of 98%. Residential treatment, on the other hand, reached it’s all time high in Quarter 14, followed by steady declines due also in part to COVID-19 with an outbreak on campus, and as programming began to wind down toward the end of the grant.

Table 6: Occupancy Rates by Modality by Quarter, Oct 2017- Jun 2021

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Social Detox</th>
<th>Residential Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 (Oct-Dec ’17)</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Q3 (Jan-Mar ’18)</td>
<td>4%</td>
<td>18%</td>
</tr>
<tr>
<td>Q4 (Apr-Jun ’18)</td>
<td>23%</td>
<td>60%</td>
</tr>
<tr>
<td>Q5 (Jul-Sep ’18)</td>
<td>38%</td>
<td>73%</td>
</tr>
<tr>
<td>Q6 (Oct-Dec ’18)</td>
<td>33%</td>
<td>87%</td>
</tr>
<tr>
<td>Q7 (Jan-Mar ’19)</td>
<td>14%</td>
<td>82%</td>
</tr>
<tr>
<td>Q8 (Apr-Jun ’19)</td>
<td>7%</td>
<td>55%</td>
</tr>
<tr>
<td>Q9 (Jul-Sep ’19)</td>
<td>48%</td>
<td>58%</td>
</tr>
<tr>
<td>Q10 (Oct-Dec ’19)</td>
<td>72%</td>
<td>66%</td>
</tr>
<tr>
<td>Q11 (Jan-Mar ’20)</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td>Q12 (Apr-Jun ’20)</td>
<td>57%</td>
<td>65%</td>
</tr>
<tr>
<td>Q13 (Jul-Sep ’20)</td>
<td>86%</td>
<td>75%</td>
</tr>
<tr>
<td>Q14 (Oct-Dec ’20)</td>
<td>76%</td>
<td>95%</td>
</tr>
<tr>
<td>Q15 (Jan-Mar ’21)</td>
<td>42%</td>
<td>66%</td>
</tr>
<tr>
<td>Q16 (Apr-Jun ’21)</td>
<td>98%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Source: SFDPH Database (Avatar)

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 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.
As Delivered. 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. Salvation Army and Transitions a good working relationship throughout.

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, and complete the plan in collaboration with RAMS (for all participants) and Felton (for TAY participants).

As delivered. Between Quarter 4 (when there was the first successful completion of the program) and Quarter 16, there was a total of 103 successful completions of the residential treatment program. For that same time period, there was record of 45 community care plans (CCPs) being completed. This demonstrates that just under half of the participants who successfully completed the program left with a CCP. However, 90% of clients who successfully completed programming were engaged in some way with a RAMS Peer Counselor, indicating that this extra support was made available to PRSPR participants to at least some extent even if it did not include the development of a CCP for everybody. (See Table 7.)

Table 7: Community Care Plans by Quarter, Oct 2017- Jun 2019

<table>
<thead>
<tr>
<th>Quarter</th>
<th># of Successful Completions</th>
<th>#/% of Successful Tx Completers w/CCPs</th>
<th>#/% of Successful Tx Completers Who Were Engaged with RAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 (Apr – Jun ’18)</td>
<td>2</td>
<td>100% (2 of 2)</td>
<td>100% (2 of 2)</td>
</tr>
<tr>
<td>Q5 (Jul – Sept ’18)</td>
<td>8</td>
<td>63% (5 of 8)</td>
<td>100% (8 of 8)</td>
</tr>
<tr>
<td>Q6 (Oct – Dec ’18)</td>
<td>8</td>
<td>88% (7 of 8)</td>
<td>100% (8 of 8)</td>
</tr>
<tr>
<td>Q7 (Jan – Mar ’19)</td>
<td>9</td>
<td>89% (8 of 9)</td>
<td>100% (9 of 9)</td>
</tr>
<tr>
<td>Q8 (Apr-Jun ’19)</td>
<td>14</td>
<td>93% (13 of 14)</td>
<td>100% (14 of 14)</td>
</tr>
<tr>
<td>Q9 (Jul-Sep ’19)</td>
<td>3</td>
<td>33% (1 of 3)</td>
<td>100% (3 of 3)</td>
</tr>
<tr>
<td>Q10 (Oct-Dec ’19)</td>
<td>8</td>
<td>50% (4 of 8)</td>
<td>100% (8 of 8)</td>
</tr>
<tr>
<td>Q11 (Jan-Mar ’20)</td>
<td>9</td>
<td>56% (5 of 9)</td>
<td>100% (9 of 9)</td>
</tr>
<tr>
<td>Q12 (Apr-Jun ’20)</td>
<td>10</td>
<td>0% (0 of 10)</td>
<td>80% (8 of 10)</td>
</tr>
<tr>
<td>Q13 (Jul-Sep’20)</td>
<td>8</td>
<td>0% (0 of 8)</td>
<td>63% (5 of 8)</td>
</tr>
<tr>
<td>Q14 (Oct-Dec ’20)</td>
<td>6</td>
<td>0% (0 of 6)</td>
<td>83% (5 of 6)</td>
</tr>
<tr>
<td>Q15 (Jan-Mar ’21)</td>
<td>15</td>
<td>0% (0 of 15)</td>
<td>87% (13 of 15)</td>
</tr>
<tr>
<td>Q16 (Apr-Jun ’21)</td>
<td>3</td>
<td>0% (0 of 3)</td>
<td>33% (1 of 3)</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>44% (45 of 103)</td>
<td>90% (93 of 103)</td>
</tr>
</tbody>
</table>

Source: PRSPR CCPs collected by HLC-Salvation Army and RAMS
Most of the CCPs, were developed just prior to planned program exits. CCPs were only completed at the target rate of 100% in the very beginning when there were only 2 successful program completers to start with. After a slight decline, the rate of completion did gradually increase between, almost reaching 100% by Quarter 8. However, there was then a rapid decline in CCP completion (dropping to 33% in Quarter 9), and by Quarter 12 (after COVID-19) CCPs were no longer getting completed.

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 103 individuals who successfully completed treatment, 96 (93%) were enrolled in Medi-Cal at the time of discharge.

Because CCPs were not getting completed at the rate that had been hoped for, challenges with community care planning were identified and discussed by program partners. These included:

- **Lack of understanding of the purpose for CCPs.** 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 then 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 and it continued to make the timing and purpose of the CCP more complicated than was originally envisioned.

- **Growing pains associated with establishing new partnerships.** 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 was a challenge, as Peer Counselors, who were only present on site at HLC at most for two days each week, were not always aware when a participant was going to be discharged. The Peer Counselors (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 often had many competing demands. Many meetings and discussions were 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 Counselor from RAMS to develop the detailed Community Care Plan. In an interview with RAMS, it was verified that it was often difficult for Peer Counselors to develop CCPs with their clients one month prior to discharge as planned. In some cases CCPs were less of a priority than other parts of work with clients, especially for those who choose to remain in treatment beyond their time in PRSPR.

- **Having to invent ways to keep communication open between multiple partners.**
  Communication was one of the biggest barriers to keeping the development of CCPs on track. Because partners do not share one common database for day-to-day program tracking, made it even more challenging for RAMS to identify exactly which clients were enrolled in PRSPR and when those who were would be ready for community care planning and discharge. However, they did meet frequently with Salvation Army and tried to build upon any open channels of communication to make processes smoother and more consistent.

Although CCPs did not get completed as hoped for, it was not for lack of trying. The implementation team work group has had several ongoing discussions about what a “good” community care plan should look like, and RAMS met several times with Salvation Army to try to find ways to make the process more efficient. These meetings helped to strengthen relationships in general, and partners remained open and flexible despite the many challenges and frustrations in this area. Also of note, RAMS Peer Counselors were able to consistently make connections with nearly all of the successful program completers and efforts were taken to make their role as meaningful and useful as possible, even if it was different than that which was originally planned.

**Peer Navigation**

**As planned.** Peer Counselors 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 Counselor would be selected to work specifically with TAY participants.

**As delivered.** Through the end of Quarter 7, there were at least 170 new initiations with Peer Counselors (i.e., first contact within each episode), representing 168 unique clients. (See Table 8.) Of these 168 unique clients, 144 were enrolled in Salvation Army Harbor Light Center. An additional 24 were TAY clients who had been connected to RAMS through Felton, but had chosen not to enroll (yet) in the Salvation Army program.

Because Peer Counselors 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 fluctuated (ranging from 9 to 24 and averaging about 16 per quarter).
Table 8: Peer Navigation Initiations by Quarter, Oct 2017- Jun 2021

<table>
<thead>
<tr>
<th>Quarter</th>
<th>New Initiations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 (Oct – Dec ‘17)</td>
<td>0</td>
</tr>
<tr>
<td>Q3 (Jan – Mar ‘18)</td>
<td>0</td>
</tr>
<tr>
<td>Q4 (Apr – Jun ’18)</td>
<td>2</td>
</tr>
<tr>
<td>Q5 (Jul – Sept ‘18)</td>
<td>26</td>
</tr>
<tr>
<td>Q6 (Oct – Dec ‘18)</td>
<td>14</td>
</tr>
<tr>
<td>Q7 (Jan – Mar ’19)</td>
<td>17</td>
</tr>
<tr>
<td>Q8 (Apr-Jun ’19)</td>
<td>13</td>
</tr>
<tr>
<td>Q9 (Jul-Sep ’19)</td>
<td>22</td>
</tr>
<tr>
<td>Q10 (Oct-Dec ’19)</td>
<td>12</td>
</tr>
<tr>
<td>Q11 (Jan-Mar ’20)</td>
<td>13</td>
</tr>
<tr>
<td>Q12 (Apr-Jun ’20)</td>
<td>18</td>
</tr>
<tr>
<td>Q13 (Jul-Sep ’20)</td>
<td>24</td>
</tr>
<tr>
<td>Q14 (Oct-Dec ’20)</td>
<td>9</td>
</tr>
<tr>
<td>Q15 (Jan-Mar ’21)</td>
<td>0</td>
</tr>
<tr>
<td>Q16 (Apr-Jun ’21)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>170</strong></td>
</tr>
</tbody>
</table>

Source: RAMS peer navigation logs

While RAMS was a dedicated program partner, and the Peer Counselors were viewed as assets to the program, peer navigation 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 Counselors 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 mid-2018, that the first Peer Counselor (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 Counselor. 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 previously there were some challenges in integrating the work between RAMS and Salvation Army. To that end, Salvation Army provided a dedicated space for Peer Counselors at Harbor Light Center which proved to be very helpful. However, only being on site two days each week at most made it challenging to be fully integrated into programming. Because there were numerous other participants at Salvation Army outside of PRSPR, it was not always clear who was in the program, and there was no easy way to track who was ready for community care planning.
• **Role confusion by clients.** There was some confusion among clients regarding the independent roles of Salvation Army staff and RAMS. During an early focus group with PRSPR participants, clients had many questions about what exactly the Peer Counselor 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.

• **Limitations affiliated with the COVID-19 pandemic.** Although this will be discussed in more detail in a later section, COVID-19 really did impede progress that RAMS had been making with program implementation. Having met several times to work though issues with Community Care Plans and other barriers, the pandemic resulted in a complete lack of access to PRSPR clients. The HLC campus was on lockdown due to public health regulations and concerns, and RAMS was unable to visit the campus to meet with the clients for quite a while. Great effort was placed into trying to open up programming through virtual means, but it took time to get the equipment and procedures in place, and it never took off as hoped for.

• **Staffing limitations.** In addition to the contracting delays that impacted staffing early on, later in the grant there were also some transitions with RAMS staff who moved on to other positions or took personal leaves of absence. One of the ways that RAMS was able to reinvent its role within PRSPR was to partner with the Felton Case Manager who was able to provide clinical supervision for the Peer Counselors and was very proactive about co-facilitating support groups with them. Through this partnership there as a new surge of activity, and engagement with participants really ramped up. However, as of Quarter 15, Felton’s Case Manager transitioned to a different job, resulting in yet another setback.

Despite the aforementioned challenges with Peer Navigation, it is not meant to imply that this aspect of programming did not work. RAMS never once gave up on dedicating themselves to the work and continued to brainstorm ways to find the best fit for them within the program. The role of the Peer Counselor ultimately looked different than that which was planned, but all partners remained highly committed to working with one another and allowing the role to take shape in response to what best fit with program and client needs. RAMS Peer Counselors continued to offer one-on-one peer support to many of the PRSPR residents to the extent possible, and also built a very strong, albeit temporary, partnership with the Case Manager from Felton to facilitate PRSPR/TAY support groups at Salvation Army in addition to their own PRSPR Support Group meetings. 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 ultimately created a more effective system of support for clients.

There is one success story of note from all of these efforts. A former PRSPR participant who worked closely with one of the RAMS Peer Counselors was inspired to become a Peer Counselor himself! This individual was accepted into and graduated from the RAMS Peer Specialist Mental Health Certificate Program Entry Course on Dec. 10th, 2020, and credited his Peer Counselor with inspiring him and helping him move forward with this new career path, which has been a vital part of his recovery.

Interestingly, in a July 2021 focus group, eight PRSPR participants were asked about their experience with the RAMS Peer Counselors and their perceptions of that type of support. None of the participants were familiar with Peer Counselors, but all were very excited to hear about the work that RAMS did and were eager to get connected.
PRSPR Participant 1: “Did you say RAMS? This is the first time I have really heard about that. And I’d like to get all of the information, a person I can contact. And since you bring it to our attention, do you think they could contact us?”

Facilitator: “It sounds like some of you would like this additional support. Is that…

PRSPR Participant 1: “Yes!”

PRSPR Participant 2: “Sure!”

PRSPR Participant 3: “Definitely!”

PRSPR Participant 4: “Especially the 60 days after discharge. It’s great!”

Although too late for this grant in particular, these sentiments should not go neglected. RAMS offers a valuable service to the community, and although filling out CCP forms together with Salvation Army Counselors may not be the best use of time and energy, there are clearly ways in which this partnership can be enhanced moving forward so that those who are in treatment get all of the additional support possible throughout their recovery.

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.

As delivered. 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, and this Clinician moved on to a new job in Quarter 15 and was not replaced. This had a negative impact on the work of RAMS Peer Counselors with TAY, as their TAY-focused Peer Counselor needed to have a Clinician on board long enough to offer them guidance and supervision. Collectively, these delays left long periods of time during which the TAY population were not receiving extra support or promised case management services. The delays also left long periods of time during which grant funds were not expended. This was one of the primary reasons why a no-cost extension (until August 15, 2021) was requested.
Seven of the 61 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. The first TAY Clinician provided 305 hours of service 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. Between Quarters 8 and 14 the second Felton TAY Clinician made 95 referrals and logged 821 case management contacts that encompassed 540 hours of engagement. She also initiated 7 outreach activities (for agencies such as Native American Health Center, Jail Behavioral Health and Reentry Services, and TAY Behavioral Health), through which 81 staff were engaged. Although there were large gaps in service, when a Clinician was on board the services provided suggested that there was great potential for Felton to make strong contributions to the TAY population. The collaboration between Felton and RAMS around the facilitation of TAY+ Support Groups was also an especially effective way for the Felton Case Manager to offer additional support to TAY clients, and for RAMS to re-envision their role in response to the fact that the majority of clients remain at Harbor Light Center long term.

**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

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<table>
<thead>
<tr>
<th>Quarter</th>
<th>New Initiations</th>
<th>#/% Also Enrolled in Salvation Army</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 (Oct – Dec ’17)</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Q3 (Jan – Mar ‘18)</td>
<td>1</td>
<td>100% (1 of 1)</td>
</tr>
<tr>
<td>Q4 (Apr – Jun ’18)</td>
<td>13</td>
<td>38% (5 of 13)</td>
</tr>
<tr>
<td>Q5 (Jul – Sept ‘18)</td>
<td>1</td>
<td>0% (0 of 1)</td>
</tr>
<tr>
<td>Q6 (Oct – Dec ’18)</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Q7 (Jan – Mar ’19)</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Q8 (Apr-Jun ’19)</td>
<td>1</td>
<td>0% (0 of 1)</td>
</tr>
<tr>
<td>Q9 (Jul-Sep ’19)</td>
<td>9</td>
<td>11% (1 of 9)</td>
</tr>
<tr>
<td>Q10 (Oct-Dec ’19)</td>
<td>5</td>
<td>0% (0 of 5)</td>
</tr>
<tr>
<td>Q11 (Jan-Mar ’20)</td>
<td>8</td>
<td>0% (0 of 8)</td>
</tr>
<tr>
<td>Q12 (Apr-Jun ’20)</td>
<td>12</td>
<td>0% (0 of 12)</td>
</tr>
<tr>
<td>Q13 (Jul-Sep ’20)</td>
<td>11</td>
<td>0% (0 of 11)</td>
</tr>
<tr>
<td>Q14 (Oct-Dec ’20)</td>
<td>8</td>
<td>0% (0 of 8)</td>
</tr>
<tr>
<td>Q15 (Jan-Mar ’21)</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Q16 (Apr-Jun ’21)</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61</strong></td>
<td><strong>11% (7 of 61)</strong></td>
</tr>
</tbody>
</table>

Source: Felton Institute case logs
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 Counselor.

As delivered. Funds were requested from all three direct service providers for PRSPR (Felton Institute, RAMS and Salvation Army). However, Salvation Army, who had the longest relationship with clients, was likewise, the highest utilizer of flex funds. The San Francisco Public Health Foundation (PHF), who was the fiscal agent in charge of flex funds, only attended initial 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 continued to submitted all documentation as required for reimbursement, and expressed satisfaction with the pace at which reimbursements were made. As mentioned, parameters around flex fund spending were kept somewhat loose by design to allow for funding to address individual client needs, especially in support of their program goals. However, the parameters of flex funds were an early source of confusion for the partners, especially Salvation Army, as well as PRSPR clients.

As a result, 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 equitable distribution was also a point of discussion. It can be challenging to distribute funds fairly to clients. As program participants began to hear about different ways in which their peers had been supported, they expressed some suspicions about the ways in which funds were 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 were told that “additional support for meeting your individual wellness and recovery goals may be available, as determined with your counselor8,” but this left room for misconceptions and confusion. Many stated the desire for a hard number.

With time, issues with flex funds seemed to sort themselves out. Participants’ basic needs were met without explicitly calling out the use of flex funds. Although these funds were tapped into regularly, it was not being utilized as much as anticipated. There were several factors contributing delays including periods of time when Felton did not have a Case Manager available to assign to the PRSPR program, barriers to the involvement of RAMS Peer Counselors and, of course, COVID-19. All of these are discussed in more detail in their respective sections.

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8 Promoting Recovery and Services for the Prevention of Recidivism (PRSPR) program brochure (2019).
Evaluation Findings: Outcomes

Preliminary Client Quality of Life Outcomes
As specified in the logic model, it was anticipated that an improvement in clients’ quality of life outcomes, such as, changes in sense of well-being and criminal mindset as a result of a treatment, as well as overall satisfaction with program services would have an impact on more distal client outcomes, such as reduced recidivism. To this end, the evaluation 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 included items designed to measure satisfaction and confidence, perceived quality of life, and positive and negative affect. Both pre- and post-surveys were needed for analysis. Collecting surveys (post-surveys in particular) proved to be a challenge. As of the end of Quarter 10, only 12 participants completed both the pre- and post-Wellbeing Surveys, and after that point there were no further submissions of post-surveys to the evaluator. Although the sample size was extremely small, and data collection stopped far before the end of the program, analysis was conducted on the completed surveys using paired sample t-tests. Results are presented in Table 10.

For the first five items on the survey (meant to measure satisfaction and confidence), a higher mean is more desirable. Among the twelve respondents, there was an overall increase on all satisfaction and confidence items, one of which (confidence in maintaining sobriety) 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 decrease in negative affect and emotions (not statistically significant, but more desirable). Although only completed by a small sample of program completers, these results suggest that participation in PRSPR led to an improved sense of wellbeing for clients.

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Pre (Mean)</th>
<th>Post (Mean)</th>
<th>Change Score</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction &amp; Confident with Life (Scale: 1-5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my current financial situation.</td>
<td>1.83</td>
<td>2.08</td>
<td>0.25</td>
<td>.835</td>
</tr>
<tr>
<td>I am satisfied with my current housing situation.</td>
<td>2.25</td>
<td>3.50</td>
<td>1.25</td>
<td>.756</td>
</tr>
<tr>
<td>I am confident that I can maintain sobriety.</td>
<td>4.00</td>
<td>4.33</td>
<td>0.33</td>
<td>* .039</td>
</tr>
<tr>
<td>All things considered; I am happy.</td>
<td>3.58</td>
<td>4.17</td>
<td>0.59</td>
<td>.118</td>
</tr>
<tr>
<td>Overall, I am satisfied with my life as it is right now.</td>
<td>2.33</td>
<td>3.58</td>
<td>1.25</td>
<td>.739</td>
</tr>
<tr>
<td>Perceived Quality of Life (Scale: 1-6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Ranking</td>
<td>2.71</td>
<td>3.58</td>
<td>+0.87</td>
<td>.073</td>
</tr>
<tr>
<td>Affectivity Score (Scale: 10-50)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Affect Sum Score</td>
<td>31.92</td>
<td>37.33</td>
<td>+5.41</td>
<td>.568</td>
</tr>
<tr>
<td>Negative Affect Sum Score</td>
<td>26.25</td>
<td>17.92</td>
<td>-8.33</td>
<td>.317</td>
</tr>
</tbody>
</table>

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)\(^9\) 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. As with the Wellbeing Survey, data collection was a challenge, especially with regard to post-surveys. A total of just thirteen participants completed both pre- and post-CTS surveys. Nonetheless, paired sample t-tests were conducted for each scale item and the results are presented in Table 11.

Table 11: Pre-/Post- Criminal Mindset Results, Dec 2017- Dec 2019 (n=13)

<table>
<thead>
<tr>
<th>Scale Scores (Scale: 10-50)</th>
<th>Pre (Mean)</th>
<th>Post (Mean)</th>
<th>Change Score</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold Heartedness</td>
<td>22.15</td>
<td>22.15</td>
<td>0</td>
<td>1.000</td>
</tr>
<tr>
<td>Power Orientation</td>
<td>23.74</td>
<td>20.33</td>
<td>-3.41</td>
<td>.092</td>
</tr>
<tr>
<td>Entitlement</td>
<td>16.03</td>
<td>16.41</td>
<td>0.38</td>
<td>.831</td>
</tr>
<tr>
<td>Justification</td>
<td>19.49</td>
<td>16.15</td>
<td>-3.34</td>
<td>.031*</td>
</tr>
</tbody>
</table>

Source: Texas Christian University Criminal Thinking Scale (CTS) - adapted
*Statistically significant at the .05 level.

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 two of the four scales from pre- to post-survey. 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 that surfaced can really only be attributed to chance as much as anything else.

Satisfaction with Program Services

Finally, to measure overall client satisfaction, HTA conducted one final focus group with PRSPR participants on July 15, 2021. There were eight participants representing a variety of experience with the PRSPR program, ranging from new enrollees to those who were ready to successfully complete the program. Questions were crafted around different components of the program (e.g., the enrollment process, Peer Counselors, 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. They mentioned that they had signed up for the program in large part because of its good reputation in the community. Word gets around when a program is strong.

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\(^9\) 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
“I knew a couple of people that said this was a really good program and the people that told me this, they are doing great, so they told me to give it a go. And also my social worker at UCSF also told me this was a great program, so that is why I decided to come here.”

-PRSPR Participant

“I came here because I heard about the program and everything I heard about it was good. Here they treat us fairly.”

-PRSPR Participant

“For me, I heard it was the best program in the city and that they have excellent chefs.”

- PRSPR participant

Overall, participants expressed that their experience with the program lived up to expectations. There were a few frustrations expressed with COVID-19 restrictions and related staffing shortages, but for the most part, participants had positive feedback to share and valued, among other things, the diverse and great people, the comradery, the healthy environment, the counselors, the support, and the chance to work on their own personal recovery plan. At least among this small sample of PRSPR participants, the level of satisfaction with the program was extremely high.

“I didn’t have any expectations, but I am thoroughly satisfied with how I am coming along. I guess they give you an opportunity to better yourself. They say the program only works if you work it, so it is there for you to utilize. I am satisfied with the opportunity that I got to better myself, and that makes me happy, so I am very satisfied.”

-PRSPR Participant

“I am satisfied too. They cover the basics: the housing, the food…Even if people need clothes, they also help you on that level too. If you know what type of resources you need, they can help you get that resource. They can lead you to it if you don’t have the information.”

-PRSPR participant

“I had no idea that programs like this existed. My experience has been extremely positive. There was a literal kind of hair raising at first because you don’t know what to expect. And there was a little learning the rules and the regulations, and getting yourself in line with that and maybe faltering from time to time, but certainly it is a well-designed program. It is with very good people. The staff is wonderful and provides a lot of support. I have always felt very supported, very protected, and it has helped me achieve stability and establish a good foundation for reentering the community.”

- PRSPR participant

Recidivism Outcomes
Arrest data was collected from the San Francisco City and County District Attorney’s records spanning from October 2014 through December 2020. 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.

The goal for recidivism data was to look at arrests and convictions for comparable time periods prior to admission and after discharge. Because our data extended through December 2020 we wanted to include in our sample only those participants who had been back in the community for at
least a six-month period of time, allowing for sufficient time to pass in which arrests or convictions could have happened. Therefore, only those who exited the program on or before June 30, 2020 were included in our sample, leaving us with data for 167 residential treatment program exits.

Of those 167 cases, 63 (38%) had no evidence of arrest and/or conviction in San Francisco between October 2014 and December 2020. It is possible that these participants had earlier periods of criminal involvement, or had criminal involvement outside of San Francisco. However, for the purposes of our study these cases were not included in the final analysis. This left 104 cases who had been in the community for at least six months and had some evidence of arrest and/or conviction in San Francisco. Of this group there were 49 cases with evidence of arrest and/or conviction within six months of PRSPR program enrollment and/or discharge. Within this group of 49 there was a total of 67 arrests up to six months prior to program enrollment. The range of pre-arrests was 0 to 6, and averaged 1.37. Within this same group there was a total of 33 arrests up to six months after discharge from the program, ranging from 0 to 3 arrests, and averaging 0.67. This decrease in arrests was statistically significant (p=.008).

There were very few convictions within this group. There were only 6 convictions up to six months prior to program enrollment. The range of pre-convictions was 0 to 1, and averaged 0.12. Within this same group there was a total of 4 convictions after discharge from the program, ranging from 0 to 1, and averaging 0.08. Although this shows a decrease in the number of convictions, the numbers were very small to start with and the change was not statistically significant.

For the majority of this six month cohort, there was a reduction in the total number of arrests from six months before program admission to six months after program discharge. Thirty-four of the 49 cases (69%) had fewer arrests in the six months after discharge than in the six months before admission. For two of the cases there was no change. Only 13 of the cases (27%) had more arrests on record after discharge.

As mentioned, there were very few convictions. However, six of the cases (12%) had fewer convictions in the six months after discharge than in the six months before admission. For the vast majority of cases (80%) there was no change in convictions (holding steady at 0). For just four cases (8%) there was an increase in the number of convictions after discharge.

Because the expectation would be that successful program completers would fare better than those who were unsuccessful (i.e., had left the program prematurely), we analyzed this same data to see if there were any differences between successful program completers and those who were not. **There were only 16 cases in our dataset for successful completers. However, among that group we found a statistically significant reduction in arrests, and three-fourths of these cases reduced their number of arrests from pre- to post.** (See Table 12). For unsuccessful completers, there were many more arrests on record both pre- and post, but they too showed a reduction in arrests (although it was **not** statistically significant), and two-thirds of these cases reduced their number of arrests from pre- to post. (See Table 13). There were very few pre and post convictions for both groups, and there were no significant findings.
### Table 12: Pre-/Post- Arrest Comparisons Between Successful Program Completers and Unsuccessful, Six Month Cohort Dec 2017- Dec 2020 (n=49)

<table>
<thead>
<tr>
<th></th>
<th># Pre arrests</th>
<th># Post arrests</th>
<th>% reducing # of arrests</th>
<th>Pre arrest avg</th>
<th>Post arrest avg</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful Program Completers (N=16)</td>
<td>21</td>
<td>9</td>
<td>75%</td>
<td>1.31</td>
<td>0.56</td>
<td>.003*</td>
</tr>
<tr>
<td>Unsuccessful Program Completers (N=33)</td>
<td>46</td>
<td>24</td>
<td>67%</td>
<td>1.39</td>
<td>0.73</td>
<td>.074</td>
</tr>
</tbody>
</table>

Sources: Salvation Army Case Logs; San Francisco City and County District Attorney’s records

*Statistically significant at the .01 level.

### Table 13: Pre-/Post- Conviction Comparisons Between Successful Program Completers and Unsuccessful, Six Month Cohort Dec 2017- Dec 2020 (n=49)

<table>
<thead>
<tr>
<th></th>
<th># Pre convictions</th>
<th># Post convictions</th>
<th>% reducing # of convictions</th>
<th>Pre conviction avg</th>
<th>Post conviction avg</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful Program Completers (N=16)</td>
<td>1</td>
<td>2</td>
<td>6%</td>
<td>.06</td>
<td>.13</td>
<td>.580</td>
</tr>
<tr>
<td>Unsuccessful Program Completers (N=33)</td>
<td>5</td>
<td>2</td>
<td>15%</td>
<td>.15</td>
<td>.06</td>
<td>.263</td>
</tr>
</tbody>
</table>

Sources: Salvation Army Case Logs; San Francisco City and County District Attorney’s records

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. Our data enabled us to look at results for up to six months post-treatment. What we found was that of our group of program completers with any record of arrest within six month before or after the PRSPR program (n=49), four (8%) were convicted of a new felony or misdemeanor six months after discharge. If we could all program completers within the same timeframe regardless of if they had record of arrest or not (n=167), then the rate of conviction is even smaller (only 2%).

One of the goals for the PRSPR program was that as a cohort, 40% of participants would demonstrate lower recidivism rates than in a comparable period prior to admission. In our six-month cohort there were six convictions within six months prior to program admission. Of those six cases, none of them had any convictions within six months of program discharge. Therefore, 100% of our participants with a conviction on record six months prior to discharge demonstrated lower recidivism rates in a comparable period post-discharge. Granted, four participants who did not have prior convictions did end up with convictions in a comparable time period post-discharge. **Combined together, we have a full sample of ten individuals with convictions on record within six months of program admission and/or discharge, six of whom (60%) had lower recidivism rates post-discharge.**

Although this recidivism data is very encouraging, the number of convictions for this population was very low to start with. It is possible that the population that was served by the program was not prone to recidivism in the first place. Nonetheless, the fact that there was a significant decrease in the number of arrests for successful program completers does strongly suggest that the PRSPR program did lead to a reduction in criminal activity for those who stuck with the program.
COVID 19

It would be remiss to submit a report for the time period in which this grant was implemented without addressing the impact of COVID-19 on program operations and outcomes. It took time for program implementation to ramp up, and the first few years of the grant involved a lot of troubleshooting and collaboration to overcome barriers and address early challenges. Within the first two years of the grant, the referral process became more streamlined and communication with referring agencies was strengthened, RAMS was working closely with Salvation Army to address ways to improve their work together especially around the development of CCPs, and Felton finally had a strong Clinician in place to address the needs of the TAY population. Just before COVID the program was in a good place, and numbers were starting to prove it. In Quarter 11, referrals were at an all-time high of 53, admissions to detox and residential treatment were up, the occupancy rate had increased to 82%, the percentage of successful program completers leaving residential treatment with a CCP was increasing, and 100% of successful completers had been connected to a Peer Counselor. And then COVID happened.

All partners responded swiftly and creatively to the situation, but business as usual was put to a halt. Salvation Army quickly developed COVID-19 protocols for their Harbor Light Center facility and remained in constant communication with their National Headquarters, the San Francisco Department of Public Health, and program partners to review and update procedures as needed, putting health and safety first. RAMS and Felton were unable to engage with clients in residential treatment. However, they tried to work with Salvation Army to find creative ways to keep clients engaged, hoping to implement virtual meetings and support groups. Everybody was eager to keep supporting PRSPR participants, and to do whatever was necessary to adapt to the unforeseen circumstances. Although it was an incredibly stressful time, program partners were resilient, adjusting and adapting to the “new normal” as best they could.

By Quarter 12 Salvation Army put the health and safety of all residents at the forefront, reconfiguring space, expanding screening criteria and adding in a requirement for medical screening in order to mitigate the spread of the virus, and meeting frequently to ensure that the latest guidelines were in place. They were unable to let program partners onto their campus, but put effort into upgrading on-site technology to make it possible for more virtual meetings and support groups. Felton’s Case Manager had already built increasingly larger caseloads over the past several quarters, but unfortunately the support groups which had been gaining quite a bit of momentum in the past were not possible at the time, so attention was placed on more one-on-one client support and outreach.

In Quarter 15 there was a small outbreak of COVID at Harbor Light Center, and Salvation Army lost its Program Director and a member of their maintenance team to the virus. An Interim Director was able to fill the Program Director position temporarily, but the prior Director had been fiercely dedicated to the PRSPR program, and her loss was a devastating blow. This same quarter, coinciding with all of the job changes taking place nationwide during the pandemic, Felton’s Case Manager transitioned to a new position and it was not expected that a replacement would be found for the remainder of the grant. One of the RAMS Peer Counselors also moved on to a new position.

By Quarter 16, after several COVID-related setbacks, the flow of new PRSPR clients began to come in again. Measures were taken to mitigate further incidents (e.g., COVID testing, mandatory quarantines, etc.) and were effective in warding off any additional outbreaks.
RAMS experienced a lot of barriers to their work throughout the course of the pandemic, as so much of it depended on being able to meet with clients at Harbor Light Center. They had to put much of their work on hold. Before COVID they expressed that “there was a palpable feeling that something big was happening through the PRSPR collaboration,” and they felt that they were getting woven into the way that things were happening at Harbor Light. Although efforts were made to bring RAMS staff back to Harbor Light Center post-pandemic, COVID was too much of a barrier. A lot of staff had some pretty serious medical conditions, so residential settings were avoided. RAMS strongly advocated for virtual access to participants and worked closely with Salvation Army to expand their capacity for telehealth and remote engagement. It was thought that with virtual access it could even be easier to meet together to develop CCPs with participants. However, there were some telehealth limitations at Harbor Light, and it was difficult to get virtual engagement off the ground. There was little opportunity to provide in-person or virtual peer support during the pandemic despite consistent efforts to do so. Wanting to remain active, RAMS offered additional peer support services to Felton’s TAY clientele who were served under this grant, but not enrolled in detox or residential treatment. However, losing Felton’s Case Manager in Quarter 15 was a barrier toward accepting more youth clients being that there was a clinical component to the work and a Case Manager was needed for oversight. In the final quarters of the grant, the Peer Counselor continued to work with existing clients to the extent possible, connecting them to resources and peer support. Although COVID did make a huge impact on the way that services could be delivered, there was agreement that the partnership that had been built through PRSPR was very powerful, and it was decided that collaboration would be sustained moving forward.

Despite all of the pandemic-related limitations, it was inspirational to see program partners adapt and respond with flexibility and creativity to their work. Although the grant could not be implemented exactly as planned and some of the numbers fell short of expectations, partners remained dedicated to the grant throughout. They leveraged their expertise and collaboration to keep services available to all PRSPR clients, to whatever extent possible.

**Conclusion**

**Did the project work as intended?**

Despite some challenges and growing pains, the PRSPR program, to a large degree, worked exactly as intended. At least four of the project objectives were met and one was almost met. Only two, community care planning and the program occupancy rate, fell short of expectations, and to some extent it was attributable to circumstances beyond the control of the program (e.g., COVID-19). Slight adjustments to programming were continuously 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 Counselor. However, despite these changes, the fundamental program model remained intact and program partners were driven to deliver services as promised as part of a coordinated system of care.
Appendix

Logic Model .......................................................................................................................................... A-2
PRSPR Procedures .............................................................................................................................. A-3
PRSPR Pamphlet ............................................................................................................................... A-14
## The Context and Situation

<table>
<thead>
<tr>
<th>What you Know</th>
<th>What You Think</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Environment:</strong> San Francisco</td>
<td>Formerly incarcerated individuals with SUD and/or co-occurring disorders would be best served by comprehensive residential SUD treatment and outpatient MH services</td>
</tr>
<tr>
<td><strong>Target population:</strong> Adults, incl TAY (transitional age youth, ages 18-25), who have been arrested, charged or convicted of a criminal offense, and who are assessed &amp; authorized for substance use disorder (SUD) residential treatment (tx)</td>
<td>TAY face additional challenges in accessing specialized tx due to extensive histories of trauma, inadequate support systems, unstable housing and minimal educational and employment histories</td>
</tr>
<tr>
<td><strong>Assets:</strong> Robust network of providers in SF w/extensive experience working with the target population</td>
<td>TAY have history of incarceration</td>
</tr>
<tr>
<td><strong>Challenges:</strong> Limited affordable housing in SF</td>
<td>Harm reduction approach is critical &amp; effective for individuals with SUD</td>
</tr>
<tr>
<td>Average of 6-week wait for residential SUD tx; shortage of SUD beds</td>
<td>Local community-based organizations (CBOs) are better suited to meet clients “where they are at”</td>
</tr>
<tr>
<td>Lacking tailored curricula to meet developmental needs of TAY with SUD and/or co-occurring disorders</td>
<td>Prop 47 legislation BSCC funding Hard March Funding</td>
</tr>
<tr>
<td>DPH w/18.5 FTE clinical and suvp staff (match) 32 residential SUD beds at Salvation Army @ $90/day 5 social detox SUD beds at Salvation Army @ $100/day</td>
<td>Local CBO partners (Felton &amp; RAMS) w/ 1 FTE clinical case manager (CCM) and 1.5 FTE peer navigators (grant-funded)</td>
</tr>
<tr>
<td>SF Public Health Foundation manages project-related expenses &amp; “flex” funds for participants (grant-funded)</td>
<td>Local evaluator (HTA)</td>
</tr>
<tr>
<td><strong>Prepared by:</strong> Hatchuel Tabernik and Associates</td>
<td><strong>The Planned Work</strong></td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
<td><strong>Activities</strong></td>
</tr>
<tr>
<td>Prop 47 legislation BSCC funding Hard March Funding</td>
<td>Partners trained in evidence-based practices</td>
</tr>
<tr>
<td>DPH TAP staff identify, stabilize, &amp; refer participants to residential SUD tx</td>
<td>TAY-specific SUD curriculum developed (Felton)</td>
</tr>
<tr>
<td>3-6 months of residential tx (SA)</td>
<td>“Warm hand-off” for participants via collaboratively developed community care plan (CCP)</td>
</tr>
<tr>
<td>60 days post-residential tx peer navigation by RAMS</td>
<td>Ave. length of stay for participants in residential and/or social detox tx</td>
</tr>
<tr>
<td><strong>The Intended Results</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Short-term Outcomes</strong></td>
<td><strong>Long-term Outcomes</strong></td>
</tr>
<tr>
<td>Engage target # of adults w/SUD or co-occurring disorders who have history of criminal justice involvement</td>
<td>PRSPR participants will demonstrate lower recidivism rates during and after program participation than they did during a similar period before participating in the program</td>
</tr>
<tr>
<td>64 individuals/yr engaged in residential tx</td>
<td>40% will demonstrate lower recidivism rates than in comparable prior period</td>
</tr>
<tr>
<td>90% occupancy rate at detox/residential tx</td>
<td>50% fewer jail beds days per year than in comparable prior period</td>
</tr>
<tr>
<td>Participants completing tx will have CCP that connects them to community-based resources supporting ongoing stabilization and recovery</td>
<td>Improved quality of life for PRSPR participants</td>
</tr>
<tr>
<td># CCPs developed</td>
<td>Connections to housing, employment, etc.</td>
</tr>
<tr>
<td># successful exits from tx</td>
<td>Reduction in substance use</td>
</tr>
<tr>
<td>Units of service of CCM provided to TAY</td>
<td>Reduction in harm</td>
</tr>
<tr>
<td># types of referrals made to TAY</td>
<td>Change in criminal thinking</td>
</tr>
<tr>
<td># of outreach events for TAY/# TAY reached</td>
<td># of TAY placed in residential tx</td>
</tr>
<tr>
<td>Units of service of peer navigation provided by RAMS</td>
<td># CCPs developed</td>
</tr>
<tr>
<td># starting residential or social detox tx at SA</td>
<td># starting residential or social detox tx at SA</td>
</tr>
<tr>
<td>Monthly occupancy rates for PRSPR beds</td>
<td>Monthly occupancy rates for PRSPR beds</td>
</tr>
<tr>
<td>TAY-specific curriculum used</td>
<td>TAY-specific curriculum used</td>
</tr>
<tr>
<td>Ave. length of stay for participants in residential and/or social detox tx</td>
<td>Ave. length of stay for participants in residential and/or social detox tx</td>
</tr>
<tr>
<td># CCPs developed</td>
<td># CCPs developed</td>
</tr>
<tr>
<td># successful exits from tx</td>
<td># successful exits from tx</td>
</tr>
<tr>
<td>Units of service of CCM provided to TAY</td>
<td>Units of service of CCM provided to TAY</td>
</tr>
<tr>
<td># types of referrals made to TAY</td>
<td># types of referrals made to TAY</td>
</tr>
<tr>
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<tr>
<td># CCPs developed</td>
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</tr>
<tr>
<td># successful exits from tx</td>
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<td>Units of service of peer navigation provided by RAMS</td>
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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
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
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
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)
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
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
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
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
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
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
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.
Your time in PRSPR

1. Accepted into PRSPR
2. Enter into detox/residential treatment at Salvation Army (SA)
3. Develop an individualized treatment plan with your counselor
4. Engage in residential treatment services (including working with counselor and RAMS Peer Navigator)
5. One month before discharge: Create community care plan (CCP) with counselor and RAMS Peer Navigator
6. Discharge from PRSPR, up to 6 months after entry
7. Either continue residential treatment at SA with non-PRSPR funds or enter back into the community

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

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.

“It’s a safe place here. I’ve never felt safe before in my life.”
– PRSPR Participant