

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

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Project Background

Faced with two seismically unsound jails and a three-month jail recidivism rate of 63%,¹ the San Francisco (SF) Board of Supervisors requested that the Director of Health and the SF Sheriff convened a workgroup in 2016 to plan for permanent closure of the unsafe jails and identify investments in services or facilities that uphold public safety and better serve at-risk individuals. The 37-member Workgroup to Re-envision the Jail Replacement Project (the “Jail Workgroup”), which included 51% community representation, engaged in an extensive seven-month community engagement and research effort from which prioritized strategies were developed. One of the most highly prioritized strategies was the need for additional residential treatment beds for system-involved adults struggling with substance use disorder (SUD) and serious mental health (MH) needs.

A significant number of the city’s system-involved individuals are in need of SUD and/or MH treatment, including approximately 75% of the 3,854 adults on probation.² Of the 13,544 people incarcerated in SF County Jail in 2015, 36% had contact with Jail Behavioral Health Services; 24% had more than one contact; and 7-14% were diagnosed with a serious mental illness (SMI). Due to the impact of substance use on MH symptoms, many individuals with dual diagnoses would best be served by comprehensive residential SUD treatment and outpatient MH services to address SUD needs prior to completing a MH residential program. However, due to the shortage of SUD beds, this best practice frequently does not occur and can impact the overall effectiveness of MH treatment. Currently, there is an approximately six-week wait for residential SUD treatment, a five-day wait for detox, and a two to four week wait for residential MH treatment. Individuals in custody can wait up to four months for MH treatment.³ Lack of timely access to treatment often leads to SUD relapse, MH decline, homelessness, criminal behavior and repeated incarceration.

Treating transitional age youth (TAY) (ages 18-25) warrants additional attention due to their increased risk-taking behavior and inexperienced decision-making abilities, inadequate support systems and housing, and minimal educational and employment histories. Additionally, TAY have been traditionally difficult to engage into treatment. TAY comprise 8% of SF’s population, but accounted for 22% of arrests⁴ and 14% of County jail inmates accessing BHS in 2015.⁵ That same year, 36% of SF TAY reported psychiatric or emotional conditions; 23% reported drug or alcohol abuse; and 26% reported PTSD.⁶ While the system of MH and SUD care is available to all TAY in need of services, tailored curricula to meet TAY developmental needs is lacking.

Project Overview

In June 2017, the San Francisco Department of Public Health (SFDPH) was awarded a three year Proposition 47 grant from the Board of State and Community Corrections (BSCC) to implement the **Promoting Recovery and Services for the Prevention of Recidivism (PRSPR)** program. This grant is funded for \$6 million dollars for 38 months (June 16, 2017-August 15, 2020).

¹ Degeneffe, M. (2011). Knocking on the revolving door: analyzing recidivism in San Francisco. SF Fellows Report.

² Community Corrections Partnership Executive Committee. (2015). Three years of realignment in San Francisco.

³ San Francisco Department of Public Health. (2016).

⁴ BSCC data set. (2015).

⁵ San Francisco Department of Public Health. (2016).

⁶ Harder + Co. Community Research. (2015). Providing stability and support: an assessment of San Francisco’s transitional age youth housing and services system.

The PRSPR program is designed to provide additional Substance Use Disorder (SUD) treatment services for individuals who have been arrested for, charged with, or convicted of a criminal offense. This grant will fund 32 residential SUD treatment beds (3-6 months stay), as well as five social detox beds, at Salvation Army Harbor Lights. 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 TAY in the 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. The following is a description of PRSPR program partners and the services that they will be providing to participants. A Client Flow Chart with data collection points is also provided in the Appendix to help summarize how participants will progress through the program.

Intake/Referrals. SFDPH will serve as lead agency and will be responsible for project coordination, grant administration and facilitation of connections to the DPH system of care. DPH-funded services are trauma informed, client centered, and rooted in principles of harm reduction, recovery and wellness. All treatment providers are required to use treatments that are appropriate, evidence-based or promising practices that have been demonstrated to improve outcomes for individuals with SUD, MH, co-occurring treatment needs and criminal justice involvement.

- Intake and referrals will 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 programs operate within SFDPH's Behavioral Health Services division.
- Staff from these four programs will conduct assessments to determine treatment needs, severity of substance use, and level of care needed; will secure consent and authorization for the program; provide care coordination; and will support individuals in the completion of program applications. Staff from TAP will also support the program by overseeing administrative processing for all intakes.

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

Utilization review. Participants will remain in residential treatment for as long as treatment is deemed to be of medical necessity. The SFDPH Transitions Division will receive all referral data from TAP in order to provided utilization management services. Salvation Army will work with Transitions to set a monthly meeting to review PRSPR cases receiving treatment at their facility. PRSPR participants will be discussed at the onset of the meeting. 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.

If a participant is determined to no longer meet necessity for residential treatment, Salvation Army and the DPH Project Director will be notified. At that time, Salvation Army may continue to serve the individual through an alternative funding source, but their PRSPR case status will be marked as closed. BHS case managers will continue to provide mental health services for as long as they are clinically indicated.

Community care planning. Prior to completion of residential treatment, each participant will 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. Salvation Army will drive the completion of the CCP 30 days prior to discharge, working closely with RAMS, Felton, and community based treatment providers, as needed.

Peer navigation. Peer Navigators from Richmond Area Multi-Services (RAMS), a non-profit mental health agency committed to advocating for and providing community-based, culturally-competent services, will 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 of the Peer Navigators will be matched to TAY participants.

TAY linkage and services. 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 will 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 will assist with the development of a TAY specific curriculum for Substance Use Disorder treatment services. FI will 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.

Flex funds. San Francisco Public Health Foundation (SFPHF) will serve as a fiscal sponsor and will manage 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. Only BSCC-eligible project expenses will be approved by SFPHF, and all partners requesting funds will maintain documentation of all costs claimed and reimbursed.

Case Conferencing. 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.

Logic Model

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

Program Goals & Objectives

Program Grant Goals and Objectives

As stated in the grant proposal:

- ✚ **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.

Partner Goals & Objectives

In addition to the grant stated program goals and objectives, SFDPH established contracts with all of their partners to help ensure fidelity and accountability to programming. Many of the partner goals and objectives overlap with program goals and objectives, but will be monitored separately as part of the evaluation to monitor the responsibilities and progress of each of the program partners.

✚ **Partner 1: Salvation Army**

SA1.1: By the end of the fiscal year, Salvation Army will have enrolled at least 64 individuals in residential treatment.

SA1.2: By the end of FY17, Salvation Army will have achieved at least a 90% occupancy rate in their residential program that will be maintained throughout the project.

SA1.3: By the end of the fiscal year, at least 50% of participants will have completed a minimum of 3 months of residential treatment.

SA1.4: By the end of the fiscal year, 100% of participants that successfully complete residential treatment will have an individually tailored community care plan.

SA1.5: By the end of the fiscal year, 90% of participants that successfully complete residential treatment will be enrolled in MediCal.

Partner 2: Felton Institute

FI1.1: By the end of the fiscal year, at least 50% of TAY participants enrolled in residential SUD treatment will complete a minimum of 3 months of residential treatment.

FI1.2: By the end of the fiscal year, 90% of TAY participants that successfully complete residential treatment will be enrolled in MediCal.

Partner 3: Richmond Area Multi-Services (RAMS)

R1.1: By the end of the fiscal year, RAMS Peer Navigators will have at least one contact with 100% of PRSPR clients who complete residential treatment.

R1.2: By the end of the fiscal year, 50% of participants that successfully complete residential treatment will be engaged with peer services for a minimum of 30 days.

Plan for Collecting Data to Measure Program/Partner Goals

The evaluator, Hatchuel Tabernik and Associates (HTA), has participated in implementation team workgroup meetings and the planning process from the inception of this project. Representatives from each of the program partners are aware of reporting needs and expectations, and have agreed to provide data as needed. Additionally, data sharing agreements were addressed in the contracts between SFDPH and partner agencies. Simultaneous to developing the local evaluation plan, HTA created partner-level data collection plans outlining all of the requested data from each of the partners along with a quarterly timeline for which data is to be submitted. To the extent possible, the data collection plans were designed to pull from existing partner instruments. However, the evaluator also created new instruments and data entry spreadsheets to facilitate the collection of information that had not been captured in other forms.

Table 1 presents a summary of the data that is being requested of program partners to measure performance and progress toward program goals and objectives, as well as their own specific partner goals and objectives outlined in their contracts.

Table 1. Data Collection Plan for Program and Partner Goals

Objective(s)	Outcome	Indicators	Data Source
1.1 SA1.1	Meet enrollment targets	<ul style="list-style-type: none"> • # of individuals referred to Salvation Army • # individuals enrolled in residential treatment at Salvation Army • demographics of individuals referred to and enrolled in program • history of substance use • history of involvement with criminal justice system 	<ul style="list-style-type: none"> • PRSPR SFDPH Case Logs • PRSPR SFDPH Referral Cover Sheet • Salvation Army Case Log
1.2 SA1.2	High occupancy	<ul style="list-style-type: none"> • -Monthly occupancy rate (sum of daily beds used/sum of daily beds available) 	<ul style="list-style-type: none"> • Avatar (daily census maintained by Salvation Army)
2.1 SA1.4	Development of community care plan before discharge	<ul style="list-style-type: none"> • # participants completing residential treatment • # participants for whom a community care plan is developed • Date community care plan developed • Date of discharge from residential treatment 	<ul style="list-style-type: none"> • Salvation Army Case Log • Community Care Plans (CCPs)
2.2 SA1.4	Individually-tailored community care plans	<ul style="list-style-type: none"> • Needs identified on Community Care Plans 	<ul style="list-style-type: none"> • Community Care Plans (CCPs)
2.3 SA1.5 FI1.2	Maximize enrollment in public benefits	<ul style="list-style-type: none"> • # participants completing residential treatment • # enrolled or re-enrolled in Medi-Cal • # enrolled or re-enrolled in other public benefit programs (e.g., SSI, GA, CalFresh, other) • Date of enrollment in programs • Demographics (i.e., age) 	<ul style="list-style-type: none"> • Salvation Army Case Log • Salvation Army Care Plans • Felton Case Log • Felton Case Plans • RAMS Case Log • RAMS Peer Service Logs • RAMS Empowerment Services Referrals

Objective(s)	Outcome	Indicators	Data Source
3.1 SA1.3 FI1.1	Successful completion of residential treatment	<ul style="list-style-type: none"> • # individuals enrolled in residential treatment at Salvation Army • Date of enrollment at Salvation Army • Program status (active, inactive, successful dx, dropout, etc.) • # participants completing residential treatment • Date of discharge from residential treatment • Demographics (i.e., age) 	<ul style="list-style-type: none"> • Salvation Army Case Log
3.2	Lower recidivism rates	<ul style="list-style-type: none"> • # of convictions for felony or misdemeanor in San Francisco for period prior to program admission (up to 3 years for each enrolled client) • # of convictions for felony or misdemeanor in San Francisco for comparable period after enrollment in program (up to 3 years for each enrolled client) • types of convictions in both time periods • dates of arrests, re-incarcerations, and new/prior offenses 	<ul style="list-style-type: none"> • SFDPH Coordinated Case Management System (CCMS) • Jail Health Records • SF District Attorney database via a data sharing MOU
3.3	Fewer days in jail (or Reduced LOS)	<ul style="list-style-type: none"> • LOS at SF jail in period prior to program admission (up to 3 years for each enrolled client) • LOS at SF jail after enrollment in program (up to 3 years for each enrolled client) 	<ul style="list-style-type: none"> • SFDPH Coordinated Case Management System (CCMS) • Jail Health Records • SF District Attorney database via a data sharing MOU
R1.1	Peer Navigator Engagement	<ul style="list-style-type: none"> • # participants completing residential treatment • # of these participants meeting with peer navigator at least once 	<ul style="list-style-type: none"> • Salvation Army Case Log • RAMS Case Log • RAMS Peer Service Logs
R1.2	Peer Navigator Retention	<ul style="list-style-type: none"> • # of participants completing residential treatment • # of these participants connected to peer services • dates of service (length of engagement) 	<ul style="list-style-type: none"> • Salvation Army Case Log • RAMS Case Log • RAMS Peer Service Logs

Evaluation Research Design

Hatchuel Tabernik & Associates (HTA) will conduct an independent evaluation of its Promoting Recovery & Services for the Prevention of Recidivism (PRSPR) program. HTA will utilize a **utilization-focused approach** combining mixed methods of program data, interviews, and surveys to address the impact of the Proposition 47 grant funds on PRSPR clients. Utilization-based evaluation is an approach whereby the evaluation activities *from beginning to end* are focused on the *intended use by the intended users*.⁷ Additionally, the evaluation will focus on both process and outcome elements. The process evaluation will be oriented towards providing information on how to continuously revise and improve the program, as needed. The outcome evaluation will be focused on describing the program's outcomes cumulatively over the three year period.

Description of Process and Outcome Evaluation

Process Evaluation

The process evaluation includes a continuous improvement model to program implementation by addressing fidelity to the program plan and monitoring specific program goals (i.e., number engaged, criminal history, substance use history, program occupancy, length of stay, etc.). Process data will include various service utilization records including referral forms, case logs, assessments, treatment/care plans, services, referrals, and exit forms. Data will be 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 will participate in quarterly implementation team meetings, and conduct periodic check-ins and interviews with program leadership and partners (e.g., SA, FI, RAMS, SFPHF, etc.) to discuss program developments. Topics of discussion will include successes/challenges in recruitment and engagement, client progress, areas for improvement, evidence-based best practices utilized, and lessons learned from the collaboration between agencies.

Table 2 specifies the evaluation questions which will guide our process evaluation, and specifies the data sources from which the information will be gathered.

⁷Patton, M.Q. (2012). *Essentials of Utilization-Focused Evaluation*. Thousand Oaks, CA: SAGE Publications, Inc.

Table 2. Guiding Process Evaluation Questions

Evaluation Question	Indicators	Data Source(s)
Program Referrals & Enrollment		
1. Is the target population being reached? What is the profile of individuals being referred to PRSPR residential SUD treatment?	<ul style="list-style-type: none"> • Point of entry? (i.e., TAP, OTP, JBHS, LEAD) • Demographics (age, gender, sexual orientation, race/ethnicity, criminal history, SUD history, etc.) 	<ul style="list-style-type: none"> • PRSPR SFDPH Case Logs
2. What is the length of time between referral to enrollment at Salvation Army?	<ul style="list-style-type: none"> • Date of referral from point of entry • Date of enrollment at Salvation Army 	<ul style="list-style-type: none"> • PRSPF SFDPH Case Log • Salvation Army Case Log
3. What is average length of stay in social detox and/or residential treatment?	<ul style="list-style-type: none"> • Date of enrollment in social detox • Date of exit from social detox • Social detox program status (e.g., active, early exit, successful completion, etc.) • Date of enrollment in residential treatment • Date of exit from residential treatment • Residential treatment program status (e.g., active, early exit, successful completion, etc.) 	<ul style="list-style-type: none"> • Salvation Army Case Log
Community Care Planning/Transitions		
4. What do transitions look like from residential treatment to case management (for TAY) and/or to peer navigation?	<ul style="list-style-type: none"> • Description of client handoff • Description of collaboration between partners • # of Community Care Plans • Date of enrollment in residential treatment • Date of exit from residential treatment • Dates when Community Care Plans are developed • Date first seen by program partners 	<ul style="list-style-type: none"> • Salvation Army Case Log • Felton Case Log • RAMS Case Log • Community Care Plans (CCPs) • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts

Evaluation Question	Indicators	Data Source(s)
Peer Navigation (RAMS)		
5. What services do Peer Navigators provide to PRSPR clients (including # and length of contacts)? Do services vary by population?	<ul style="list-style-type: none"> • Dates of service • Service categories • Time spent (in minutes) • Demographics 	<ul style="list-style-type: none"> • RAMS Case Log • RAMS Peer Service Logs • RAMS Empowerment Services Referrals • Community Care Plans (CCPs)
6. What is quality of the pairing (i.e., similar demographics, level of trust, pattern of regular connection, level of commitment and mutual satisfaction)?	<ul style="list-style-type: none"> • Member/Navigator self-report • Demographics • Description of successes and challenges throughout program implementation 	<ul style="list-style-type: none"> • RAMS Member/Navigator Surveys • Member and Navigator Interview/Focus Group Transcripts
TAY Outreach, Support & Case Management (Felton)		
7. What does TAY outreach look like? <ul style="list-style-type: none"> ○ Which outreach strategies were employed? Which of those were most effective with TAY? 	<ul style="list-style-type: none"> • # of outreach events • Type of outreach events • # of participants at each event • Description of outreach strategies used 	<ul style="list-style-type: none"> • Felton Case Log • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts
8. What services does the Case Manager provide to TAY clients (including # and length of contacts, types of services and referrals)? <ul style="list-style-type: none"> ○ What types of support services are provided by Felton specifically to TAY youth receiving services at Salvation Army? 	<ul style="list-style-type: none"> • Dates of service • Service categories • Time spent (in minutes) • Referrals made 	<ul style="list-style-type: none"> • Felton Case Log • Felton Case Plans • Community Care Plans (CCPs)

Evaluation Question	Indicators	Data Source(s)
9. Do services for TAY differ from services provided to adult participants? If so, how?	<ul style="list-style-type: none"> • Dates of Service • service Categories • time spent (in minutes) • demographics • description of differences, if any, working with TAY as compared to adults 	<ul style="list-style-type: none"> • Felton Case Log • Felton Case Plans • RAMS Peer Service Logs • RAMS Empowerment Services Referrals • Community Care Plans (CCPs) • Quarterly Implementation Team Meeting Minutes
TAY-Specific Curriculum		
10. How did Felton and Salvation Army work together to develop and implement a TAY-specific curriculum for participants?	<ul style="list-style-type: none"> • Description of collaborative process • Length of time to develop curriculum • Description of how the curriculum us being utilized 	<ul style="list-style-type: none"> • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts
11. How does the TAY-specific curriculum differ from the curriculum already in use at Salvation Army?	<ul style="list-style-type: none"> • Copies of curricula • Description of characteristics and needs specific to TAY • Description of differences in TAY-specific curriculum 	<ul style="list-style-type: none"> • TAY-specific curriculum • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts
Fidelity and Collaboration		
12. What are the successes and challenges that emerge throughout the implementation of the program? <ul style="list-style-type: none"> ○ What were the providers' experiences of collaborating with each other? ○ Are there benefits of utilizing multiple providers to support participants? Hindrances? 	<ul style="list-style-type: none"> • Description of program successes, challenges and lessons learned • Description of collaborative process 	<ul style="list-style-type: none"> • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts

Evaluation Question	Indicators	Data Source(s)
13. How are SF Public Health Foundation flex funds allocated? In what ways are partners supported by these flex funds?	<ul style="list-style-type: none"> • Reimbursement categories • Amount spent on each category • Categories that emerged as most needed • Description of ways in which the flex funds supported programming 	<ul style="list-style-type: none"> • SFPHF Monthly Program Disbursement Request Forms • Partner Expense Tracking • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts
14. Do any barriers emerge to program entry, connecting clients with services, and retention? If so, how were they overcome?	<ul style="list-style-type: none"> • Description of barriers • Description of strategies and solutions • Descriptions of any barriers that could not be overcome 	<ul style="list-style-type: none"> • Quarterly Implementation Team Meeting Minutes • Partner Interview Transcripts

Outcome Evaluation

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

In the grant application, it was proposed that there would be a total of 192 enrollees over the three year grant-funded period (through September 2020). (See Table 3.) The first five months of the grant have been spent on planning. Implementation of the program will begin on November 13, 2017. To achieve target enrollment, an average of 16 individuals would need to be enrolled each quarter (approximately 5-6 individuals per month). We anticipate that baseline data will be collected for all participants. The grant application proposed that 50% of participants would complete 3-6 months of residential treatment. This would be the sample from which we can pull our post discharge data⁸. We can begin collecting discharge data in the third quarter, the point at which three months of treatment completion could have been achieved. The grant application did not specify the numbers of individuals who would be engaged with Peer Navigators. However, partner specific objectives lead us to anticipate that 50% of participants who successfully complete residential treatment will be engaged with peer services for a minimum of 30 days. Therefore, we will use this as our proxy for the anticipated sample size at 60-days post. We can begin collecting this data in the fourth quarter, the point at which individuals could have been discharged for 60 days.

Table 3. Anticipated Outcome Data Collection Sample

Grant Quarter	Calendar Months	Avg. Enrollments/Quarter	Anticipated Baseline N	Anticipated Discharge N	Anticipated Post-Release N
1	Jun – Sep 2017	--	--	--	--
2	Oct – Dec 2017	16	16	0	0
3	Jan – Mar 2018	16	16	8	0
4	Apr – Jun 2018	16	16	8	5
5	Jul – Sep 2018	16	16	8	4
6	Oct – Dec 2018	16	16	8	4
7	Jan – Mar 2019	16	16	8	4
8	Apr – Jun 2019	16	16	8	4
9	Jul – Sep 2019	16	16	8	4
10	Oct – Dec 2019	16	16	8	4
11	Jan – Mar 2020	16	16	8	4
12	Apr – Jun 2020	16	16	8	4
13	Jul – Sep 2020	16	16	8	4
	Total	192	192	88	41

⁸ The N will be greater if higher percentages of participants successfully complete programming.

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

Because recidivism is of particular interest for this grant, this outcome will be a highlight of the evaluation. For the purposes of this study, recidivism is defined as the conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction. We will be exploring recidivism within the SF Jail system specifically for each individual for up to three years prior and up to three years after enrollment in the PRSPR program. Because admission to the program is rolling, it will be most useful to conduct this study using a cohort model, taking into account the length of time an individual is involved with the PRSPR program. For example, an individual who enrolls at the start of the first year of programming cannot be compared equally to an individual who enrolls toward the end of the third year. More time will have passed for the first individual since discharge from treatment, allowing for more time to recidivate. Therefore, recidivism for this study will be calculated as if they were follow-up rates, calculating pre-post recidivism rates for each individual at 6-month intervals following their enrollment in PRSPR.

Table 4 outlines each cohort, or group of participants, who enroll during the same time span, and what recidivism rates will be calculated. For example, for clients who enroll in the second and third quarters, recidivism rates can be calculated at 6-months post-intake, at 1-year post-intake and so on.

Table 4. Recidivism Rates that Can Be Calculated for each Program Cohort

Grant Quarter	Calendar Months	6-m	1-yr	1.5-yr	2-yr	2.5-yr	3-yr
1	Jun – Sep 2017						
2/3	Oct 2017-Mar 2018	☑	☑	☑	☑	☑	☑
4/5	Apr – Sept 2018	☑	☑	☑	☑	☑	
6/7	Oct 2018 – Mar 2019	☑	☑	☑	☑		
8/9	Apr – Sept 2019	☑	☑	☑			
10/11	Oct 2019 – Mar 2020	☑	☑				
12/13	Apr – Sept 2020	☑					

Table 5 specifies all of the evaluation questions which will guide our outcome evaluation of recidivism and all other outcome measures, and specifies the data sources from which the information will be gathered.

Table 5. Guiding Outcome Evaluation Questions

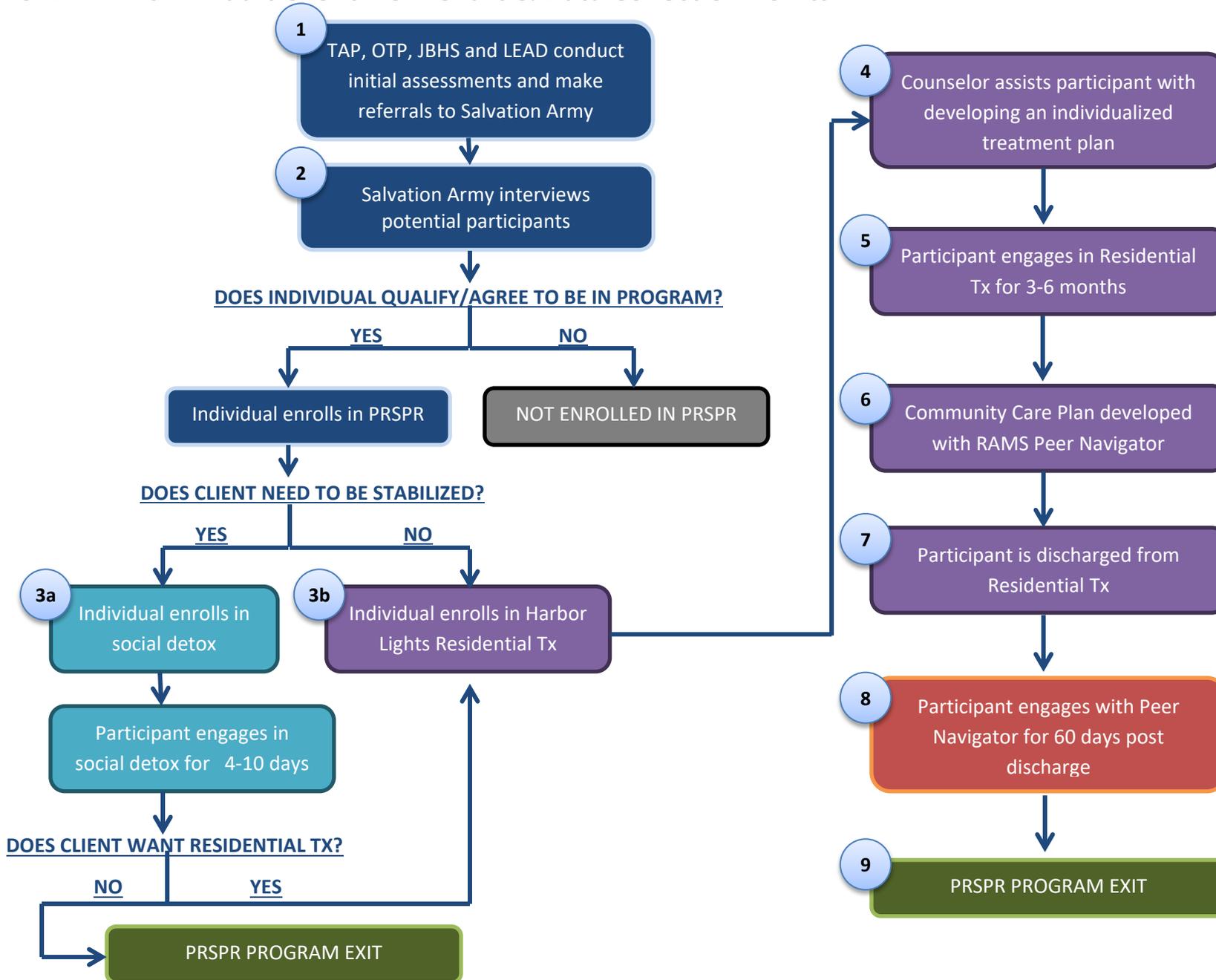
Question	Indicators	Data Source(s)
Program Start		
1. What is the baseline of individuals on key outcomes when they start the program?	<ul style="list-style-type: none"> • Baseline behavioral health and substance use issues (i.e., diagnoses; SMI; SUD; SUD/MH and psychiatric hospitalization history) • Recent criminal history & criminal thinking • Housing, employment, public benefits • Perceived quality of life 	<ul style="list-style-type: none"> • PRSPR SFDPH Case Logs • PRSPR SFDPH Referral Cover Sheet • Salvation Army Case Log • Salvation Army Intake Interview • Salvation Army Intake Outcomes Form • TCU Criminal Thinking Scale (Salvation Army Intake) • Wellbeing Survey (Salvation Army Intake)
Program Completion (i.e., residential SUD treatment)		
2. What is profile of clients who successfully complete 3-6 months of residential treatment? When clients leave residential treatment...	<ul style="list-style-type: none"> • Key demographics • Connections made to housing, employment, medical care, behavioral health treatment • Other connections made • Changes in behavioral health and substance use issues (i.e., diagnoses; SMI; SUD; SUD/MH and psychiatric hospitalization history) • Changes in criminal thinking • Changes in housing, employment, enrollment in public benefits • Changes in perceived quality of life 	<ul style="list-style-type: none"> • PRSPR SFDPH Referral Cover Sheet (demographics) • Salvation Army Case Log • Salvation Army Exit Plan • Felton Case Log • Felton Case Plans • RAMS Peer Service Logs • RAMS Empowerment Services Referrals • Community Care Plans (CCPs) • Salvation Army Discharge Outcomes Form • TCU Criminal Thinking Scale (Salvation Army Discharge; 60-days Post) • Wellbeing Survey (Salvation Army Discharge; 60-days Post)

Question	Indicators	Data Source(s)
3. Are there differential outcomes for transitional-age youth (TAY); others?	<ul style="list-style-type: none"> • Key demographics • Connections made to housing, employment, medical care, behavioral health treatment • Other connections made • Changes in behavioral health and substance use issues (i.e., diagnoses; SMI; SUD; SUD/MH and psychiatric hospitalization history) • Changes in criminal thinking • Changes in housing, employment, enrollment in public benefits • Changes in perceived quality of life 	<ul style="list-style-type: none"> • PRSPR SFDPH Referral Cover Sheet (demographics) • Salvation Army Discharge Outcomes Form • TCU Criminal Thinking Scale (Salvation Army Discharge; 60-days Post) • Wellbeing Survey (Salvation Army Discharge; 60-days Post)
Recidivism Reduction		
4. Do clients re-offend? <ul style="list-style-type: none"> ○ If so, what type and severity of crimes? ○ Do they spend fewer days in jail? 	<ul style="list-style-type: none"> • # of arrests (baseline and follow-up) • # of convictions for new charges (baseline and follow-up) • # of days in jail (baseline and follow-up) • Severity of crimes committed (baseline and follow-up) 	<ul style="list-style-type: none"> • Coordinated Case Management System (CCMS) records
5. Are there differential recidivism outcomes for transitional-age youth (TAY); others?	<ul style="list-style-type: none"> • Key demographics • # of arrests (baseline and follow-up) • # of convictions for new charges (baseline and follow-up) • # of days in jail (baseline and follow-up) • Severity of crimes committed (baseline and follow-up) 	<ul style="list-style-type: none"> • Coordinated Case Management System (CCMS) records • PRSPR SFDPH Referral Cover Sheet (demographics)

Appendix

PRSPR Client Flow ChartA-2
PRSPR Logic Model.....A-5

SFDPH PRSPR Adult Client Flow Chart & Data Collection Points



SFDPH PRSPR Adult Client Flow Chart & Data Collection Summary

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

¹ Treatment Access Program

² Offender Treatment Program

³ Jail Behavioral Health Services

⁴ Law Enforcement Assisted Diversion

SFDPH PRSPR Adult Client Flow Chart & Data Collection Summary

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

PRSPR Logic Model (10/04/17)

