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February 2019

From Arrest to Service Connection through a Pre-Arraignment Diversion Program:

An Implementation Evaluation of the Staten Island HOPE Program

Executive Summary

SUBMITTED TO:
New York City Mayor's Office of Criminal Justice

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Artis Bergman, Donna Tapper, Chloe Rinehart, and Jessica Dinac

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Executive Summary

In 2016, Staten Island had the highest overdose rate in New York City, having increased 66 percent from 2015.[1] In response, the Richmond County District Attorney, Michael E. McMahon, in partnership with the New York City Police Department, other city agencies, and community organizations on Staten Island, developed the Heroin Overdose Prevention and Education (HOPE) program. The program, launched in January 2017 after a 9-month collaborative planning process, was designed to address the growing opioid epidemic on Staten Island, as well as increases in other substance use, through pre-arraignment diversion to community-based harm reduction services of individuals arrested for a low-level substance-related crime.

In April 2017, the New York City Mayor's Office of Criminal Justice (MOCJ) selected Metis Associates to conduct an evaluation of the first year of the HOPE program. The evaluation was conducted with the cooperation and assistance of the Richmond County District Attorney and the Mayor's Office of Criminal Justice, as well as the program partners.

Partners in the Staten Island HOPE Program, 2017

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- New York City Police Department
- NYC Department of Health and Mental Hygiene
- Mayor's Office of Criminal Justice

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The report presents findings from a descriptive study of the program's implementation from inception through the end of December 2017, based on interviews with representatives of the partner organizations, program staff, and participants; and analysis of available data. The evaluation examined program assumptions and structure, participants' pathway into and experiences in the program, and the results of their engagement.[2]

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The HOPE Program

The impetus for and design of the HOPE program was driven by a sense of absolute urgency felt by the office of the Richmond County District Attorney (RCDA) and shared by agencies and organizations working to address substance use on Staten Island. The choice to offer the program to individuals prior to arraignment was in response to the belief that they face a strong risk of overdose prior to appearing in court and that waiting until after arraignment to provide treatment may be too late in some instances. The changing substance landscape—stronger substances, incorporation of fentanyl, increased use prescription drugs with illicit substances–is believed to have increased the likelihood of an overdose and therefore the need for immediate action.

Several assumptions underlie the program: [3]

1. substance misuse and overdose is exacerbated when individuals do not have easy access to support networks and services when needed;
2. substance misuse and overdose rates can be decreased by serving individuals with a range of needs, including those who are at risk of future misuse (e.g., prescription holders), but do not currently have a substance use disorder;
3. the time of arrest for a drug possession offense offers an opportunity to engage individuals who are at risk of substance misuse and/or overdose in services; and
4. the HOPE program can reduce substance misuse and overdose across the borough of Staten Island by creating connections between participants and the Staten Island service provider community that will be sustained after program completion.

Eligibility criteria include arrest on a §220.03 charge (Criminal Possession Of A Controlled Substance In The Seventh Degree)[4] in Staten Island and issuance of a Desk Appearance Ticket (DAT), which allows for the person's release pending a court date.

While at the precinct, individuals determined to be eligible meet with a trained peer mentor who explains the program; they are also contacted by staff from the Legal Aid Society. To avoid arraignment, participants must meet with a licensed counselor at one of the programs' designated Resource and Recovery Centers within seven days of the date of their DAT for an assessment, development of a service plan, and help with accessing services in support of their goals, and they must engage in services within 37 days post-arrest. Successful completion of the program, which results in case dismissal and no criminal record, is based on the determination by a Resource and Recovery Center that a participant has been "meaningfully engaged" in a service in some way within the 30-day program timeframe.

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Summary of Evaluation Findings

Participant Engagement. Many individuals agreed to participate in the program to clear their arrest record and avoid going to court. Most of those who hesitated but ultimately participated were concerned that their employer would learn of their involvement. For most of the participants, the HOPE program was their first interaction with any type of social service.

A key element of the program that is believed to contribute to participants' follow-through and engagement with staff at a Resource and Recovery Center is the initial engagement by a peer mentor at the precinct. Peer mentors are also responsible for distributing naloxone kits and providing instructions in how to use them. Of the participants who were met by a peer mentor at a precinct, 81 percent received a naloxone kit.[7] Interview findings indicate that for most participants, this was their first and only opportunity to receive a kit.

Resource and Recovery Center services begin with intake and assessment, discussion of participant's goals for treatment, care, or other needs, and development of a service plan based on goals set by participants and/or Resource and Recovery staff. The process was found to be implemented in a fairly standardized way across the three Resource and Recovery Centers, with some variation in Centers adding additional forms, encouraging drug testing, and having an additional peer encounter. Participants' goals were wide-ranging and included "getting clean", reducing substance use, "bettering" themselves, and staying out of trouble. Almost all interviewed participants said they felt comfortable at the Center they attended and reported a positive program experience overall. A total of 287 individuals (89% of those offered the program) completed intake and assessment at a Resource and Recovery Center.[8]

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Program Approach. The HOPE program is designed around a harm reduction approach—explained in the accompanying box[9]—insofar as the program is intended to provide tailored services to each individual including a full range of recovery and treatment options. Yet, the program's expectation that all participants would be served through a harm reduction approach was interpreted differently by various stakeholders across multiple partner organizations and agencies. All Resource and Recovery Centers used this approach, but some staff at these centers believed that harm reduction did not align with their own preferred methods (such as abstinence *only* programs) of addressing the substance use epidemic. These stakeholders were also skeptical about whether the program's timeframe would achieve the goal of facilitating participants' sustained connection to and engagement with the service community. Furthermore, feedback from agency partners indicates disagreement as to whether the goal-setting portions of a participant's intake are sufficiently consistent with a harm reduction approach. According to those expressing concern, linking meaningful engagement to an intervention—even if participant chosen—diverges from the intention of the program model.

Harm reduction refers to a set of evidence-based public health practices focused on reducing the harms of drug use. This umbrella term encompasses a wide range of strategies, such as nicotine replacement therapy (such as nicotine gum), methadone maintenance treatment for opioid dependence, and supervised injection facilities, among others. What these strategies have in common is an emphasis on promoting personal and community health without an insistence on abstinence. A common critique regarding harm reduction, which has invited resistance to the term, is the belief that non-abstinence-based approaches encourage or condone drug use. However, robust scientific evidence supports the effectiveness of these interventions. As jurisdictions grapple with how best to address overdose deaths, public health, law enforcement, and corrections officials are increasingly recognizing that these interventions are important aspects of the solution.

To ensure that participants have access to a full range of service options, as well as to allow for centralized data collection on participant service use, the program design included a requirement that all referrals would be made through Staten Island (SI) Connect, a 24/7 provider-only referral service developed for the HOPE program by the Staten Island Performing Provider System. However, use of SI Connect for referrals, which was not monitored by HOPE program staff, was substantially under-used. Resource and Recovery Center staff believed they had the ability to make referrals, and, because it is limited to Staten Island providers, SI Connect does not offer access to the broadest range of treatment options. SI Connect does not collect information about a participants' engagement with providers, which has limited its usefulness as a tool for tracking program outcomes.

[9] Source: Pope L, Davis C, Cloud D, Delany-Brumsey A. A New Normal: Addressing Opioid Use through the Criminal Justice System. New York: Vera Institute of Justice, no date.

Participant Experience. Overall, participants engaged in a variety of services while in the HOPE program and the majority completed the program within four weeks, Most used only one or two types of services with the majority receiving either one-on-one counseling or group counseling or both. Most participants interviewed were very satisfied with the services, especially with the harm reduction group classes and one-on-one counseling. They perceived the Resource and Recovery staff as very accepting, and were happy with the quality of the services and the educational aspects of the group counseling sessions. Participants also valued the wrap-around services that the Centers provided.

At the same time, some participants who had abstinence as their personal goal found it uncomfortable to attend activities at a Resource Recovery Center where individuals were present who continued to use substances. Feedback from stakeholders suggests that in these instances, it is possible that participants' needs and interests were not well-aligned with their service plan and, rather than referring them to abstinence programs offered by other community providers, they were referred to services at the Center.

Program Completion and Results. Successful completion of the program—meaningful engagement—was determined by Resource Recovery Center staff. Defined flexibly, meaningful engagement was not tied to any particular service type or duration. However, it was designed to ensure that the burden on participants would not be greater than what they would have faced had they continued with the court process following arrest. Program data from the first year of operations indicate that 94 percent of participants were determined to have meaningfully engaged in services and had their arrest cases dismissed.[10]

These findings are based on data provided by the NYPD. See the full report for details of the comparative analyses and characteristics of the comparison population. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the NYPD.

Meaningful engagement was found to be associated with a reduction in participants' subsequent arrests.[11] Only 15 percent of HOPE participants who meaningfully engaged in 2017 were re-arrested (as of June 30, 2018)[12] compared to 60 percent of those who had not meaningfully engaged. Furthermore, regardless of their meaningful engagement, HOPE participants were considerably less likely to be rearrested than a comparison population (19% vs. 44%).

Prevention of opioid overdose remains the longer-term outcome of the initiative. However, stakeholders understood the primary or desired outcome to be that of connecting participants to

[10] RCDA Weekly Update, January 3, 2018.
[11] Data interpretations, points of view, and opinions contained within this document are those of Metis Associates and do not represent the official position or policies of the NYPD.
[12] The extent of our analysis window.

ongoing services. They expect that participants will have a greater understanding of the services available and which services they need, and that they will know how to access those services. Avoidance of the criminal justice system, which further disrupts lives and can exacerbate substance use, is an additional outcome. Change in participants' substance use also was described as a potential outcome of the program, but one that may or may not be achieved within the timeframe of the program.

The majority of participants interviewed indicated that they did not have plans to continue services, but they felt able to do so later. However, some did report following a service plan that extended beyond the program's timeframe. Participants described the program as breaking down the stigma of substance use, which had prevented them from accessing related services. They emphasized the importance of avoiding the court process as a major positive outcome of participating in the HOPE program. And a large portion of them described having reduced their substance use as a result of program participation, which varied depending on reported substances used, extent of reduction, and type of service received. Some participants who used opioids as well as those who used cannabinoids reported "getting clean" though the program. The means differed, however, with some emphasizing the educational element of the program while others crediting their participation in structured treatment activities leading to abstinence; others said that it was the arrest that motivated them. Many participants also described themselves as adjusting their behavior to better protect their health and safety.

Key Program Elements. The evaluation identified the following key elements of the program:

- leadership and vision of the District Attorney and a partnership structure;
- adoption of a harm reduction approach;
- development of a set of criteria and standard procedures for determining program eligibility;
- inclusion of a participant advocate (Legal Aid Society) in the partnership;
- deployment of peer mentors trained as peer recovery coaches to introduce the program to eligible individuals;
- use of community-based organizations as Resource and Recovery Centers for intake, assessment, and referral; and
- assignment of responsibility for determining participant completion (meaningful engagement) to staff of the Resource and Recovery Centers.

Of note, access to overdose prevention training and naloxone was not identified as a defining element of the HOPE program. While critical to reducing overdose deaths on Staten Island, evaluation findings indicate that, as implemented, the distribution of naloxone is not essential to the HOPE program model and it could be distributed (along with training) through some other means.

Overall, the program offered participants a considerable benefit: the opportunity to receive supportive services and treatment for substance use in response to self-directed goals instead of court involvement, which even in the case of dismissal requires a substantial time commitment. Qualitative feedback suggests that participation in the HOPE program may lead to a connection to providers that will allow individuals to seek out and obtain services after program completion.

Recommendations for Program Improvement

The HOPE program can be strengthened by addressing stakeholders' understanding and/or expectations regarding several design elements such as the program's harm reduction approach, when and how referrals should be made, how meaningful engagement should be defined, and details about the reporting of services and participation. Based on the evaluation findings, we offer the following recommendations:

1. Codify expectations in a memorandum of understanding signed by all program partners that ensures agreement and buy-in on: the program's harm reduction approach and meaningful engagement, the role of Resource and Recovery Centers in referrals, and the sharing and reporting of program and participation data.
2. Increase transparency around the frequency and reasons for a determination by the District Attorney's Office that an individual arrested on a covered charge and issued a DAT is not eligible for the program.
3. Explore with relevant partners whether the deployment and oversight of peer mentors would be better managed by an independent program partner rather than a Resource and Recovery Center that is providing services to participants.
4. Incorporate into the program model ongoing support from peer mentors to participants so that participants have the opportunity to interact with peer mentors from recruitment through completion.
5. Support peer mentors through additional education and training (on topics such as navigating law enforcement and treatment systems) and by creating peer support networks of their own. Develop dedicated support and coordination positions for the peer mentors.
6. Review peer mentor training on naloxone kit distribution to identify areas of improvement, particularly concerning the distribution of kits to individuals who decline to participate in the HOPE program as well as to individuals who do not self-identify as using substances.
7. Expand distribution of the naloxone kits beyond the initial meeting at the precinct. Provide access to naloxone kits at all points of interaction with participants. Leverage the lived experience of peer mentors to convince participants that carrying a naloxone kit and training in its use is important.
8. Provide training and opportunities for counselors across the Resource and Recovery Centers to share practices for conducting intake and assessment that they have found to be effective within the HOPE program's timeframe.
9. Offer support to Resource and Recovery Centers for data collection and tracking of intake, assessment, and referral information.
10. Re-open the discussion about the length of time a participant has to complete the HOPE

program before a meaningful engagement determination has to be made, in response to the preference expressed by a majority of program partners that the potential for a longer duration will allow for broader treatment options and more opportunities for participants to successfully exit the program.

Implications for Replication

We believe that the HOPE program design lends itself to replication. Successful replication would likely require adapting the design to the local context, including:

- arrest patterns;
- court-based strategies for addressing substance abuse (e.g., court-mandated or offered treatment programs);
- patterns of substance use among community members;
- community access to services;
- current relationships among service providers; and
- relationships between community-based organizations, the local prosecutor, and the local law enforcement agency.

The replication of the HOPE program design also offers the opportunity for many of the current challenges to be avoided through initial development of written memoranda of understanding between partners, covering the topics addressed above. We also believe that replications of the program within and outside New York City will benefit from the support and insight of HOPE program partners. Replications should leverage these partners as sources of expertise and advocates for the program model. For example, the support provided by NYPD's leadership can help to build legitimacy for the program design among other law enforcement agencies and may facilitate the buy-in of arresting officers.

Through the evaluation we also identified two areas of program development that are critical to the success of the program: the selection of appropriate community organizations as Resource and Recovery Centers and the engagement of the local law enforcement agency as an active partner. For each, we offer the following guidance drawn from the collective feedback of HOPE program stakeholders.

In selecting community providers to fulfill the role of Resource and Recovery Centers, consider the following: prior experience providing similar services; willingness to identify their capabilities and areas where they would benefit from additional support; ability to comply with program expectations; commitment to the treatment approach adopted by the program; and evidence of relationships with providers of complementary services such as health, education, vocational, mental health, job readiness, and/or housing services.

To facilitate the partnership with the local law enforcement agency: engage all levels of staff within the agency; identify and support champions within the agency who can advocate for the program's success and address any concerns; develop and maintain open lines of communication with other program partners; provide training to arresting officers that emphasizes the "mission-oriented" nature of the program; and provide ongoing training to new and newly transferred officers. If necessary, introduce law enforcement officers to individuals who are personally affected by the substance abuse epidemic so that the "personal component of the program" is conveyed.

Topics for Further Study

As this evaluation was focused on implementation of the first year of the HOPE program, it did not examine the full extent to which participants achieved the program's intended outcomes. One year later, assuming the availability of data, such an evaluation could be undertaken. At the same time, the evaluation could further explore fidelity to the harm reduction approach and the manner in which meaningful engagement is determined. To carry this out study, mechanisms need to be put into place to allow for follow-up information to be collected from active program participants once they are referred outside of a Resource and Recovery Center and once they are meaningfully engaged.

Additional topics for further study include:

- The relationship between service types included in a participant's service plan (e.g., harm reduction, in-patient, abstinence-based, outpatient) and subsequent awareness of and willingness to reach out to additional programs.
- Landscape analysis of provider capacity within Staten Island to determine referral opportunities available to current participants as well as considerations for program expansion.
- Program cost and cost-sharing among program partners (including agency partners, Resource and Recovery Centers, and other community stakeholders).

Finally, we recommend a revision and replication of the criminal justice outcomes analysis to take into account a longer timeframe and a larger number of participants. Further criminal justice outcomes analyses will need to better address the challenge of gaining participants' consent. The consenting process should be undertaken in a centralized manner by the District Attorney's Office and/or follow-up could be undertaken with both Resource and Recovery Center staff and non-consenting participants to address concerns. With a larger dataset and a longer window for tracking criminal justice interactions, we recommend further study of whether rates of re-arrest differ by treatment option. Finally, we encourage a second layer of analysis that includes not only arrests but convictions, to allay concerns that arrests alone are a premature measure.

ABOUT METIS ASSOCIATES

Metis Associates is a national research and consulting firm headquartered in New York City, bringing over 40 years of experience in evaluation, information management, and grant development to its work with a wide range of organizations committed to making a meaningful difference in the lives of children, families, and communities.

Our mission is to support public and private organizations in achieving results for the children, adults, families and the communities they serve. All of our interactions with clients, as well as all of our products and services, are driven by this goal of empowering clients. We help clients to identify and build on their strengths and expand their capacity with our knowledge, skills and technical expertise.

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[8] ibid

Program Approach. The HOPE program is designed around a harm reduction approach—explained in the accompanying box[9]—insofar as the program is intended to provide tailored services to each individual including a full range of recovery and treatment options. Yet, the program's expectation that all participants would be served through a harm reduction approach was interpreted differently by various stakeholders across multiple partner organizations and agencies. All Resource and Recovery Centers used this approach, but some staff at these centers believed that harm reduction did not align with their own preferred methods (such as abstinence *only* programs) of addressing the substance use epidemic. These stakeholders were also skeptical about whether the program's timeframe would achieve the goal of facilitating participants' sustained connection to and engagement with the service community. Furthermore, feedback from agency partners indicates disagreement as to whether the goal-setting portions of a participant's intake are sufficiently consistent with a harm reduction approach. According to those expressing concern, linking meaningful engagement to an intervention—even if participant chosen—diverges from the intention of the program model.

Harm reduction refers to a set of evidence-based public health practices focused on reducing the harms of drug use. This umbrella term encompasses a wide range of strategies, such as nicotine replacement therapy (such as nicotine gum), methadone maintenance treatment for opioid dependence, and supervised injection facilities, among others. What these strategies have in common is an emphasis on promoting personal and community health without an insistence on abstinence. A common critique regarding harm reduction, which has invited resistance to the term, is the belief that non-abstinence-based approaches encourage or condone drug use. However, robust scientific evidence supports the effectiveness of these interventions. As jurisdictions grapple with how best to address overdose deaths, public health, law enforcement, and corrections officials are increasingly recognizing that these interventions are important aspects of the solution.

To ensure that participants have access to a full range of service options, as well as to allow for centralized data collection on participant service use, the program design included a requirement that all referrals would be made through Staten Island (SI) Connect, a 24/7 provider-only referral service developed for the HOPE program by the Staten Island Performing Provider System. However, use of SI Connect for referrals, which was not monitored by HOPE program staff, was substantially under-used. Resource and Recovery Center staff believed they had the ability to make referrals, and, because it is limited to Staten Island providers, SI Connect does not offer access to the broadest range of treatment options. SI Connect does not collect information about a participants' engagement with providers, which has limited its usefulness as a tool for tracking program outcomes.

[9] Source: Pope L, Davis C, Cloud D, Delany-Brumsey A. A New Normal: Addressing Opioid Use through the Criminal Justice System. New York: Vera Institute of Justice, no date.

Participant Experience. Overall, participants engaged in a variety of services while in the HOPE program and the majority completed the program within four weeks, Most used only one or two types of services with the majority receiving either one-on-one counseling or group counseling or both. Most participants interviewed were very satisfied with the services, especially with the harm reduction group classes and one-on-one counseling. They perceived the Resource and Recovery staff as very accepting, and were happy with the quality of the services and the educational aspects of the group counseling sessions. Participants also valued the wrap-around services that the Centers provided.

At the same time, some participants who had abstinence as their personal goal found it uncomfortable to attend activities at a Resource Recovery Center where individuals were present who continued to use substances. Feedback from stakeholders suggests that in these instances, it is possible that participants' needs and interests were not well-aligned with their service plan and, rather than referring them to abstinence programs offered by other community providers, they were referred to services at the Center.

Program Completion and Results. Successful completion of the program—meaningful engagement—was determined by Resource Recovery Center staff. Defined flexibly, meaningful engagement was not tied to any particular service type or duration. However, it was designed to ensure that the burden on participants would not be greater than what they would have faced had they continued with the court process following arrest. Program data from the first year of operations indicate that 94 percent of participants were determined to have meaningfully engaged in services and had their arrest cases dismissed.[10]

These findings are based on data provided by the NYPD. See the full report for details of the comparative analyses and characteristics of the comparison population. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the NYPD.

Meaningful engagement was found to be associated with a reduction in participants' subsequent arrests.[11] Only 15 percent of HOPE participants who meaningfully engaged in 2017 were re-arrested (as of June 30, 2018)[12] compared to 60 percent of those who had not meaningfully engaged. Furthermore, regardless of their meaningful engagement, HOPE participants were considerably less likely to be rearrested than a comparison population (19% vs. 44%).

Prevention of opioid overdose remains the longer-term outcome of the initiative. However, stakeholders understood the primary or desired outcome to be that of connecting participants to

[10] RCDA Weekly Update, January 3, 2018.
[11] Data interpretations, points of view, and opinions contained within this document are those of Metis Associates and do not represent the official position or policies of the NYPD.
[12] The extent of our analysis window.

ongoing services. They expect that participants will have a greater understanding of the services available and which services they need, and that they will know how to access those services. Avoidance of the criminal justice system, which further disrupts lives and can exacerbate substance use, is an additional outcome. Change in participants' substance use also was described as a potential outcome of the program, but one that may or may not be achieved within the timeframe of the program.

The majority of participants interviewed indicated that they did not have plans to continue services, but they felt able to do so later. However, some did report following a service plan that extended beyond the program's timeframe. Participants described the program as breaking down the stigma of substance use, which had prevented them from accessing related services. They emphasized the importance of avoiding the court process as a major positive outcome of participating in the HOPE program. And a large portion of them described having reduced their substance use as a result of program participation, which varied depending on reported substances used, extent of reduction, and type of service received. Some participants who used opioids as well as those who used cannabinoids reported "getting clean" though the program. The means differed, however, with some emphasizing the educational element of the program while others crediting their participation in structured treatment activities leading to abstinence; others said that it was the arrest that motivated them. Many participants also described themselves as adjusting their behavior to better protect their health and safety.

Key Program Elements. The evaluation identified the following key elements of the program:

- leadership and vision of the District Attorney and a partnership structure;
- adoption of a harm reduction approach;
- development of a set of criteria and standard procedures for determining program eligibility;
- inclusion of a participant advocate (Legal Aid Society) in the partnership;
- deployment of peer mentors trained as peer recovery coaches to introduce the program to eligible individuals;
- use of community-based organizations as Resource and Recovery Centers for intake, assessment, and referral; and
- assignment of responsibility for determining participant completion (meaningful engagement) to staff of the Resource and Recovery Centers.

Of note, access to overdose prevention training and naloxone was not identified as a defining element of the HOPE program. While critical to reducing overdose deaths on Staten Island, evaluation findings indicate that, as implemented, the distribution of naloxone is not essential to the HOPE program model and it could be distributed (along with training) through some other means.

Overall, the program offered participants a considerable benefit: the opportunity to receive supportive services and treatment for substance use in response to self-directed goals instead of court involvement, which even in the case of dismissal requires a substantial time commitment. Qualitative feedback suggests that participation in the HOPE program may lead to a connection to providers that will allow individuals to seek out and obtain services after program completion.

Recommendations for Program Improvement

The HOPE program can be strengthened by addressing stakeholders' understanding and/or expectations regarding several design elements such as the program's harm reduction approach, when and how referrals should be made, how meaningful engagement should be defined, and details about the reporting of services and participation. Based on the evaluation findings, we offer the following recommendations:

1. Codify expectations in a memorandum of understanding signed by all program partners that ensures agreement and buy-in on: the program's harm reduction approach and meaningful engagement, the role of Resource and Recovery Centers in referrals, and the sharing and reporting of program and participation data.
2. Increase transparency around the frequency and reasons for a determination by the District Attorney's Office that an individual arrested on a covered charge and issued a DAT is not eligible for the program.
3. Explore with relevant partners whether the deployment and oversight of peer mentors would be better managed by an independent program partner rather than a Resource and Recovery Center that is providing services to participants.
4. Incorporate into the program model ongoing support from peer mentors to participants so that participants have the opportunity to interact with peer mentors from recruitment through completion.
5. Support peer mentors through additional education and training (on topics such as navigating law enforcement and treatment systems) and by creating peer support networks of their own. Develop dedicated support and coordination positions for the peer mentors.
6. Review peer mentor training on naloxone kit distribution to identify areas of improvement, particularly concerning the distribution of kits to individuals who decline to participate in the HOPE program as well as to individuals who do not self-identify as using substances.
7. Expand distribution of the naloxone kits beyond the initial meeting at the precinct. Provide access to naloxone kits at all points of interaction with participants. Leverage the lived experience of peer mentors to convince participants that carrying a naloxone kit and training in its use is important.
8. Provide training and opportunities for counselors across the Resource and Recovery Centers to share practices for conducting intake and assessment that they have found to be effective within the HOPE program's timeframe.
9. Offer support to Resource and Recovery Centers for data collection and tracking of intake, assessment, and referral information.
10. Re-open the discussion about the length of time a participant has to complete the HOPE

program before a meaningful engagement determination has to be made, in response to the preference expressed by a majority of program partners that the potential for a longer duration will allow for broader treatment options and more opportunities for participants to successfully exit the program.

Implications for Replication

We believe that the HOPE program design lends itself to replication. Successful replication would likely require adapting the design to the local context, including:

- arrest patterns;
- court-based strategies for addressing substance abuse (e.g., court-mandated or offered treatment programs);
- patterns of substance use among community members;
- community access to services;
- current relationships among service providers; and
- relationships between community-based organizations, the local prosecutor, and the local law enforcement agency.

The replication of the HOPE program design also offers the opportunity for many of the current challenges to be avoided through initial development of written memoranda of understanding between partners, covering the topics addressed above. We also believe that replications of the program within and outside New York City will benefit from the support and insight of HOPE program partners. Replications should leverage these partners as sources of expertise and advocates for the program model. For example, the support provided by NYPD's leadership can help to build legitimacy for the program design among other law enforcement agencies and may facilitate the buy-in of arresting officers.

Through the evaluation we also identified two areas of program development that are critical to the success of the program: the selection of appropriate community organizations as Resource and Recovery Centers and the engagement of the local law enforcement agency as an active partner. For each, we offer the following guidance drawn from the collective feedback of HOPE program stakeholders.

In selecting community providers to fulfill the role of Resource and Recovery Centers, consider the following: prior experience providing similar services; willingness to identify their capabilities and areas where they would benefit from additional support; ability to comply with program expectations; commitment to the treatment approach adopted by the program; and evidence of relationships with providers of complementary services such as health, education, vocational, mental health, job readiness, and/or housing services.

To facilitate the partnership with the local law enforcement agency: engage all levels of staff within the agency; identify and support champions within the agency who can advocate for the program's success and address any concerns; develop and maintain open lines of communication with other program partners; provide training to arresting officers that emphasizes the "mission-oriented" nature of the program; and provide ongoing training to new and newly transferred officers. If necessary, introduce law enforcement officers to individuals who are personally affected by the substance abuse epidemic so that the "personal component of the program" is conveyed.

Topics for Further Study

As this evaluation was focused on implementation of the first year of the HOPE program, it did not examine the full extent to which participants achieved the program's intended outcomes. One year later, assuming the availability of data, such an evaluation could be undertaken. At the same time, the evaluation could further explore fidelity to the harm reduction approach and the manner in which meaningful engagement is determined. To carry this out study, mechanisms need to be put into place to allow for follow-up information to be collected from active program participants once they are referred outside of a Resource and Recovery Center and once they are meaningfully engaged.

Additional topics for further study include:

- The relationship between service types included in a participant's service plan (e.g., harm reduction, in-patient, abstinence-based, outpatient) and subsequent awareness of and willingness to reach out to additional programs.
- Landscape analysis of provider capacity within Staten Island to determine referral opportunities available to current participants as well as considerations for program expansion.
- Program cost and cost-sharing among program partners (including agency partners, Resource and Recovery Centers, and other community stakeholders).

Finally, we recommend a revision and replication of the criminal justice outcomes analysis to take into account a longer timeframe and a larger number of participants. Further criminal justice outcomes analyses will need to better address the challenge of gaining participants' consent. The consenting process should be undertaken in a centralized manner by the District Attorney's Office and/or follow-up could be undertaken with both Resource and Recovery Center staff and non-consenting participants to address concerns. With a larger dataset and a longer window for tracking criminal justice interactions, we recommend further study of whether rates of re-arrest differ by treatment option. Finally, we encourage a second layer of analysis that includes not only arrests but convictions, to allay concerns that arrests alone are a premature measure.

Introduction to the Implementation Evaluation

In 2016, Staten Island had the highest overdose rate in New York City, having increased 66 percent from 2015.[13] In response, the Richmond County District Attorney (RCDA), Michael E. McMahon, in partnership with the New York City Police Department (NYPD), other city agencies, and community organizations on Staten Island, developed the Heroin Overdose Prevention and Education (HOPE) program. The program, which began in January 2017, was designed to address the growing opioid epidemic on Staten Island, as well as increases in other substance use, through pre-arraignment diversion to community-based harm reduction services[14] of individuals arrested for a low-level substance-related crime. In 2017, the first year of implementation, the HOPE program was offered to 323 individuals.[15]

Partners in the Staten Island HOPE Program, 2017

Public Agency Partners

- Richmond County District Attorney's Office, under the leadership of Michael E. McMahon
- New York City Police Department
- NYC Department of Health and Mental Hygiene
- Mayor's Office of Criminal Justice

Community Partners

- Legal Aid Society
- Staten Island Performing Provider System
- Staten Island Partnership for Community Wellness
- Christopher's Reason*
- Community Health Action of Staten Island*
- Staten Island YMCA*

** Resource and Recovery Center site*

In April 2017, Metis Associates—a national research and evaluation firm headquartered in New York City—was awarded a contract by the New York City Mayor's Office of Criminal Justice (MOCJ) to conduct an evaluation of the first year of the HOPE program (January 1, 2017 through December 31, 2017).

The evaluation was guided by three research objectives that were outlined in a Request for Proposals (RFP) issued by MOCJ. The objectives were to describe the intent of the intervention; explain the implementation process, including barriers, opportunities, and context; and describe the results of the program. To address these objectives, researchers from Metis collected information through interviews and focus groups with key initiative stakeholders,[16] program participants, and program staff; and

[13] Paone D, Nolan ML, Tuazon E, Blachman-Forshay J. Unintentional Drug Poisoning (Overdose) Deaths in New York City, 2000–2016. New York City Department of Health and Mental Hygiene: Epi Data Brief (89); June 2017.
[14] Pope L, Davis C, Cloud D, Delany-Brumsey A. A New Normal: Addressing Opioid Use through the Criminal Justice System. New York: Vera Institute of Justice, no date.
[15] RCDA Weekly Update, January 3, 2018.
[16] Throughout the report, the term "stakeholders" refers to representatives of the HOPE program partner organizations listed in Appendix A.

analyzed administrative/program data from program partners.[17] (See Appendix A for the evaluation questions and methods.)

There were several challenges to evaluating the HOPE program. First, interviews with participants were conducted only with individuals who had consented to participating in the evaluation at the time the program was introduced to them. As a result, there may be biases in the interview findings related to self-selection; however those interviewed generally resemble the full population of 2017 participants in race/ethnicity and gender. Second, program data, which were obtained from several different partners, and only for those consenting individuals, were incomplete and inconsistent across sources. As a result, those findings may not be fully representative of the program.

This report presents findings from a descriptive study of the program's implementation from inception through the end of December 2017. The report begins with a description of the program including the initiative's theory of change—the assumptions and design elements that comprise the initiative—and graphic depictions of the program design. Findings are presented in the following sections:

- Program structure and key partners;
- Pathway into the program, including eligibility, reasons participants opt in, deployment of peer mentors, and naloxone kit distribution;
- Development of service plans, including intake and assessment, acceptance of harm reduction approach, and referrals;
- How participants meaningfully engage in services; and
- Results of participants' meaningful engagement.

The final section presents what we consider to be the key elements of the HOPE program model, and recommendations for program improvement and replication.

[17] Interviews were conducted with participants who consented to participate in the evaluation. De-identified administrative/program data were also provided for participants who consented.

Introduction to the Staten Island HOPE Program

Eligibility for the HOPE program is based on arrest on a §220.03 charge (Criminal Possession Of A Controlled Substance In The Seventh Degree) and issuance of a Desk Appearance Ticket (DAT), which allows for the person's release pending a court date. Those who are eligible for the program meet with a trained peer mentor who explains the program, and those who agree to participate are introduced to a licensed counselor at a Resource and Recovery Center. The next steps are intake and assessment at the Center, development of a service plan, and help with accessing services in support of the person's goals.

The program offers diversion from court if participants choose to join the program, receive an assessment within seven days of the date of the DAT, and meaningful engage with services within 37 days after their arrest. Participants considered to have successfully completed the program have their cases dismissed and avoid a criminal record.

HOPE Program Theory of Change

Based on information collected through the evaluation, we identified a set of core assumptions that underpin the design of the HOPE program and comprise the program's theory of change. A theory of change details the reasons why those involved in a program expect it to be effective. Although variation is often built into a program model, or develops through the realities of implementation, the theory of change often acts as the underlying conceptual framework. The HOPE program theory of change is based on the perspectives of key stakeholders, combined with a review of the program design, including information on the program's procedures and the participant experience.

Overall Assumptions

1. Substance misuse and overdose is exacerbated when individuals do not have easy access to support networks and services when needed.
2. Within a community, substance misuse and overdose rates can be decreased by serving individuals with a range of needs, including those at risk of future misuse (e.g., prescription holders).
3. There is a benefit to targeting individuals who have just been arrested for a substance-related offense.
    a. This early intervention is appropriate because the criminal justice interaction indicates that they are at risk of immediate substance misuse and/or overdose.
    b. This is the appropriate time to target these individuals because the arrest forces participants into considering the merits of the program, which is expected to lead to greater initial engagement and uptake of services than would general outreach to and recruitment of the same high-risk population.

4. Addressing substance use solely through the criminal justice system is not effective. Arrest, conviction, and sentencing of individuals for substance-use-related crimes will not lead to a reduction in substance use or a reduction in overdoses, because arrest, conviction, and sentencing:
   a. are not effective deterrents, and
   b. do not result in arrested individuals effectively connecting with and engaging in services.

5. A harm reduction approach[18] that focuses on reducing the harms of drug use through evidence-based public health practices and that encompasses a wide range of strategies is an effective intervention.

6. There is a strong pre-existing network of service providers, funders, and coordinating organizations on Staten Island that are equipped to serve individuals in need of assistance. The HOPE program is intended to tap into the existing service infrastructure and therefore will have only a minimal need to build the capacity of providers.

7. The HOPE program can reduce substance misuse and overdoses across Staten Island by creating connections between participants and the Staten Island service provider community that will be sustained after a participant completes the HOPE program.

Partnership Structure

8. The HOPE program is best implemented as a partnership led by a single agency with the inclusion of multiple stakeholder perspectives through regular workgroup meetings and ongoing communication between organizations and agencies.

9. Participant rights are sufficiently protected through the inclusion of a partner organization acting on behalf of current and potential program participants.

10. The partnership works best with a flexible design and a limited number of mandated program elements. This is because each partner brings their own strengths and pre-existing service designs that can be leveraged for the HOPE program, and because the program works best if the additional burden on partners is reduced to the maximum extent possible. As such,

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[18] **Harm reduction refers to a set of evidence-based public health practices focused on reducing the harms of drug use.** This umbrella term encompasses a wide range of strategies, such as nicotine replacement therapy (such as nicotine gum), methadone maintenance treatment for opioid dependence, and supervised injection facilities, among others. What these strategies have in common is an emphasis on promoting personal and community health without an insistence on abstinence. A common critique regarding harm reduction, which has invited resistance to the term, is the belief that non-abstinence-based approaches encourage or condone drug use. However, robust scientific evidence supports the effectiveness of these interventions. As jurisdictions grapple with how best to address overdose deaths, public health, law enforcement, and corrections officials are increasingly recognizing that these interventions are important aspects of the solution.

(Source: Pope L, Davis C, Cloud D, Delany-Brumsey A. A New Normal: Addressing Opioid Use through the Criminal Justice System. New York: Vera Institute of Justice, no date.)

a. The partnership model works best when each provider is able to make its own determination that a participant has meaningfully engaged in their services.
b. The partnership model works best when each Resource and Recovery Center make its own determination, based on participants' own needs, goals, and preferences, whether to provide services to a participant in-house or make a referral to other services.

Program Delivery

11. The most effective means of determining program eligibility is through a clearly defined and standardized process that limits individual discretion.

12. The most effective means of introducing the program to potential participants is through person-to-person explanation from dedicated staff (i.e., peer mentors) who can leverage their own life experiences to increase trust.

13. Participants are best equipped to identify their own needs and, in collaboration with trained staff at partner organizations, identify specific goals that inform the delivery of program services.

Program Outcomes

14. Meaningful engagement is an effective indicator of an individual's likelihood of:
    a. continuing to actively engage in the services necessary to better the individual's life,
    b. reducing substance use or misuse, and
    c. reducing further interactions with the criminal justice system.

15. Consistent with a harm reduction approach and the goal of connecting individuals to services, the scope of potential services a participant can meaningfully engage with is best left undefined. This recognizes that an individual's likelihood of misusing substances (or overdosing) may be due to multiple factors.

16. Thirty days from joining the HOPE program is an appropriate amount of time to allow a participant to be assessed and have the opportunity to meaningfully engage in a service or with a provider, while also being commensurate with the severity of the arrest charge.

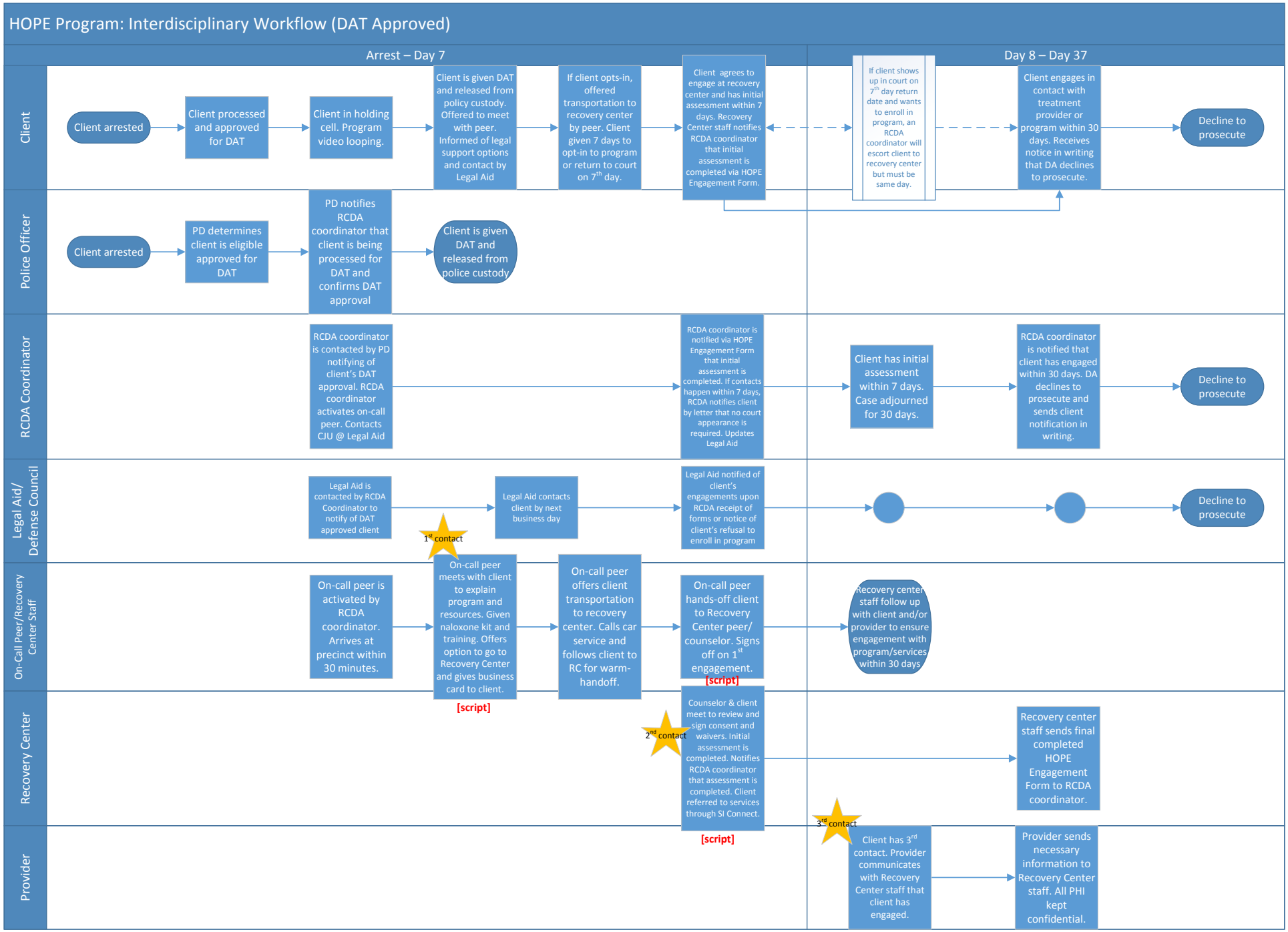
Timeline of the Participant Experience

Figure 1 presents a visual depiction of the program developed by the District Attorney's Office. It traces the involvement and role of partners and staff—police officer, RCDA Coordinator, Legal Aid, Peer/Recovery Center staff, and providers—from the time a client is arrested, through the 7-day period, to the end of the 37-day window for program engagement.

Program Logic Model

Figure 2 offers another depiction of the program that is based on information obtained through the evaluation. Presented as a logic model, this depiction emphasizes the connection between program activities (services) and program outcomes (results).

Figure 1. Timeline of Participant Experience



Source: HOPE program (Submitted 1/17)

Figure 2. HOPE Logic Model

Resources and Program Design

Partners

- Richmond County District Attorney Office
- New York City Police Department
- Department of Health and Mental Hygiene *(DOHMH)*
- Mayor's Office for Criminal Justice
- Legal Aid Society
- Staten Island Performing Provider System *(SIPSS)*
- Staten Island Partnership for Community Wellness *(SIPCW)*
- Christopher's Reason*
- Community Health Action of Staten Island*
- Staten Island YMCA*

** Resource and Recovery Centers*

Program Resources

- Dedicated RCDA HOPE program staff
- Peer mentors provided under contract through SIPCW by a community based organization
- Resource and Recovery Centers responsibilities provided by staff partnering community based organizations
- Naloxone kits provided by DOHMH
- SI Connect through SIPPS

Core Design Elements

- Harm reduction service approach
- Leadership from RCDA
- Partnership model

Program Activities

- Determination of eligibility (RCDA)
- Deployment of peer mentors to meet with eligible participants (RCDA)
- Distribution of naloxone kits and training by peer mentors
- Ongoing recruitment over 7-day period
- Intake, assessment, and development of service plan by Resource and Recovery Center staff
- Arrangement of services and referrals by Resource and Recovery Center staff or through SI Connect
- Determination and reporting of meaningful engagement to RCDA (Resource and Recovery Centers)
- Notification that participants have completed program (RCDA)

Partnership planning

- Regular partner workgroup meetings (all partners)
- Weekly case conferences (RCDA, Legal Aid, Resource and Recovery Centers)

Short-term Outcomes

- Diversion from criminal justice system
- Meaningful engagement in services
- Reduced stigma of receiving services for substance use

Medium- and Long-term Outcomes

- Awareness of services
- Connection to services
- Reduction in re-arrests
- Reduction in drug use and/or safer drug use
- Reduction in drug overdoses and deaths
- Improvement in Staten Island residents' trust in public agencies and community organizations
- Stronger connections among Staten Island service providers

Program Population

- Arrest on a misdemeanor §220.03 charge on Staten Island
- Eligible for a Desk Appearance Ticket
- No prior or concurrent ineligible arrests
- Voluntary agreement to participate

Structure of the Program and Key Partners

The defining components of the HOPE program include the leadership and vision of the Richmond County District Attorney, the partnership structure, inclusion of the NYPD and Legal Aid Society as key partners, and designation of community-based providers as Resource and Recovery Centers with responsibility for determining whether a participant has meaningfully engaged within the program timeframe and thus successfully completed the program. These elements are discussed below Additional key partners, also described below, include the New York City Department of Health and Mental Hygiene, Staten Island Performing Provider System, and the Staten Island Partnership for Community Wellness.

Stakeholders cited the District Attorney's leadership as critical to the success of the HOPE initiative. The District Attorney provided a strong vision of the program's overall scope and structure, yet equally encouraged a collaborative decision-making environment. Stakeholders indicated that without D.A. McMahon's leadership it was unlikely that an initiative of this scope would have taken place or that the partnership with the NYPD would have been solidified.

The District Attorney was also described as advocating a "big tent" approach to program development, meaning that a breadth of partners were invited to join in the design of the initiative. This approach to developing the program was described by multiple stakeholders as relatively unique and critical to its success. The District Attorney was described as conscientious about including a variety of perspectives, including "patients' rights, criminal justice, NYPD, community-based partners," and others. As explained by one stakeholder, this was a "critical component of success… that all the right people were at the table from the beginning."

"[The District Attorney] had a vision of what he wanted to do [and he] could have just done it all by himself. He could have figured out the funding, brought people on, and made this happen without taking input from outsiders. But it wouldn't have ended up as a success as it is, in that sort of way. Instead, [he decided to] bring in all the different perspectives, all the different players that will touch upon a successful program. [The District Attorney chose to] listen to what [partners] do, what they can offer, and how they can contribute.... We all felt that we had a piece of this, that our voices were being heard, that adjustments were being made based on our perspectives.

- Stakeholder on the inclusive development of the program

The NYPD was an equal partner in the initial development of the HOPE program. The involvement of senior staff from the NYPD was described as pivotal to ensuring that the program would go forward. Furthermore, the ongoing support of the NYPD at multiple levels—from the leadership of the Deputy Commissioner for Collaborative Policing, to the support and oversight of borough and precinct leadership, to the buy-in of arresting officers—was cited by some stakeholders as essential to the program's ongoing success.

Finally, the involvement of, and coordination between, multiple offices within the NYPD—including the Office of Management Analysis and Planning and the Legal Bureau—was also cited as critical to the strength of the partnership with the District Attorney's Office.

I've had a phenomenal relationship with them. There was nothing we couldn't discuss at any time of the day, and they were receptive to listening.

- Stakeholder on the relationship between the NYPD and the District Attorney's Office

Inclusion of the NYPD in the initial development of the program was invaluable to the strength of the partnership as it further developed. The NYPD was described as "being on the ground floor during the inception phase" and that their "input was heavily weighed." NYPD representatives were always "at the table" and involved in key strategic decisions as well as conversations about specific participants when necessary.

The Legal Aid Society was a strategic-thought partner during the development and implementation of the program while also providing direct services to program participants. Stakeholders agreed that the involvement of Legal Aid staff from point of program inception strengthened the initiative. In addition, multiple stakeholders described the inclusion of Legal Aid as a strategic decision to invite potential critics of the program model into the conversation early on. Legal Aid staff were described as:

- providing critical perspectives on the relative burden that the program placed on an individual compared with the burden for that person of remaining in the court system;
- emphasizing the need to safeguard participants' privacy and confidentiality as procedures for sharing information across partners were developed; and
- offering perspectives at key junctures to ensure that the respect for participants envisioned by stakeholders—including the District Attorney's Office—was appropriately built into the program's operating procedures.

New York City Department of Health and Mental Hygiene (DOHMH) played a key role in planning for the HOPE program by encouraging the use of harm reduction as an approach and by co-creating the naloxone distribution component of the program model. DOHMH also helped strategize the role of peer mentors within the program model and collaborated on the development of informational materials for potential HOPE participants as well as community members. According to interviewed stakeholders, DOHMH representatives have also continued to advocate for an expansion of the program through the

inclusion of additional arrest charges and have pressed to keep the HOPE program focused on "building recovery capital" among those using substances.

The Staten Island Performing Provider System (SIPPS) was invited into the initiative at an early stage based on the organization's ability to effectively convene the broader community of partners. One of multiple performing provider systems across New York State, SIPPS is an "alliance of clinical and social service providers focused on improving the quality of care and overall health for Staten Island's Medicaid and uninsured populations, which include more than 180,000 Staten Island residents."[19] SIPPS contributed to the initiative a deep understanding of the provider community; the option of hosting a program database;[20] and the development of Staten Island Connect, a 24/7 referral center developed for the HOPE program. SIPPS provided start-up funding for the program and was considered an essential partner for its ability to navigate the funding options available to community providers. According to the District Attorney's Office, the HOPE program could not have begun or expanded without this initial financing. The Staten Island Partnership for Community Wellness (SIPCW) was also an initial funder of the program and helped oversee the initial piloting of the peer mentors.

The involvement of highly-regarded local community-based service providers to serve as the program's Resource and Recovery Centers was universally praised. More specifically, assigning the decision for determining meaningful engagement to the Centers was viewed by stakeholders as a significant indicator of the District Attorney's trust in the community. Multiple stakeholders spoke of the importance of this decision, noting that it gave the program "an independent voice." It was described as a protection against prosecutorial overreach, and was considered a bulwark against "too much power" being concentered in a single office. Overall, findings suggest that community-based service providers would have been less likely to participate in the program if they had not been given this role.

Furthermore, by anchoring the program in the Resource and Recovery Centers, participants are able to quickly separate themselves from the arrest which precipitated their initial involvement. In interviews, participants were asked to describe the extent to which they associated the HOPE program with the District Attorney's Office; findings strongly suggest that the program was successful at presenting itself as independent. This was believed by stakeholders to increase the likelihood that participants would attend the program and continue engaging in services after program completion.

Several structures were established to support the program as a partnership. During the first year of the initiative, the HOPE program directors held monthly workgroup meetings that included representatives from each partner organization. These workgroup meetings were described as allowing stakeholders to remain informed of changes to the initiative and providing the opportunity to learn about patterns of participation and any contextual updates from the District Attorney and the NYPD. In addition, the HOPE

[19] http://www.statenislandpps.org/about/
[20] A database was not developed.

program includes a smaller working group that meets regularly to discuss and troubleshoot challenges facing specific participants. These meetings were described by multiple stakeholders as important for information-sharing between partners and encouraging joint decision making.

The urgency of Staten Island's opioid crisis meant there was a tradeoff between rapid start-up and time to plan. As a result, memoranda of understanding and other agreements between partners were not developed, and there were some instances in the first year when partner expectations were not clear. Such agreements, had they been developed, would have more clearly defined the program goals and stated a commitment to a harm reduction approach, clarified eligibility criteria, and outlined specific expectations for each partner organization related to the provision of services and the reporting of data.

With regard to the reporting of participant data, stakeholders unanimously agreed that a top priority of the initiative is ensuring that decision-making and service provision is transparent and accountable while maintaining the highest level of privacy for participants. They acknowledged the challenge of balancing the need to address participants' situations in a holistic manner by drawing on data from different partners, while also adhering to what they saw as federal privacy requirements. Yet, the absence of requirements related to the maintenance and reporting of program data has resulted in inconsistencies that have prevented the program from tracking outcomes. Across the Resource and Recovery Centers, data collection has been inconsistent and responsibilities are unclear. As a result, participant information varies in level of detail and there are substantive gaps in participant background information and intake and assessment records, referrals, and the results of referrals. In addition, data are maintained in electronic form by some partners and on paper by others. As a result, it has not been possible to assess whether the provider community on Staten Island is being appropriately engaged and to understand the reasons behind a determination of meaningful engagement.

Finally, feedback from stakeholders also indicates that some partner organizations did not share the same expectations for the program's overall goals. While all partners agreed in interviews that a goal of the program is to connect participants to ongoing services, stakeholders from at least one Resource and Recovery Center also expected participants to begin actively addressing their substance use habits while in the program. As a result, this partner's interpretation of meaningful engagement differed from that of the District Attorney's Office. According to a stakeholder, this resulted in a series of situations where the District Attorney's Office would determine a participant had meaningfully engaged over the objections of the Resource and Recovery Center. The disagreement created considerable tension and risked the Center's willingness to remain involved in the initiative.

Participants' Pathway into the Program

Program Eligibility

Individuals who are arrested on a misdemeanor **§**220.03 charge on Staten Island are brought to a NYPD police precinct. If deemed eligible for a Desk Appearance Ticket (DAT)[21] and determined to be eligible for the HOPE program by the District Attorney's Office, officers describe the program or let participants know that a peer mentor will arrive shortly to explain the program. Peer mentors emphasize that the program is not one-size-fits-all, that participants can elect to go to any Resource and Recovery Center and get any services that will help them, or they can refuse the program. Peer mentors often share a bit of their own personal story. They also attempt to give each individual a naloxone kit, no matter what drug they were arrested for or whether they take up the program. With each kit, peer mentors provide a brief training on its use if the situation allowed.[22] Peer mentors offer to accompany every individual they meet to a Resource and Recovery Center, but most participants do not choose this option. The peer mentor may make an appointment for the person or offer a contact card so that participants can make their own appointment.

I was told about [the program] before I even got to the precinct. The two arresting officers told me, "Don't worry. There's HOPE, and there's help."

–Participant on initial information

DATA SNAPSHOT: PATHWAY INTO THE PROGRAM

- In 2017, 323 individuals arrested on a §220.03 charge on Staten Island and determined eligible for a DAT qualified for the HOPE program.
- Substances found at the time of arrest varied: cannabinoids were present in 50% of the cases, opioids in 34%, prescription medications in 30%, and cocaine/crack in 17%.

[21] The DAT allows an individual to be released after an arrest, pending a court date scheduled seven days later.
[22] Reasons that training may not occur include lack of time or other pressing priorities related to the arrest. This was the extent of the peer mentors' overdose prevention efforts through the program.

- Almost three quarters of those offered the HOPE program (74%) were male, and 79% were identified as White, 10% as Hispanic/Latino, 8% Black, and 3% Asian.

- Of those met at a precinct by a peer mentor, 81% received a naloxone kit.
- A total of 287 individuals (89% of those eligible) went through intake and assessment at a Resource and Recovery Center.

Source: RCDA Weekly Update, 1/3/18

- For almost half of the HOPE participants (46%), this was their first arrest, indicating that overall the program was reaching individuals without prior criminal justice interaction. An additional 30% had 1 to 3 prior arrests.
- A small subset of HOPE participants (14%) had extensive arrest records with seven or more arrests prior to enrolling in the HOPE program.
- Overall, HOPE participants were less likely to have had a prior arrest than a comparison population of individuals arrested in 2017 on 220.03 charges on Staten Island. In fact, while only 5% of HOPE participants had 10 or more prior arrests, 40% of individuals in the comparison population had 10 or more prior arrests.

Source: NYPD data

Note: Additional data are presented in Appendix B.

Stakeholders generally agreed that eligibility of an arrested individual for a DAT was an effective screening tool for whether or not the program was appropriate. According to those interviewed, using the DAT as the primary criterion ensured that only low-level offenders would be directed to the program. Stakeholders also agreed that the use of the DAT to inform program eligibility was effective for identifying those individuals most likely to achieve the outcome of an increased connection to services. However, stakeholders indicated an interest in learning more about how New York State and the NYPD (often in consultation with the District Attorney's Office) determine eligibility for a DAT. This element of the process remained opaque for multiple stakeholders and, as a result, detracted from the otherwise transparent nature of the program's eligibility criteria.

Stakeholders trusted that eligibility for the HOPE program was designed to be "objective." By setting clear criteria and developing a transparent process for determining eligibility, the initiative was described as setting itself apart, in a positive way, from other discretion-based programs. The decision to limit discretion for determining program eligibility was described positively by all stakeholders. They believed and appreciated that eligibility decisions were clear and tied to objective items such as arrest

charges and prior criminal history. Furthermore, stakeholders believed that this aspect of the program design allowed it to be independent, while still being administered out of the District Attorney's Office.

Although the lack of discretion in determining eligibility was reported to be initially challenging for some arresting officers, feedback suggests that the willingness of the HOPE program directors to listen to the NYPD's concerns helped to facilitate the NYPD's eventual buy-in.

[Eligibility criteria] should be expanded. Individuals using substances are frequently going to be coming into contact with the criminal justice system in many different ways, and it's not going to be possession itself—it very well may be theft, it may be arguments or assaultive type behavior. It may be trespassing, being places where they shouldn't be. People who are in the throes of addiction are frequently trying to figure out how to fund that addiction, or because of the drugs themselves, are not acting as they normally would. So, there's a large swath of people [currently ineligible] who could benefit from linking up with services quickly, and could benefit from the HOPE program.

- Stakeholder on the current set of arrest charges that can lead to program participation

Multiple stakeholders also suggested that the eligibility criteria could be tweaked slightly, although they disagreed about how eligibility should be modified. For some, the program's selection criteria should be expanded (e.g., by considering individuals with deeper criminal histories who may still benefit from the program), while for others the program's selection criteria should be further restricted (e.g., by reconsidering whether those arrested for cannabinoid should be included).[23] As shared by one stakeholder, "there's also the issue of proportionality—which goes back to the question of cannabis—is a 37-day-long program a proportional response for possession of a cannabinoid? I don't know that that is true."

Stakeholders' opinions also varied as to whether or not cannabinoid-related substances (e.g., marijuana) are "gateway" substances, which lead users to more severe substances.[24] For those holding this opinion, it is important to include individuals who use these substances in the HOPE program because it prevents their subsequent escalation into use of opioids and other "more addictive" and "more harmful" substances. One stakeholder elaborated further on this matter, suggesting that it is essential to consider cannabinoid use within the context of generational differences in substance use. According to this

[23] Interviewed stakeholders disagreed as to whether or not the HOPE program was always intended to include individuals arrested (only) for cannabinoid-related substances. According to some stakeholders this was always included in the program design; other stakeholders indicated otherwise.

[24] This topic remains controversial and it is out of the scope of this evaluation to assess the veracity of the claim. However, what remains relevant here is that disagreement among stakeholders regarding this claim directly informs discussion on whether individuals who use cannabinoids should be eligible for the HOPE program.

stakeholder, older users of marijuana, for example, are more likely to be recreational users without a predisposition towards further substance addiction, while marijuana use by a younger person may be a valid indicator of an addictive personality and potential for broader substance use over time.[25] Therefore, according to this stakeholder, whether or not individuals who use cannabinoids should be included in the HOPE program depends on one's age as well.

Introduction to the Program

Stakeholders, staff, and participants appreciated that the program involved local providers who were considered credible and trusted by the community at large. Several participants indicated that their initial decision to participate in the HOPE program rested, in part, on their peers' prior experiences and positive opinions of a Resource and Recovery Center. According to these individuals, between learning about the HOPE program at the precinct and choosing to join, their peers' positive opinions of the organizations serving as Resource and Recovery Centers helped sway them to participate.

[I emphasized] letting them know that they were being given a chance that I wasn't offered when I was out there. Just letting them know, you know, I've been in your shoes.

- Peer mentor

If that wall was broken down, and you kind of meet them on that level, that peer-to-peer level, then they're more likely to accept HOPE services, or want to comply with the services.

- Peer mentor

Although some individuals learned of the program from the officers at the time of their arrest, most first learn of the program at their meeting with a peer mentor. Employed by two of the three Resource and Recovery Centers, peer mentors are deployed by the HOPE program to the precincts, where they are responsible for introducing the program to eligible individuals, offering naloxone kits and providing training in the use of the kits, and making a connection to the Resource and Recovery Centers.[26] They are required to be certified Peer Recovery Advocates or Recovery Coaches—or to be working towards certification—through the New York State Office of Alcoholism and Substance Abuse Services, and to receive on-the-job training and support from the organization responsible for their deployment (currently one of the Resource and

[25] Assessing the veracity of this claim is also outside the scope of this evaluation. However, the role of age as a mediating factor when considering the program's substance-use criteria is worth further exploration.
[26] Individuals who, for some reason, did not meet a peer mentor at the time of their arrest, as well as those who decided to continue with their court date, were still met at court by another mentor or by the HOPE program director.

Recovery Centers). According to participants, the peer mentors described the program clearly, provided them with brochures and handouts, and made them feel like they had "a second chance."

[After the arrest] I was in tears. I was very upset when I went. I thought my life was over…I've never been in trouble with law enforcement… I didn't know what to think or who to trust and [the peer mentor] really stepped up for me.

- Participant

Both participants and peer mentors saw the mentor role as very important. For the peer mentors, being able to point to their own experiences as formerly addicted individuals now in recovery was a big factor in gaining potential participants' trust and in them being open to hearing about the program. Many peer mentors have themselves been arrested, and they emphasized that they tried to focus on making potential participants feel at ease, listened to, and empowered by the option they were presenting, because they know that an arrest and the environment of the precinct can feel overwhelming. Participants agreed that this really helped and they felt comfortable and respected. One participant shared that, "they didn't treat me like an addict."

Legal Aid staff directly engage with potential participants during the initial seven-day period after an individual learns about the program and before they choose to participate. According to stakeholders, there are usually two "touch-points" with potential participants, including on the seventh day if an individual has not yet decided whether to participate. Legal Aid staff help individuals understand their options by answering questions about the legal process that they may face, and ensure that individuals who enter the program are fully informed of the obligations.

Findings indicate that Legal Aid staff worked independently from peer mentors and Resource and Recovery Center staff. In fact, peer mentors reported that they had little to no interaction with Legal Aid, beyond knowing that they were listed in the contact card distributed to participants. Participants also reported only minimal interaction with Legal Aid staff.

Reasons Participants Opt In

Participants cited record clearance as the factor for program participation. Whether or not they thought they needed the help, most individuals stated that they thought the program was a much better option than the alternative of court and jail time.[27] Overall, participants had a clear understanding of what would happen with their case—a dismissal—if they chose to engage in the program.

[27] While unlikely that participants would have received jail time, this prospect was described by several of those interviewed.

Some participants, primarily those who had prescription medications but were carrying them improperly, or people arrested for cannabinoid possession, thought their arrest was unjustified but felt that going through the program was easier than going to court.

However, there was also a different set of individuals who thought the program was indeed relevant to their situation and came just at the right time, because of their substance use and their legal situation. There were other participants who recognized right away their need for services and said this was a factor in their decision.

It offers a way out of my criminal charges. It offers a way out of me not losing my job. And most importantly, it offered me to be drug free.

I wouldn't necessarily call it pressure, it's more like, you really don't have an option. Either you do this HOPE program, or you get a misdemeanor, or whatever the charges against you are. So it's kind of a no-brainer.

I knew that I was having an issue with [oxycodone]. So I kind of felt like, if I didn't take the help —there's overdoses on this island, I mean, every few hours, it's insane. So I just—I didn't—I don't want that for me.

- Participants on reasons for participating

Hesitations at point of program enrollment

A few of those participants who said they were not using opioids or heroin reflected negatively on their participation in the program, thinking that they were taking "a spot" away (or taking away resources in general) from someone else who needed it more.

My only hesitation was that it would be somehow figured out, or the information would be acquired that I was participating in the program, even after the fact.

- Participant on concerns about participating

Some participants had significant hesitations, which they described as mostly relating to a concern about their job and not wanting employers to learn of their involvement. A few participants expressed specific concern about the name of the program and suggested the stigma of being associated with heroin may be worse than the arrest record itself. As explained by one participant, "I didn't want my name linked to anything about heroin. And that was my biggest fear. You know, I'm smoking pot, and now you're linking me to heroin? Like, that's two different ball fields."

Other participants were wary of the police and/or the District Attorney's Office and therefore did not trust the program as it was described. One participant, for example, when he was told about the program at the precinct, said he thought it was "too good to be true."

Additionally, a few participants were concerned about who they would run into while accessing treatment. One participant mentioned that Staten Island is small and they were "nervous" about who they would see and also how that would impact their career. Finally, one participant said he hesitated to join the program because he felt as if it would be an admission of "guilt."

Role of the NYPD in individual's decision-making

Nearly all respondents indicated that the involvement of the NYPD and the District Attorney did not factor into their decision to participate in the HOPE program. Several participants made it clear that they didn't feel pressured or "forced" to join, rather it was their decision to join the program. Overall, it was clear that peer mentors were effective at emphasizing that the program was voluntary.

> **They just thought it was a better thing for me. You know, in the way that they explained it. But I didn't feel forced to it. It was my choice.**
>
> - Participant on the peer mentor

Participants described NYPD officers as encouraging eligible individuals to participate. Officers were often described as explicitly introducing individuals to the program or at least alluding to the program and encouraging them to wait for and listen to the peer mentors. As shared by one participant, the officers were "very adamant about the program," but did not directly pressure him join, instead describing the program in favorable terms and explaining it as a "win-win situation." Several participants reported seeing the HOPE program materials at the precinct where they were arrested. In addition, officers were described by participants as helping them understand that despite the name of the program, it was not limited to heroin or opioid users.

Depending on an individual's pre-conceptions about the NYPD, however, officers' support of the program may have had a discouraging effect. One participant, for example, explained that distrust of the NYPD led to an initial trepidation regarding the program, exactly because the NYPD officers were describing it in such a positive manner. Another participant noted that the lack of information about the program available to the public made it difficult to verify the claims that the NYPD was making, and therefore gave the impression that the program was less independent than described.

Deployment of Peer Mentors

DATA SNAPSHOT: PEER MENTORS

- On average, HOPE peer mentors were deployed 30 minutes after an individual was determined to be eligible for the program, no matter the time of day or night.
- More than half (54%) of deployments occurred in the evenings (between 5 PM and midnight), 23% occurred overnight (between midnight and 5 AM), and 23% occurred during the day (between 5 AM and 5 PM).
- Approximately one out of every four participants (26%) went immediately from the precinct to a Resource and Recovery Center accompanied by a peer mentor.

Source: CHASI Peer Deployment Records

Note: Deployment records cover the time period from October through December, 2017. Additional data are presented in Appendix B.

Stakeholders consistently cited the deployment of peer mentors as one of the key elements of the HOPE program. Stakeholders indicated that without these peer mentors making face-to-face contact, it would be unlikely that as many individuals would choose to join the program. Furthermore, initial contact with a peer was described as making it more likely that participants would subsequently engage with Resource and Recovery Center staff.[28]

Feedback from peer mentors as well as stakeholders suggests that mentors were able to cultivate the trust of NYPD officers because of their personal stories of recovery, but their past criminal justice involvement could also jeopardize this trust. NYPD officers were described as responding positively to

I think that peer involvement is amazing. This is the first place I've worked at that had peers. Usually, when clients sit down with me—even clients who come in on their own in the outpatient programs—they are very resistant, they don't want to talk to me. But to have that peer [engagement take place first], and to have that connection with them first, you know, these clients [are more willing to open up.]

- Intake staff

[28] Peer mentors were employed by at least two Resource and Recovery Centers prior to involvement in the HOPE program. At these Centers, they help guide and inform a participant's recovery. Incorporating peer coaches into the HOPE program model was seen as a logical extension of their work.

the "legitimacy" of the peer coaches and their demonstrated commitment to recovery. However, feedback from stakeholders suggests that officers' perceptions of peer mentors who had previously been arrested are complex. According to stakeholders, for some officers, despite mentors' training and certification, it cast doubt on the program. As shared by one stakeholder, speaking from the perspective of an arresting officer, "it doesn't feel like an authentic, real, qualified program if I know I just arrested this guy a short time ago and now he's coming as the authority for the HOPE initiative."

[Participants] get a sense of comfort knowing that we overcame a challenge that they're currently going through. Or, we're not better than them, because we're not trying to act better than them. Instead, we're coming to them with: 'Hey, I can relate.' 'You know, listen, I've been there. I've had my share of issues I had to deal with. But I've straightened my life out. I'm on the right road now. Now you can do that, too.'

I think it's valuable, because there's a lot of shame and a stigma that comes with addiction. And I'm here to share my personal experience, to share that I've been where they've been, and I understand, and there is a way out.

It was very fulfilling, for a person in recovery, to be able to give somebody an opportunity that I never had when I got arrested.

- Peer mentors on engagement with potential participants

Stakeholders also shared an interest in better supporting and managing the peer mentors through the HOPE program. Since peer mentors have had their own experiences with substance use and recovery, according to stakeholders, their frequent interactions with individuals who are using substances and their presence at sites such as police precincts that may be trigger-points, puts them at risk of relapse. In addition, peer mentors are often less familiar with workplace procedures. Therefore, peers would benefit from enhanced workplace training and support. The potential stigma for peer mentors of returning to the workforce after a prior conviction also necessitates that supervisory staff bring sensitivity to workplace training for all program employees. Stakeholders also indicated that oversight of peer mentors should focus on core activities such as engagement of participants as well as operational aspects such as deployment.

Feedback suggests that peer mentors may be underutilized; they need to be "on demand" for deployment to precincts, but otherwise have few program responsibilities. Multiple stakeholders indicated an interest in expanding the role of these staff. Anecdotal feedback suggests that peer mentors may be able to extend their responsibilities while still carrying out their primary responsibilities. Additional roles, suggested by stakeholders, included having more scheduled/planned touch-points with participants throughout the program and involvement in any services for participants upon program completion.

Naloxone Kit Distribution and Overdose Prevention Training

The HOPE program model includes the distribution of naloxone kits, and training in its use, to all individuals who are offered the program, regardless of their decision to participate in the program. Kits are offered to potential participants by the peer mentors when they introduce the program at the precinct. Distribution of the kits at this point in time relies upon the trust-building skills of the peer mentors. However, it also occurs at a moment when potential participants are often fraught with concern over their arrest and may still be under the influence of one or more substances. Furthermore, some of the participants acknowledged that immediately after arrest was not the best time for them to learn how to use the kit. Some participants described themselves as having been angry, confrontational, and distracted, and others remarked that they only vaguely remember the training.

I would say, 'This addiction is hidden....You don't really know who is using what. You never know if one day you could save a life!' And then sometimes they would want to learn how to use the kit....[I would also say] This disease does not discriminate. You don't know who is using opiates: Is it your neighbor? Is it your doctor? Is it your dentist? Is it your mom? It is whoever.

- Peer mentor on overcoming hesitations to accept a kit

Interview findings indicate that for most participants, this was their first (and only) opportunity to receive a kit. This affirms the importance of incorporating kit distribution into the program model, as the population served is unlikely to receive kits through other channels. Only a small minority of participants indicated having encountered the kits in other circumstances. Furthermore, a majority of those who received the kit indicated a high level of confidence and willingness to use it if necessary. These participants stated that they would be able to use the kit easily and believed that it would be unacceptable not to keep the kits near them if it could save a life. In fact, at least one participant was able to describe, concretely, how they would incorporate the kit into their routine. This participant spoke about monitoring how long friends were in the bathroom after using a substance, with the knowledge that an extended time may indicate an overdose and therefore the need for the naloxone.

The people who were going to take their chances in court, you know, they wanted nothing to do with it at all.

- Peer mentor on the uptake of kits

However, even among those who received the kits, use may be hampered by counter-productive behavior or misinformation. For example, multiple participants described keeping the kits at home or "stored away." This is in sharp contrast to other participants who described keeping the kits with them always or in their cars for easy access. Other participants described not remembering their training or a reluctance to use the kits if needed.

Interview responses from participants and peer mentors suggest that participants were unlikely to take the kit unless they belonged to social circles where opioid use was prevalent. Furthermore, participant feedback suggests that rejection of the kit by some individuals was fueled by their belief that they "did not belong" in the program. Some participants, for example, described themselves as "recreational" substance users who do not "travel in those circles" and therefore didn't need a kit.

Service Planning and Uptake

Most participants have their first appointment with the Resource and Recovery Center scheduled by the peer mentor or they make their own appointment using the contact card within seven days of their arrest. Across all three Centers, staff indicated that they often re-explain the program and its requirements to participants to make sure they fully understand the program. At two of the Resource and Recovery Centers participants might meet again with a peer mentor (although not necessarily the same one who was at the precinct) to review the details of the program again.[29] After officially enrolling in the program, participants may meet directly with a trained counselor for intake and assessment or they might make an appointment to return at a later date.

The majority of them don't want to go right away, because they've been in jail for an hour, and they just want to go home… Especially if they're going through withdrawal, they don't want to go right away.

- Peer mentor

Intake and Assessment

It made me realize I needed some type of intervention at that point, because if it wasn't for the HOPE program and that arrest, I don't know if I would still be alive right now.

- Participant

The intake and assessment session or sessions include a discussion of the participant's goals in terms of treatment and care and any other needs. The counselor makes recommendations and together they decide on a service plan, that is, what treatment or services the participant will pursue in order to be meaningfully engaged. The process of intake and assessment was implemented in a fairly standardized way across the three Resource and Recovery Centers, with some variation in Centers adding additional forms, encouraging drug testing, or having an additional peer mentor encounter.

Although the intake forms used varied between the Resource and Recovery Centers, each intake process included the collection of a set of common elements: history of drug use, past experience with treatment or rehabilitation, mental and physical health, and family history. At one Center, counselors use a standardized (almost 20-page) intake form. At two Centers, staff mentioned that participants were often asked or encouraged to take a drug test as part of the assessment process, but at another Center, counselors mentioned that they add a "screening tool" to verify the claim of participants who say they are not using any substances.

[29] One center does not have peer mentors employed as recovery coaches on staff.

DATA SNAPSHOT: SERVICE PLANNING AND UPTAKE

- Participants' goals recorded at one Resource and Recovery Center included: substance use education (35%); outpatient services (20%); recovery programming (15%); continuation of existing treatment (15%); screening, brief intervention, and referral to treatment (10%); and mental or medical health (5%).
- At another Center, participants' goals included: substance use services (36%), counseling services (35%), harm reduction services (19%), mental or medical health (12%), and recovery services (8%).
- Service plans often but not always reflected the needs identified by participants. At one Resource and Recovery Center, 60% had a final service plan that aligned with both staff and individual goals listed for the participant, 15% had a service plan that reflected only the staff goals, and 5% had a service plan that reflected the goals of the participant. An additional 20% had a treatment plan that reflected neither the staff nor participant goals.

Sources: Resource and Recovery Center Service Records

Note: Additional data are presented in Appendix B.

And [we] have to be willing to meet them where they're at, but it's a plan that actually addresses what their needs are, and what they're willing to do.

- Staff on how treatment plans are self-directed

At each Resource and Recovery Center, the purpose of the intake and assessment was for counselors to learn about HOPE participants' needs, to help participants set goals for their time in the program, and to develop a unique treatment and service plan. Staff from all three Centers spoke about how they ultimately let the participant self-direct their service plan based on their own goals, although staff would make suggestions for what they saw to be in the participants' best interest. Counselors gained an understanding of participants' arrest "stories," their lives before that point, the extent and nature of their substance use, and other related and unrelated challenges. They also asked participants to explicitly describe what they hoped to get from their time in the program. Furthermore, staff reported that they saw the assessment process as working to build an understanding of a participant's "motivators"—what each individual uses to stay committed to their own goals on a daily basis.

Based on what is shared and their perception of the participant and "where they are," counselors develop a recommendation for a set of services that they think the participant should utilize during their

time in the program. Yet, participants have the ultimate say over their own service plans and counselors described emphasizing this during the planning process.

Intake and assessment occasionally took place over several sessions and in some instances constituted a participant's sole program experience. For example, staff at one Resource and Recovery Center spoke about the program as if all the sessions that a given participant might attend were comprised of getting through all aspects of the assessment. Interviewed stakeholders indicated that this might be due in part to the higher insurance reimbursement that providers receive for assessment compared to service provision.

Participants' goals for their time in the program ranged from getting entirely clean, to reducing substance use, to "bettering" themselves, to staying out of trouble. Some participants described their arrest experience as a wakeup call about their drug use, and they came into the program knowing their goal would be to get clean. Others didn't have this goal going in, but developed it through the course of speaking with a counselor. For example, one participant who was arrested for possession of cannabinoids said he did not initially think the program was for him. But when his counselor asked him how often he smoked, and if he wanted to smoke less, he realized that he wouldn't mind cutting back and set his goal to be reducing use. Many participants said they set goals to "better themselves" during their time in the program, including wanting to become a drug counselor, doing better in school, "getting back into exercise or sports, becoming a better parent, or to "stay on the right path."

[My counselor and I set as my goal to] just either not carry my medication with me anymore, or instead of having it in my pill organizer, to basically just bring my bottles with me to keep myself safe.

- Participant

Some participants—particularly those who were not struggling with intense use but were arrested for not properly carrying a prescription or because they were with someone who had a substance on them—set goals with their counselor for how to avoid future criminal justice involvement and potential misuse of substances.

People there, they know what you're actually going through...it's not just people that just went to school, and that's all they know. Like, they're people that actually really understand, so they can help you, and they can understand how you're feeling, and what you're going through.

- Participant on the sense of camaraderie with staff

Almost all participants said they felt comfortable at the Center they went to, and further indicated that this sense of ease was essential to a positive program experience overall. HOPE participants made it clear that having staff who worked with them; who were very warm, friendly, and non-judgmental;

and who as a result made them feel comfortable and listened to was a very important part of the intake and assessment process, and of the program overall. Some related this to the fact that their counselor had also "been through this before," and some contrasted this with other experiences they've had at other programs. Participants shared that they could tell their counselors were trying to build trust with them, and genuinely wanted to understand their own personal story and help them with their own particular problems. A few emphasized that they didn't feel coerced into program participation and engagement. The atmosphere was open; Centers offered refreshments. One participant described how he played a round of pool before his intake meeting. These approaches are important because, as described by one stakeholder, participants may feel "guarded" at their initial visit before trust has been built.

A snapshot of participants' goals, based on data from one Resource and Recovery Center is presented in Appendix B.

Service Plans

As part of a service plan, HOPE participants and their counselors agree on the services they will use and the frequency of visits during their time in the program. Staff described making recommendations based on the results of intake and assessment, but were committed to determining the service plan in collaboration with participants. Participants somewhat similarly described having options to choose from, and that they could pick the options that worked best for them. The Centers were also flexible with the selection of services. For example, one person who entered the HOPE program was already in a treatment program, and instead of having this participant come up with a new plan and access new services, the staff chose to consider the participant's existing treatment as meeting the criteria for meaningful engagement. All Centers are able to refer participants to outside service providers that either have other service options or might be preferred by the participant.

They laid everything out for you. And it was mostly on me, what I wanted out of the program. They did not try to force-feed any of their theories...They just wanted to put everything in front of me, all the tools in front of me, in order for me to succeed.

- Participant on goal setting and service selection

Based on an analysis of program data, services for participants who set the goal of getting clean or reducing their substance use included referral to detox or other more intensive treatment and referral to a psychiatrist. For participants who set the goal of bettering themselves, services included resources for becoming certified as a drug counselor, one-on-one counseling, and referrals to parenting classes. For participants who set the goal of staying out of trouble or away from people and places that could pull them back into substance use, services included group counseling and referrals to Narcotics or Alcoholics Anonymous or other support groups.

Most interviewed participants seemed aware that there were additional service options beyond what was recommended in their service plan. Although the development of a service plan was tailored to each participant's needs and goals, and based partially on a counselor's recommendation, a few participants we spoke with said that services were chosen for them by their counselors and that they were simply told what to do. For those participants, this finding mostly seemed to be an indication that they interpreted their counselors' recommendations as prescriptions. The same person who was told by his counselor he "had to go" somewhere for services also said that his counselor asked during intake and assessment what she could do to help him with what he wanted.

Resource and Recovery Centers are responsible for overseeing participants' service plans (and helping to determine participants' self-directed service goals) as well as providing direct services. Findings suggest a potential tension between the Centers as intake and assessment "hubs" and as service providers. It is unclear how it was determined whether or not an individual should receive services at the Resource and Recovery Center or be referred elsewhere. A benefit of co-locating these two aspects of the program is that the participant experience is greatly simplified. Participants spoke positively of being able to attend counseling and harm reduction programs at their Resource and Recovery Center. In contrast, the referral process was frequently described as complex by stakeholders and staff, with stakeholders having expressed concern that staff involved in conducting intake and assessment would not be objective about where a participant should be directed to services.

Acceptance of Harm Reduction Approach to Service Planning

An expectation that all participants will be served through a harm reduction approach is a defining component of the program design. However, HOPE program partners joined the initiative with varying degrees of familiarity and acceptance of this approach. Stakeholder feedback indicates that the choice of harm reduction as the program's primary method of addressing substance use remains controversial. They described a prevalence of misinformation and confusion around what harm reduction means and a misperception among some individuals that it encourages substance use and illegal behavior. In addition, stakeholders believed the term "harm reduction" is understood differently by law enforcement and by social service providers.

Furthermore, some Resource and Recovery Center staff described their organization's core philosophy as "abstinence-based" and while these staff did acknowledge that they follow harm reduction if it is the preference of the participant, they nevertheless see their Center's ultimate objective as complete abstinence. Some staff also cited a wariness of this approach because of

I feel like it's more, like I said, harm reduction, as opposed to treatment. I don't understand how somebody could come in with a drug problem, and continue to use while engaged in this program. That does not make any sense to me, and I'm just being honest.

- Peer mentor on the perceived contradiction of a harm reduction model

their own personal histories with substance use and the belief that they would be unable to function if they used any substances at all. In addition, one stakeholder was adamant that the harm reduction approach to addressing substance use may no longer be relevant based on the current risk of "adulterated drugs." According to this interviewee, with the rise of fentanyl "safe substance use" is not possible among opioid users. Yet, several staff also shared that they had personal biases against harm reduction and were working on addressing them.

Among the tenets of harm reduction is a commitment to individuals directing their own goal-setting. Some stakeholders and staff questioned whether this approach would achieve the program's primary goal of facilitating participants' sustained connection to and engagement with the service community. They strongly believe that a true connection requires participants to engage in extended "deep" service use and that intensive participation is necessary for an individual to see actionable results in their own lives. Only then will they be more likely to engage in services, voluntarily, in the future. In their view a harm reduction approach is unlikely to lead to this type of deep service use because participants on their own would choose minimal, low-touch service options. These stakeholders and staff strongly preferred to more prescriptively encourage or require a greater level of engagement in the program.

The addition toward the end of 2017 of a third Resource and Recovery Center that emphasizes abstinence-based treatment, as well as planned expansion to additional Centers, have raised concerns among some stakeholders regarding the program's commitment to harm reduction. According to these stakeholders, participants going through intake and assessment at these Centers may not be empowered to pursue the same service options as those going to a Center that embraces a harm reduction approach.[30] At the same time, however, some interviewed participants did have abstinence as their personal goal. These participants described a self-awareness of their own triggers and shared that being around individuals who continued to use substances was detrimental to their own progress. For these participants, any follow-up meetings at the Resource and Recovery Center, even if they were receiving intensive treatment elsewhere, were described as especially difficult. In addition, a subset of these participants believed that they needed external methods of accountability such as urine testing tied to program completion.

Finally, evaluation findings also indicate disagreement among partner organizations as to what should be accepted as a service. For example, a concern was raised by stakeholders from one agency that certain programs such as Alcoholics Anonymous and Narcotics Anonymous discourage individuals from participating in medication-based treatment and, as a result, are too limiting for the HOPE program. According to these stakeholders, programs such as these may dampen the prospect for further connection to services.

[30] It should be noted that information provided to participants when the program is introduced to them includes only the locations of the Centers and not their treatment approach.

Referrals

Included in the HOPE program design was an expectation that Centers will always make referrals for services through Staten Island (SI) Connect, a 24/7 referral service developed for the program by the Staten Island Performing Provider System. This speaks to the commitment of the District Attorney's Office to: a) obtain the best outcomes for program participants by protecting their best interests; b) use the HOPE initiative to catalyze a broader response to the opioid crisis across Staten Island; and c) ease the burden on Resource and Recovery Centers. According to stakeholders, the initial reasons for promoting the use of SI Connect were that:

We were able to get them into detox, get them into rehab, if they chose to go to the Y, we would call up the Y, set up an appointment for them there. We would go in, and we would verify that they're engaged over at the YMCA, if they wanted to go to a different facility. We give them an opportunity.

- Resource and Recovery Center staff on their ability to make referrals directly

- SI Connect guaranteed that program participants would be offered a full range of service provider options from which to choose. This mechanism would protect against Resource and Recovery Centers giving preference to providers with which they had pre-existing relationships, at the expense of a participant's best interests.
- The HOPE program would have a centralized point of data collection on participant service uptake, thereby reducing the Resource and Recovery Centers' data collection and tracking responsibilities.

However, although the District Attorney's Office intended for SI Connect to be a required element of the program design, use was not closely monitored and, as a result, it was not used as expected. Resource and Recovery Centers largely did not see its benefits, and most staff seemed confident in their ability to connect participants to the resources needed. This included making referrals among the Centers—staff seemed to have good lines of communication between them and through the District Attorney's Office. SI Connect was described as helpful in limited circumstances but often unnecessary, creating an unnecessary burden on Centers that were able to make referrals quicker and more effectively on their own. While delays in using SI Connect were described as only a few hours, this was considered substantial by staff who wanted an immediate hand-off, either to maintain participant engagement or because participants required immediate detoxification or other time-sensitive services. At least one stakeholder described SI Connect as lacking the intimate knowledge of Staten Island that made the HOPE initiative successful, pointing out that it operated from a call-center outside of New York City. In addition, SI Connect was limited to Staten Island, which was less advantageous for participants who preferred to receive services outside of the borough for reasons of privacy or proximity to their place of employment or residence.

Staff and other stakeholders indicated that the information shared about the benefits of SI Connect as well as expectations for its use were inconsistent. Some staff at one Resource and Recovery Center, for

example, indicated that they did not know that they could use SI Connect, while staff at another Center indicated that they only recently learned of certain benefits, such as transportation, for participants. Thus the requirement that Resource and Recovery Centers use SI Connect for all referrals was not uniformly understood.

According to staff, all referrals were entirely participant-driven, and they made every effort to connect participants with services or providers that would best address the needs identified. Participants corroborated this; for example, one participant who wanted treatment for an opioid pill addiction decided not to pursue the full outpatient treatment program available through the Resource and Recovery Center, so the counselor made a referral to another provider.

DATA SNAPSHOT: REFERRALS

- More than half (61%) of referrals made by staff of one Resource and Recovery Center were to services provided in-house, 17% of referrals were made directly by Center staff to an external provider, and 16% were made through SI Connect (with the remainder unknown).

Source: Resource and Recovery Center Service Records

- Among the 168 participants that consented to share their data for the evaluation, only 31 (18%) were indicated to have been referred to services through SI Connect.
- Participants referred through SI Connect were referred to only six providers (two Resource and Recovery Centers, two hospitals, a treatment center, and a rehabilitation center).
- Information on whether or not a participant followed through on a referral was available in only 65% of records.
- SI Connect was most commonly used with participants who meaningfully engaged through outpatient treatment (32% of the 53 participants who engaged through outpatient treatment were referred through SI Connect).

Source: SIPSS Records on SI Connect Utilization

Note: Additional data are presented in Appendix B.

An examination of the data provided for the evaluation indicates that SI Connect does not capture information on a participant's subsequent use of the referral information. Nor does SI Connect consistently capture whether a participant remained engaged with the referred provider after an initial interaction. As a result, its usefulness as a centralized tracking tool is severely limited.

Several Resource and Recovery Center staff and stakeholders believe that Staten Island as a borough—and therefore SI Connect as a service—does not provide access to a sufficient range of treatment

options. Those interviewed expressed an interest in being able to refer participants to services in other boroughs when most convenient or necessary for a participant's service plan. For example, a need for greater same-day options (especially in relation to medically assisted treatment) was expressed. In addition, both staff and participants highlighted the need for service options that would satisfy participants who wanted the sense of support that comes with an inpatient detoxification program but do not qualify due to the substances they use (e.g., opioids and cannabinoids, which do not have medically dangerous withdrawal symptoms).

Stakeholders also recognized that substance use is driven, to some extent, by concurrent challenges facing participants. As a result, concerns were raised among those interviewed that the initiative–through SI Connect or otherwise–does not have the appropriate referral resources to address some of these other challenges, such as housing and job readiness.

Service Uptake

You walk out with a better sense of yourself, and your community, and the people around you.

- Participant on the reasons for satisfaction with services

Overall, participants took up a variety of services while in the program, although most utilized only one or two. The majority received one-on-one or group counseling, or both; some opted for more intensive treatment services. Services also included wrap-around services. While plans are individualized to meet each participant's needs, the majority of participants interviewed elected only one-on-one counseling occurring once a week, and completed the program within 30 days. In the individual sessions, participants talked through their histories, their problems, and their goals. In group sessions, participants said they learned from others' experiences and were educated, especially about the potential health consequences of drug use and how to avoid such complications.

A participant could adjust the services they were receiving at any point during their time in the program, or add additional services. A few participants we spoke with mentioned that they were constantly revisiting their goals, and that they would adjust their services, if necessary.

A significant factor in participants' satisfaction was their perception that staff at the Resource and Recovery Centers were accepting of them. As one participant who was using opioid pain medications without a prescription to help manage pain shared, "At no time did I ever feel like…you never want to go into a place and feel like you're a bad person and they made me feel like I was a human being and that I just had a problem and [had to figure out] how to deal with it."

Most participants were very satisfied with specific services, especially with the harm reduction group classes and one-on-one counseling. Multiple participants explained that they had participated in group counseling previously in rehabilitation programs, but these were much better. The educational aspects

of the harm-reduction-focused groups were also cited as very important and better than those offered through other programs on Staten Island. In fact, some participants were surprised by how much they liked their time in the HOPE program and the services they received. For many, this was the first counseling they had ever received, and while they might have entered the program thinking they didn't need it, they found it was very valuable.

Participants also valued the additional wrap-around services that the Centers provided. These included providing MetroCards or help from counselors with other types of transportation (picking them up or ordering car service). As one participant shared, "I mean, they'd even give you, like, free MetroCards, and give you sandwiches and stuff like that, and tell you where you can go to get some help. They help you out with things, like, you know, they'd help you out. I feel like they went above and beyond."

For the majority of participants, the HOPE program was their first receipt of any type of social services, and, upon reflection, they stated that they don't believe they would have ended up receiving services if it wasn't for the HOPE program. In addition, for most participants, the program was their first introduction to treatment programs specifically available to them as individuals who use substances. Very few participants described receiving any government entitlements, which suggests that the benefits counseling that is available through the HOPE program is also new to the majority of those who are participating. Participants indicated that prior to the HOPE program they didn't know where to find or how to access treatment. Several also described how difficult it had been to understand the costs and insurance implications of services on their own. Finally, participants also alluded to the stigma of substance use and the difficulty of pursuing services on their own when they would have to describe "their struggle" to strangers.

In addition, several participants indicated that without the HOPE program they would not have known they needed help. One participant shared how they didn't know that substance use was "holding me back" until they started to talk to somebody outside of their friends and family. Those participants who did have prior experience participating in substance-related services largely participated in detox, methadone, suboxone, and in-patient rehabilitation programs.

Meaningful Engagement and Immediate Results

Meaningful Engagement

DATA SNAPSHOT: MEANINGFUL ENGAGEMENT

- In 2017, 94% of participants were determined to have meaningfully engaged in services and had their cases withdrawn by the District Attorney's Office.
- Almost all participants who meaningfully engaged (and thus completed the program) did so within 30 days (95%); the average duration in the HOPE program was 26 days from intake to completion.
- Rates of meaningful engagement were relatively similar across subgroups and did not differ by arrest date, arrest precinct, Center, or participant characteristics (gender, race/ethnicity).
- Rates of meaningful engagement were relatively similar regardless of which substances a participant used, with the exception of participants using Benzodiazepines and/or Hallucinogens who were slightly less likely to have meaningfully engaged.
- The three most prevalent services in which participants were meaningfully engaged were: outpatient treatment programs (35%), recovery readiness programs (28%), and harm reduction programs (16%).

Source: RCDA Meaningful Engagement Records; RCDA Weekly Update, 1/3/18

Note: Additional data are presented in Appendix B.

Although many participants were unaware of the concept of "meaningful engagement," they were found to be universally aware that their participation in the HOPE program had a defined endpoint based on an assessment of their involvement, after which time their court case would be vacated. Consistent with the use of meaningful engagement as a signal that a participant has connected or is likely to connect to services, some participants said they knew they needed to be "active" and "present" during their time (instead of just "showing up") at a Resource and Recovery Center if they were to successfully complete the program.

Some participants had different understandings of what had been required of them to reach program completion. In part, this reflects the nature of participant-led goal setting, but it also reflects variation among Resource and Recovery Centers. That is, some participants saw program completion as driven by their own goals while others believed it was tied to "mandated" or required services to which they were assigned. For example, one participant who had been referred to an outside provider phrased it as "you go until they tell you you've completed it… and I guess it's based on your progress and what's getting reported back to [the staff at the Resource and Recovery Center]." Even here though, it was clear to the participant that the Resource and Recovery Center makes the final determination.

I had to be active. I had to follow the requirements. If they said I had to be at the meetings, I had to be at the meeting. I couldn't be one of those call-in people, who keeps saying, "Oh, I'm coming," or keep rescheduling, because that would lead to them kicking me out of the program, and my case would go before a judge.

- Participant

Participants also varied in their understanding of whether or not meaningful engagement was tied to a specific time period. While the majority of interviewed participants reported being told 30 days or four weeks, others reported being told longer periods of time such as six, eight, or 10 weeks. Participants also described surprise at being told they had meaningfully engaged prior to the 30 days. This feedback aligns with the broader finding that staff at Resource and Recovery Centers were not always sure of the relationship between the program's time period and meaningful engagement as the criteria for successful completion. In particular, staff were unsure when participant's goals and or service plan necessitated a longer period of time and also when a participant's needs could be resolved relatively quickly. In the latter instance, staff expressed confusion about what was required for the remainder of the 30-day period.

A few participants wanted more specificity regarding meaningful engagement; it was important to them to have a clear understanding of what they needed to accomplish. For these participants, the amorphous nature of meaningful engagement and the inability to assess, on their own, how they were doing in regards to this benchmark detracted from the program experience.

In general, however, participants described the communication around the determination of meaningful engagement as transparent, rapid, and easily understandable. Participants appreciated receiving text-message updates from HOPE program directors and indicated that they felt well informed about their status in the program throughout. Participant feedback indicates that upon program completion they quickly learned that their court cases were vacated.

Stakeholder perceptions of meaningful engagement

Stakeholders valued how the requirements for meaningful engagement were carefully designed to not exceed the perceived burden of remaining in the court system. Although avoiding court was, in itself, understood to be an incentive to agree to participate in the program, multiple program partners strongly advocated, during the program's development, for establishing criteria for completion that would be less serious than going to court and commensurate (according to partners) with the low-level reasons for arrest. Stakeholders largely remained satisfied that this balance has been maintained.

Almost all stakeholders would prefer a longer time period before a decision is made about whether or not a participant has successfully completed the program (meaningfully engaged) or should have their DAT re-instated. Stakeholders from multiple partner organizations indicated that extending the period of time for meaningful engagement would benefit the program; a majority of stakeholders would prefer a period of 60 days or more. According to those interviewed, this would allow Resource and Recovery Centers to co-create service plans that include treatment options of a longer duration. In addition, it would allow Centers to retain participants in the program for longer if they do not seem sufficiently connected to services after the 30 days instead of having to recommend that they have not meaningfully engaged and need to return to court.

Results of Participants' Meaningful Engagement

> **I think HOPE works because the program is tailored around its mission. Its mission isn't to make people sober right now. Its mission is to connect people before something worse happens, before somebody overdoses and dies, right? That's the mission. And therefore, the program is connected to that mission, is tailored to that mission. This isn't 18 months of residential, followed by outpatient, followed by after-care, right? That's a different mission. And the program would have to be structured differently as well.**
>
> - Stakeholder on the program's intended outcomes

The need for an immediate response to Staten Island's opioid epidemic was an impetus for the HOPE program and remains the longer-term outcome of the overall initiative. However, stakeholders see the primary result or desired outcome of the program as connecting participants to ongoing services. This is understood as the extent to which, having completed the HOPE program, participants have a greater understanding of the service providers available to them on Staten Island and are more likely to pursue further services if so inclined. Connection to services does not necessarily mean that a participant *will* pursue further services but that, at a minimum, they will feel empowered and able to pursue services. Stakeholders expect that participants will have a greater understanding of the services available, which services they may need, and how to access them.

In addition, stakeholders expect that, through involvement in the HOPE program, participants will find it "easier" to begin services or will be more likely continue services that they've already started to receive. In part, this expectation is related to the program's timeframe for demonstrating meaningful engagement. A participant may be receiving a service that continues beyond the point of successful completion of the HOPE program. In this example, voluntary continuation of services is a demonstration of a participant's connection to services.

Reduced criminal justice involvement is a key expectation of the program. Primarily, this takes place through participants' immediate avoidance of the criminal justice system, which is directly tied to their program completion (insofar as meaningful engagement results in a vacated arrested). Furthermore, completion of the HOPE program is intended to result in fewer re-arrests as participants address their substance use and are better connected to other supports within the service community.

Change in participants' substance use is also an outcome, but one that also may or may not be achieved within the timeframe of the program. HOPE program participants' substance use varies tremendously, from self-described heroin "addicts" to recreational users of cannabis, to "non-users" who describe themselves as having been arrested for having their prescribed drugs in an unmarked container or for being in the presence of friends who were using an illegal substance. Because of these variations and the short program timeframe, stakeholders indicated it was not appropriate to set a single program-wide expectation for change in participants' substance use. Together, these program outcomes are aimed at reducing overdoses on Staten Island.

I dealt with a couple of rearrests, and people who had been offered the HOPE program the first time, and when I saw them the second time, I asked them what happened, and they said, 'Nothing really. You know, they said I was meaningfully engaged…' I love those words, 'meaningfully engaged'… 'They said I was meaningfully engaged, and I was discharged.' And so I always had my questions about [the connection between program completion and program outcomes]… I felt like nobody was on the same page, as far as meaningful engagement was concerned.

- Peer mentor on meaningful engagement and changes in criminal justice interactions

The assumption that successful program completion, as defined by meaningful engagement, will lead to the above results remains untested. Several factors prevent such an assessment, including the fact that the large majority of participants have meaningfully engaged in the program, reducing the number of cases for comparison, and the absence of follow-up data.

According to interviewed participants, staff, and stakeholders, the most likely factor influencing whether or not a participant completes the program is their motivation to remain involved. Stakeholders agreed that participants needed to be self-motivated to engage with the program, especially since the criteria for meaningful engagement includes more than just attendance.

Connection to services

Connection to services takes two primary forms: continuing services that began while in the program and participating in new services after program completion. Some participants described themselves as following a service plan that extended beyond the program's 37 days. One participant, for example, continued to pursue methadone treatment (a program that extended for several months) while another continued to attend group sessions. Others continued to participate in Narcotics or Alcoholics Anonymous.

These types of group meetings are not my cup of tea in general. So, for me to want to continue going to this program after I was released from it says a lot. I just found it so insightful, and I just enjoyed meeting... You know, having discussions, talking to people about the community, and raising awareness on STDs, raising awareness on drug use, raising awareness [in general]. Bouncing around ideas, and just getting to, you know, talk about all that stuff.

- Participant on wanting to continue services after program completion

Some participants reported engaging in new services after completing the HOPE program. For these participants, a major benefit of the program was learning about services that they didn't know existed. For example, several participants described learning that they could obtain services without insurance or at low cost. Upon reflection, one participant shared, "I mean, we always think that we have to have so much insurance to get into a treatment program, or there's such long wait for beds, or... we put so many obstacles in our own way. And there are places, nonprofit organizations, that can help you, and you don't really need much money. But I wasn't aware of that until after I got arrested. That's why I made it my business to tell people about it."

Other participants described learning about resources and types of providers they could visit; one participant named learning about a soup kitchen and about a pet care clinic, another learned about a rehabilitation facility.

You can walk in there, and have a meeting, and sit there and talk to somebody, if you need to, at any time. They'll always be there, open for me, they said.

- Participant on the dependability of the Center

Connection to services was also facilitated through ongoing outreach by Resource and Recovery Center staff. Almost all participants, across the Centers, reported receiving follow-up contacts from their Center, such as mailings or phone calls. Participants were encouraged to come back to the Center "if they needed it" or "if they wanted someone to talk to." Several participants reported receiving periodic calls months after completing the program, which they reported being "grateful for" as they "felt cared for by the counselors."

Among participants who remained engaged at their Resource and Recovery Center following program completion, a vocal few participants appreciated the evening hours of their particular Center. These participants noted that it was important for the Center to be open after work hours and at night because, that way, they could stop by whenever they needed help the most. This dependability was reassuring to those interviewed.

The majority of interviewed participants indicated that while they did not have any concrete plans to continue services, they felt able to do so at a later time. For these participants, simply knowing that services were there for them was cited as an important impact. As explained by one participant, "it is awareness that I can go talk to somebody or call for help."

Through the HOPE program, participants were able to gain trust in institutions and service providers. This was important for several individuals who described being reluctant to engage with providers and ask for help. One participant described an increased trust in their Resource and Recovery Center (which was then extended to other providers) while another described gaining trust in the NYPD.

Participants also described the program as breaking down the stigma of substance use, which had prevented them from accessing related services in the past.

Those participants who indicated it was unlikely they would continue to participate in services were also people who indicated the HOPE program was "not for them" in the first place. Several participants strongly believed that they were inappropriately arrested and therefore did not believe the HOPE program was relevant to their personal situations. These participants were adamant that they would not connect with services in the future because, they reported, they "don't use drugs" or they "had a prescription." According to these participants, they only completed the program because it was the best option for avoiding court. Participant feedback as well as statements made by other stakeholders suggests that a participant's internal motivation was often immutable despite the efforts of peer mentors and staff. This coincides with a shared opinion among stakeholders that participant motivation to engage in each stage of the program (intake and assessment, service planning, participation in services) is also a factor in whether or not a participant meaningfully engages.

One of the reasons that it took me so long to reach out for help is that I was extremely embarrassed over the fact that I had a problem. And when I went and did the intake with [staff at my Resource and Recovery Center], I explained that to her, and she said, "We've had people come in here that are judges, plastic surgeons, lawyers. You know, basically, don't be embarrassed. Drug addiction doesn't discriminate against your level of education or your skin color or your financial status. If you have a problem, you have a problem." So that made me feel better, and you know, more comfortable admitting the fact that I had a problem, a very, very bad problem.

- Participant on the stigma of substance use

Immediate avoidance of court after meaningful engagement

Participants emphasized the importance of avoiding the court process (and subsequent jail sentence)[31] as a major outcome of participating in the HOPE program. Feedback from those interviewed indicates that the repercussions of the court process, a possible criminal record, and possible jail time could have further exacerbated their substance use (rather than help to address their substance use). In fact, many participants noted that having a criminal record would have led to the loss of their job and damage to their career, which subsequently could have led to increased substance use. To one participant, being able to keep his job after the arrest (due to program participation) was a "lifesaver." Stakeholders elaborated further, explaining that even if an individual's court case is eventually dismissed, the number of mandatory court appearances can also lead to job loss.

Other participants described how jail would actually have been conducive to continued drug use. As explained by one participant, there is access to heroin in jail and "no incentive not to use." Finally, one participant raised the point that an arrest without the corresponding validation of having the arrest vacated through the HOPE program would have resulted in an additional stigma, leading to further negative consequences. As explained by this participant, "The reason I was doing drugs at the time was I had a very low opinion of myself and very low self-esteem. Having an arrest, and having that stigma put on top of me would have… just pulled me down deeper and darker."

Analysis of recidivism

The analysis of data presented on recidivism is organized into two sections. The first section presents the rates of re-arrest among HOPE participants as well as the charges upon re-arrest. The second section compares the re-arrest rates of HOPE participants to the re-arrest rates of the comparison population. Re-arrest data were analyzed through June 30, 2018.

Analyses presented in this section are drawn from a dataset provided by the NYPD Office of Office of Management Analysis and Planning in response to a research request submitted by the Mayor's Office of Criminal Justice. The dataset included records for 152 HOPE participants that had consented to having their individual-level data shared for the evaluation as well as a comparison group of 601 individuals who were arrested on Staten Island with a top charge of §220.03 in 2017 and who were not identified through their consent as HOPE participants. Note, however, that this latter comparison group includes those who were in the HOPE program

These findings are based on data provided by the NYPD. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the NYPD.

[31] While unlikely that participants would have received jail time, this prospect was described by several of those interviewed.

but did not consent to have their data shared.[32] Yet, while not ideal, the presence of this confounding group in the comparison population will only dampen any differences identified and therefore we have deemed their inclusion acceptable for purpose of this evaluation.

Re-arrests of HOPE participants

Among HOPE participants, 19 percent were re-arrested during or after participation in the HOPE program (through June 30, 2018). Of these 29 individuals who were re-arrested, the majority (66%) were re-arrested more than 30 days after the arrest that precipitated their enrollment in the program. Individuals who were indicated as having meaningfully engaged in the HOPE program were less likely to have been re-arrested than individuals who were indicated as not having meaningfully engaged (15% compared to 60%).[33]

Findings also show a difference in re-arrest rates between the two Resource and Recovery Centers with the most participants in 2017.[34] Participants served at one of the Centers had a re-arrest rate of 24 percent while participants at the other had a re-arrest rate of 5 percent.

Furthermore, differences in re-arrest rates were found by race/ethnic subgroup. Findings indicate that re-arrest rates were highest among HOPE participants who are Black (36%), followed by HOPE participants who are Hispanic (21%), and then HOPE participants who are White (15%).[35] No differences by gender were found.

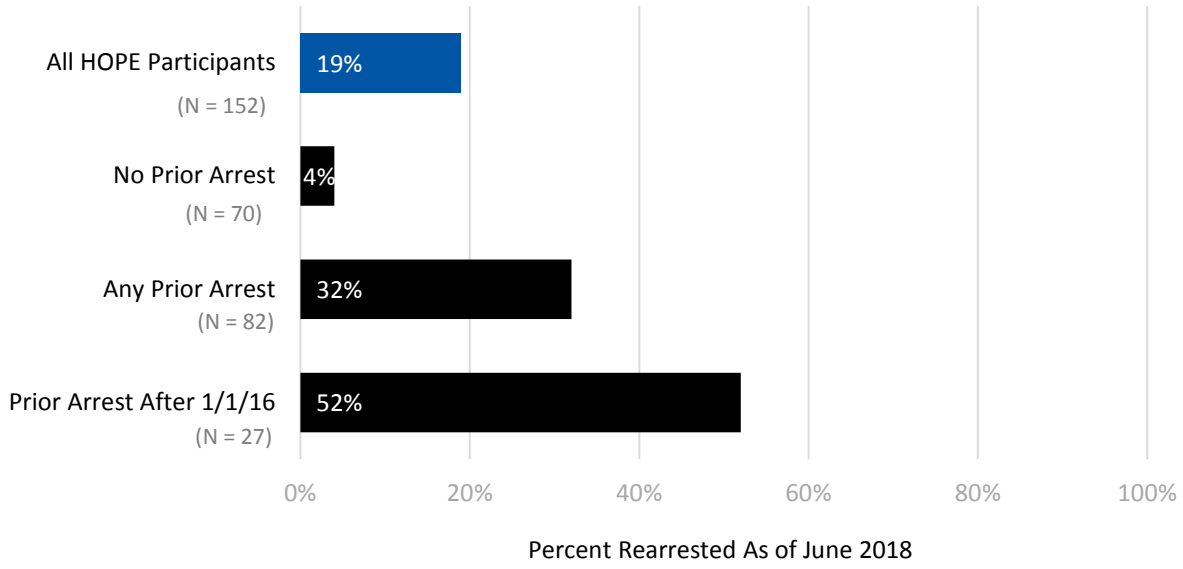
If people went through the program, and then came back, and asked for additional services, to me, that's a success as well, regardless of whether that's because they got rearrested, or because they independently realized that they've got an issue still that they need to deal with. I think re-arrest is a sign that there are still issues. But I wouldn't necessarily say that re-arrest means that the program failed ....because that wasn't the goal of the program.

- Stakeholder on re-arrest as a program outcome

[32] We estimate that approximately one-third of the comparison group falls into this category.
[33] It is important to note that the Richmond County District Attorney's Office may have determined that many of these individuals had not meaningfully engaged specifically because they had been rearrested (which likely precluded continuing in the program). Furthermore, our overall evaluation findings suggest that the designation of meaningful engagement may be less relevant to a participant's criminal justice outcomes than the actual services they received.
[34] The third Resource and Recovery Center joined the HOPE program late in 2017 and had minimal records in our dataset.
[35] This finding does not necessarily suggest that the program experience differs by race/ethnicity, but should be interpreted within a broader social context of higher arrest rates among Black and Hispanic individuals.

Finally, the relationship between re-arrest and criminal justice history was also examined. Consistent with the assumption that the HOPE program works best for those with limited past criminal justice involvement, re-arrests were substantially lower for individuals who had not been arrested prior to the precipitating arrest (4% compared to 32%). Furthermore, findings indicate that individuals with a recent prior arrest (occurring in 2016 or 2017) were more likely to be re-arrested after program enrollment. See Exhibit 1.

Exhibit 1 – Re-arrest rate of HOPE participants, by arrest history



The top charges[36] for the 29 individuals re-arrested through June 30, 2018 after participating in the HOPE program were also examined. Results indicate that these individuals were most likely to be re-arrested with the same top charge that precipitated their initial HOPE involvement. Specifically, 35 percent were issued a top charge of Criminal Possession Controlled Substance-7th Degree (and for an additional 13% this was an additional charge), 10 percent were issued a top charge of Petit Larceny, and 7 percent were issued a top charge of Aggravated Unlicensed Operation Motor Vehicle-1st Degree. Additional data are presented in Appendix B.

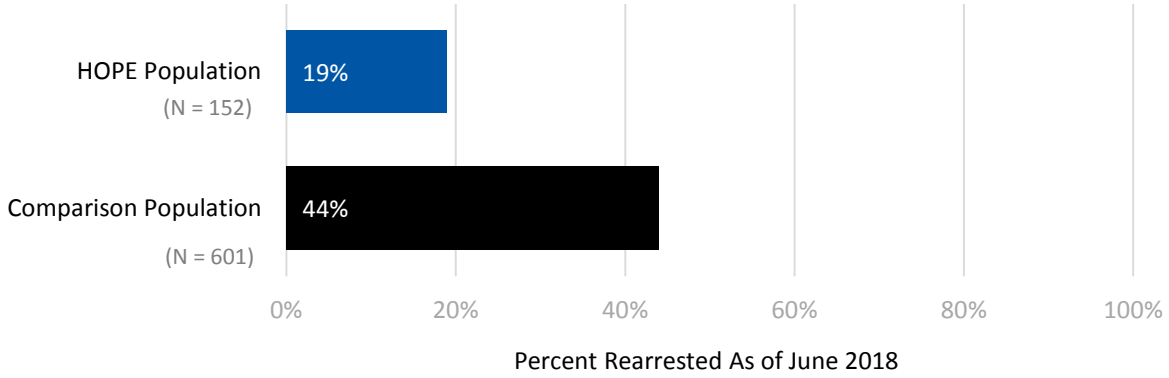
Comparative examination of re-arrest rates

A comparative analysis of arrest data indicates that HOPE participants were less likely to be re-arrested than individuals in the comparison population, suggesting a possible relationship between program participation and subsequent criminal justice involvement. Specifically, 44 percent of the comparison

[36] Top charges are the highest ranked charge using the following sequencing: felony before misdemeanor, class A ahead of class B, 1st degree before 2nd and then by law article and section number.

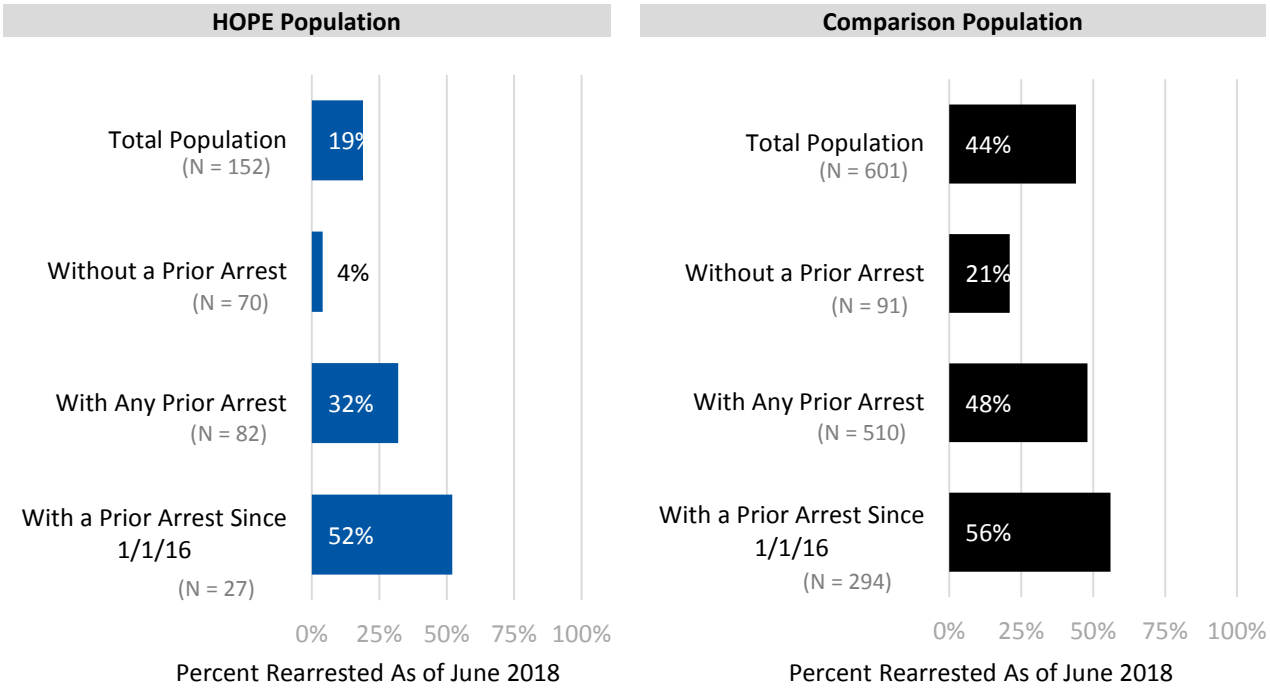
population had been re-arrested through June 30, 2018 compared to only 19 percent of HOPE program participants. The result of this comparison is presented in Exhibit 2.

Exhibit 2 – Re-arrest rates of HOPE participant and comparison populations



Re-arrest rates of individuals by whether or not they were arrested previously were also examined. For each group, HOPE program participants were less likely to be re-arrested than the comparison population. However, this difference was substantially less among those who had been arrested since January 1, 2016. The result of this comparison is presented in Exhibit 3. Additional data are presented in Appendix B.

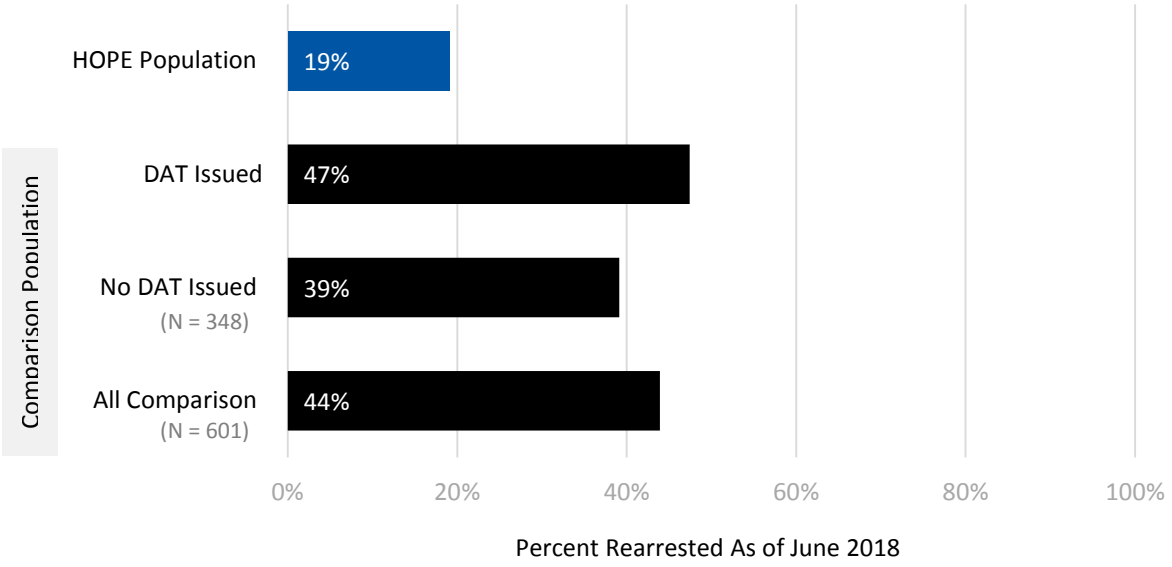
Exhibit 3 - Re-arrest rates of HOPE participants and comparison populations, overall and by prior arrests



Finally, re-arrest rates of HOPE participants, all of whom received DATs as a condition of program eligibility, were compared with the comparison population, disaggregated by whether or not they were

issued a DAT as part of their precipitating arrest. Findings show that the HOPE participant group was less likely to be re-arrested than either comparison subgroup. This comparison can be interpreted in two ways. On the one hand, individuals in the comparison population who were issued a DAT are more comparable to HOPE participants. On the other hand, however, because DAT-eligibility is a pre-requisite for program participation, this subgroup is more likely to include un-identified HOPE participants.[37] Therefore, a comparison with those not eligible for a DAT is more likely to represent a cleaner program/non-program distinction. These results are presented in Exhibit 4.

Exhibit 4 – Re-arrest rates of HOPE participant and comparison populations, by Desk Appearance Ticket issuance



Change in substance use

A large portion of participants described having reduced their substance use as a result of participating in the program. Participants reporting this outcome varied in reported substances used, extent of reduction, and type of service received through the program. Participants who used opioids as well as those who used cannabinoids reported "getting clean" through the program. The means of reducing substance use, however, differed. Several participants emphasized the educational element of the program. For these individuals, learning about the downsides of a substance was reported to have led to

[I chose to participate] because it offers a way out of many things. It offers a way out of my criminal charges. It offers a way out of me not losing my job. And most importantly, it offered me a chance to be drug free.

- Participant on program outcomes

[37] Because they did not consent to share their data for the evaluation.

their own behavioral changes (e.g., for one participant learning about the health effects "scared him" into "getting clean"). For others, it was participation in structured recovery treatment activities that led to an ability to completely abstain. A third group of participants described reduction in substance use as resulting from the arrest itself and the "shock" this provided. For these individuals, the arrest was the motivation and the program gave them an opportunity to pursue this without having to navigate the court system.

Even among participants who did reduce their substance use, this outcome was often described as an unexpected benefit of the program. Most participants described entering the program to avoid court and only then, once in the program, realizing that they actually needed help.

Many participants also described adjusting their behavior to, in their opinion, better protect their health, safety, and likelihood of further criminal justice interaction. Participants described, for example, deciding to use substances only in private settings or avoiding certain social groups. According to interviewed stakeholders, it was a focus of the program that its participants recognize the social and environmental triggers to one's substance use, which is seen as especially important among low-level substance users.

Other outcomes

Participants were described as leaving the program with higher levels of motivation to make progress towards their own goals. As explained by one Resource and Recovery Center counselor, "participants put certain goals in place that they would have to accomplish. And getting them to [identify goals] is an accomplishment on its own. So, it shows that they actually want change. So that's what would be a successful [outcome] in my opinion." According to Resource and Recovery Center staff, motivation is a factor that mediates a participant's achievement of other program outcomes, but it was also highlighted as a valid outcome on its own.

Finally, evaluation findings indicate that through the HOPE program participants have been able to begin addressing other barriers in their lives, many of which negatively impact their ability to achieve sustained recovery from substance misuse. For example, participants have been connected to providers able to help them resolve housing disputes, obtain employment, enroll in benefits, obtain mental health treatment, and access medical care (including management of prescription drugs). As noted by one stakeholder, the validation and resolution of these challenges is wholly consistent with the harm reduction framework embraced by the HOPE program.

Conclusion and Recommendations

The HOPE program, under the leadership of the Richmond County District Attorney's Office, has demonstrated a significant accomplishment: the development of a complex program designed to connect individuals who have been arrested for a low-level substance-related crime to services as a means of addressing the current opioid and substance use epidemic on Staten Island. The evaluation findings suggest that the HOPE program holds promise in this endeavor, with key stakeholders across the partnership supporting the initiative.

Based on the evaluation findings, we believe that the program design offers a model and lessons—as presented in this report—for committed organizations and public agencies looking to connect people who are using or misusing substances to community supports and treatment programs. We have identified a set of key elements that we believe underpin the design of the HOPE program as it was implemented in the first year. These are:

- leadership and vision of the District Attorney and a partnership structure;
- adoption of a harm reduction approach;
- development of a set of criteria and standard procedures for determining program eligibility;
- inclusion of a participant advocate (Legal Aid Society) in the partnership;
- deployment of peer mentors trained as peer recovery coaches to introduce the program to eligible individuals;
- use of community-based organizations as Resource and Recovery Centers for intake, assessment, and referral; and
- assignment of responsibility for determining participant completion (meaningful engagement) to staff of the Resource and Recovery Centers.

Overall, we conclude that the HOPE program has offered participants a considerable benefit: at minimum, the opportunity to receive supportive services and treatment for substance use in response to self-directed goals instead of court involvement. Furthermore, qualitative feedback suggests that participation in the HOPE program may lead to a connection to the service provider community that will allow individuals to seek out and obtain services, on their own, after they complete the program.

We also believe that the HOPE program can be strengthened by addressing an overarching challenge that was found to hamper several aspects of the program: a lack of clear and consistent expectations across the partnership. In particular, partners (including agency partners and Resource and Recovery Centers) diverged in their understanding related to the program's harm reduction approach, when and how referrals should be made, how meaningful engagement should be defined, and details about the reporting of services and participation. We offer the following recommendation:

1. Codify expectations in a memorandum of understanding signed by all program partners that:
    - Defines and adheres to a harm reduction approach;
    - Defines the referral role of Resource and Recovery Centers, including guidelines for when referrals can be made directly by the Centers and when they should be made through SI Connect, taking into account accessibility to services and participant preferences for services in boroughs outside of Staten Island;
    - Defines meaningful engagement and connection to services, including the meaning of "connection" and parameters of acceptable services;
    - Details a standardized process for obtaining consent from participants to share information about them and the services they received for the purposes of program evaluation; and
    - Specifies the types of data that Resource and Recovery Centers and SI Connect must collect and report to the District Attorney's Office, along with agreed-upon timelines for reporting the data. At a minimum the data should be standardized across partners (through the use of a program-side data dictionary) with the collection by each organization of: a consistent set of background characteristics, information on intake and assessment, and information on service plans. Further recommendations for data specifications include:
        - Creating a reporting form for participants' service plans (used internally and reported in aggregate or on a de-identified basis).
        - Increasing the specificity of the data collected. For example, participants' needs, referral options, and choices should be collected with details on the content/topic of services in addition to the modalities (e.g., outpatient counseling *to address anger management as means of reducing use of substances)*.
        - Collecting information on service uptake once a participant is referred from a Resource and Recovery Center—including duration of participation, modifications to service plan, additional services sought, and services "completed" (if measured in such a way)—up to determination of meaningful engagement.
        - Revising the reporting mechanism for meaningful engagement to include reference to and measurement of connection to services in addition to the current service reporting.

Through the evaluation we have also identified several specific areas of the program for improvement, identified below.

Program eligibility

2. Increase transparency around the individuals who are arrested on the covered charge and issued a DAT but are subsequently determined not eligible for the program by the District

Attorney's Office. Address stakeholder concerns about potential disparities on the basis of immigration status, race/ethnicity, and/or gender by periodically circulating reports on eligibility decisions to interested stakeholders.

Training and deployment of peer mentors

3. Support the peer mentors through education and training and by providing work space and time for peers to meet and network with each other. Recognize that peer mentors' responsibilities may make them likely to relapse and offer services to support them.

4. Explore with relevant partners whether the deployment and oversight of peer mentors would be better managed by a program partner other than a Resource and Recovery Center. Benefits of this change would be the lessening of any conflicts of interest (real or perceived) between responsibilities related to peer mentor deployment and those related to service planning and referral.

5. There is agreement across program partners that peer mentors are under-utilized. Incorporate ongoing peer mentoring into the program model by:
    - Including the peer mentor in participants' initial meeting at the Resource and Recovery Center even if a participant chooses not to go directly from the precinct to the Center.
    - Offering peer support to participants throughout the duration of the program through regular check-in calls. Explore whether peer mentors could assist Resource and Recovery Centers in better understanding the uptake of services post-referral.
    - Developing an aftercare component in which, with training, peer mentors could provide peer recovery support services to participants after program completion. See, for example, discussion of this role and its effectiveness provided by SAMHSA.[38]

Naloxone kit distribution and training

6. Review peer mentor training and supervision regarding naloxone kit distribution to identify areas for improvement, particularly concerning the distribution of kits to individuals who decline to participate in the program and to those who do not self-identify as people using substances and choose to participate as a means of avoiding court.

[38] Peers Supporting Recovery from Substance Use Disorders, published by SAMHSA as part of the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). Accessible at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

7. Expand distribution of the naloxone kits beyond the initial meeting at the precinct. Ensure that kits and training are available from the Resource and Recovery Centers throughout a participant's involvement in the program and consider distributing kits upon exit from the program. Create opportunities for participants to hear from peers (both HOPE participants and other service recipients) at the Resource and Recovery Centers who have used the naloxone kits in their own lives.

8. Expand the scope of the naloxone kit distribution and training to include general overdose prevention strategies. Partner with the Department of Health and Mental Hygiene on content and training for peer mentors. Messaging should include safe substance use techniques and the importance of increasing the availability of naloxone kits in the community among bystanders as well as among those who use substances.

9. Ensure that peer mentors only distribute Narcan® brand or equivalent naloxone kits that include a nasal spray delivery mechanism and not an injection-based delivery mechanism. This change and assurance will assuage the concerns of participants and stakeholders wary of distributing syringes. In addition, ensure that that outreach materials to participants and community members explicitly reference the nasal-spray delivery mechanism to deter broader misunderstandings.

Service planning

10. Provide training and opportunities for counselors across the Resource and Recovery Centers to share practices for conducting intake and assessment practices that they have found to be effective within the HOPE program's timeframe.

11. Offer Resource and Recovery Centers support for data collection and tracking of intake, assessment, and referral information. Support should include helping organizations transition from paper to electronic record-keeping as well as identifying funding that would allow staff to spend sufficient time on record keeping.

Program duration for meaningful engagement

12. Re-open the discussion about the length of time a participant has to complete the HOPE program in response to the preference expressed by a majority of program partners for a longer duration. Explore ways of maintaining a low burden on participants while simultaneously giving more flexibility to Resource and Recovery Centers in co-determining with participants the services necessary for meaningful engagement.

Considerations for Replication

We believe that the HOPE program design lends itself to replication. Successful replication would likely require adapting the design to the local context, including:

- arrest patterns;
- court-based strategies for addressing substance abuse (e.g., court-mandated or offered treatment programs);
- patterns of substance use among community members;
- community access to services;
- current relationships among service providers; and
- relationships between community-based organizations, the local prosecutor, and the local law enforcement agency.

The replication of the HOPE program design also offers the opportunity for many of the current challenges to be avoided through the initial development of written memoranda of understanding between partners, covering the topics addressed above. We also believe that replications of the HOPE program within and outside New York City will benefit from the support and insight of current program partners. Replications should leverage current partners as sources of expertise and advocates for the program model. For example, the support provided by NYPD's leadership can help to build legitimacy for the program design among other law enforcement agencies and may facilitate the buy-in of arresting officers.

Through the evaluation we also identified two areas of program development that are critical to the success of the program: the selection of appropriate community organizations as Resource and Recovery Centers and the engagement of the local law enforcement agency as an active partner. For each, we offer the following guidance drawn from the collective feedback of HOPE program stakeholders.

In selecting community providers to fulfill the role of Resource and Recovery Centers, consider the following: prior experience providing similar services; willingness to identify their capabilities and areas where they would benefit from additional support; ability to comply with program-wide expectations; commitment to the treatment approach and participant goals adopted by the program; and evidence of relationships with providers of complementary services such as health, education, vocational, mental health, job readiness, and/or housing services.

To facilitate the partnership with the local law enforcement agency: engage all levels of staff within the agency; identify and support program champions within the agency who can advocate for the program's success and address any concerns; develop and maintain open lines of communication with other program partners; provide training to arresting officers that emphasizes the "mission-oriented" nature of the program; and provide ongoing training to new and newly transferred officers. Stakeholders described this training as essential to gaining officers' buy-in. If necessary, introduce law enforcement

officers to individuals who are personally affected by the substance abuse epidemic so that the "personal component of the program" is conveyed.

Topics for Further Study

As this evaluation was focused on implementation of the first year of the HOPE program, it did not examine the full extent to which participants achieved the program's intended outcomes. One year later, assuming the availability of data, such an evaluation could be undertaken. At the same time, the evaluation could further explore fidelity to the harm reduction approach and the manner in which meaningful engagement is determined. To carry this out study, mechanisms need to be put into place to allow for follow-up information to be collected from active program participants once they are referred outside of a Resource and Recovery Center and once they are meaningfully engaged.

Additional topics for further study include:

- The relationship between service types included in a participant's service plan (e.g., harm reduction, in-patient, abstinence-based, outpatient) and subsequent awareness of and willingness to reach out to additional programs.
- Landscape analysis of provider capacity within Staten Island to determine referral opportunities available to current participants as well as considerations for program expansion.
- Program cost and cost-sharing among program partners (including agency partners, Resource and Recovery Centers, and other community stakeholders).

Finally, we recommend a revision and replication of the criminal justice outcomes analysis to take into account a longer timeframe and a larger number of participants. Further criminal justice outcomes analyses will need to better address the challenge of gaining participants' consent. The consenting process should be undertaken in a centralized manner by the District Attorney's Office and/or follow-up could be undertaken with both Resource and Recovery Center staff and non-consenting participants to address concerns. With a larger dataset and a longer window for tracking criminal justice interactions, we recommend further study of whether rates of re-arrest differ by treatment option. Finally, we encourage a second layer of analysis that includes not only arrests but convictions, to allay concerns that arrests alone are a premature measure.

Appendix A: Evaluation Questions and Methods

The evaluation was guided by the following research questions. Wherever possible, each question was addressed through a combination of data sources. The scope of the evaluation was limited to the first year of the program (January 1, 2017 through December 31, 2017).

1. **Describe the intent of the intervention**
    a. What are the key program components and relationships among inputs, outputs, and outcomes in the program's logic model? What is the program's theory of change?
    b. What does previous research suggest about the implementation and efficacy of this intervention?

2. **Explain the implementation process, including barriers, opportunities, and context**
    a. What is the current landscape of service and treatment options and providers in the target area? Are relevant service and treatment options effectively integrated into the HOPE initiative?
    b. What proportion of eligible individuals enter the program? What are the barriers to entry among the target population? Are there segments of the target population who are missed in program recruitment?
    c. Is program data being collected in a reliable and valid way? Are relevant outputs and outcomes being tracked effectively to support an outcome evaluation?

3. **Describe the program inputs**
    a. What program activities are provided to participants, including referral and follow-up procedures?
    b. How do program fidelity, dosage, and reach vary across Resource and Recovery Centers and across police precincts?

4. **Describe the program outputs**
    a. Do program participants reflect the target population? Are there segments of the target population who are missed in program delivery?
    b. What is the program completion rate? Do these rates vary across Resource and Recovery Centers? What are the barriers to completion for program participants?

5. **Intermediate outcomes**[39]
    a. What are the HOPE participants' rates of non-fatal and fatal overdose, naloxone saves, and arrest and jail admissions?
    b. What are the HOPE participants' rates of service utilization (entitlements, treatment, and other support services)?

Data Sources and Methods

Data Sharing Agreements. Metis developed data sharing agreements with the Richmond County District Attorney's Office, the New York Police Department, the Staten Island Performing Provider System, and each of the three community partners providing direct services.

Interviews and Focus Groups. Metis solicited feedback on all data collection protocols from both the Mayor's Office of Criminal Justice and the Richmond County District Attorney's Office. In addition, protocols and consent forms were reviewed and approved by Metis's Institutional Review Board. Qualitative data were transcribed verbatim and analyzed using emergent and prescriptive content analytical techniques designed to identify thematic findings within and across respondent groups. The following groups and individuals were interviewed:

Key Stakeholders. Metis conducted initial (June/July 2017) and summative (March/April 2018) interviews with individuals from the following partner organizations and agencies:

- Christopher's Reason
- Community Health Action of Staten Island (CHASI)
- Legal Aid Society
- New York Police Department
- Richmond County District Attorney's Office
- Staten Island Performing Provider System
- Staten Island YMCA Counseling Service

Resource and Recovery Center Staff. Metis conducted focus groups with intake and assessment staff at Christopher's Reason, Community Health Action of Staten Island, and the Staten Island YMCA Counseling Service.

Peer Mentors. Metis interviewed peer mentors from Christopher's Reason (which oversaw the peer coaches from January through September 2017) and Community Health Action of Staten Island (which oversaw the peer coaches beginning in October 2017).

[39] Findings on intermediate outcomes are limited due to a lack of relevant program and administrative data, including the absence of data from the NYPD.

Program Participants. Metis interviewed 35 HOPE program participants, recruited from a sample of 205 individuals for whom contact information was provided. Although efforts also were undertaken to interview participants who had not meaningfully engaged, all interviewed participants had meaningfully engaged during the first year of the HOPE program.

- A total of 21 participants who were interviewed were engaged at Community Health Action of Staten Island, 12 participants were engaged at Christopher's Reason, and 2 participants were engaged at the Staten Island YMCA Counseling Service.
- Among the interviewed participants interviewed, 25 identified as male and 7 as female; gender information was not available for three participants. This generally aligns with program characteristics overall: in 2017, 75 percent of the HOPE participants were identified as male.
- The majority of interviewed participants (73%) identified as White (non-Hispanic), which generally approximates participants in the program at-large where 78% identified as White.

The majority of interviewed participants indicated having been arrested for marijuana at the time of their enrollment in the HOPE program. A smaller portion indicated opioids (including heroin) or other substances. Compared to the general population of program participants, this is a higher portion of marijuana users.

Metis researchers informed participants of the interview opportunity through email, telephone calls (and voicemails), and text messages. Interviews were conducted by phone and those interviewed received an incentive for their participation ($50 American Express gift card). An additional 33 individuals were contacted and refused to participate and 14 individuals agreed to an interview date and time but were unable to be reached.

Program and Administrative Data. Metis worked closely with initiative partners to craft data submissions in response to evaluation research questions. The following submissions were received:

- Meaningful engagement records from the District Attorney's Office
- Participant characteristics, intake and assessment records, and service data from Staten Island YMCA Counseling Service, Community Health Action of Staten Island, and Christopher's Reason
- Peer mentor deployment records (October through December 2017) from Community Health Action of Staten Island
- Staten Island Connect utilization from Staten Island Performing Provider System

Records were received for participants who completed or exited the program in 2017 and who consented to share their program data with an external research and evaluation partner. The consent process was led by the District Attorney's Office with consultation from Metis Associates and was undertaken upon intake at each Resource and Recovery Center. In 2017, approximately 60 percent of HOPE program participants consented to share their data with the evaluator. Program and administrative data were summarized using descriptive statistics.

Submitted data varied in quality and scope across Resource and Recovery Centers. As explained in the report, each partner organization was responsible for their own data collection and management, resulting in significant inconsistencies between organizations. All program and administrative data were closely reviewed by Metis researchers who subsequently identified where program data could best inform the evaluation's research questions. In many instances, data from only one source was used to address a particular question.

The table below presents the gender and race/ethnicity for participants who consented to participate in the evaluation compared with all 2017 program participants.

Table A-1. Characteristics of participants consenting to share data for evaluation

Participant characteristics		Participants in the evaluation	2017 program participants
Gender	Male	78%	75%
	Female	22%	25%
Race/Ethnicity	Asian	3%	3%
	Multiracial	1%	0%
	Black	9%	8%
	Hispanic	13%	10%
	White	74%	79%

Criminal Justice Outcome Data. A dataset was provided by the NYPD Office of Office of Management Analysis and Planning in response to a research request prepared by Metis and submitted by the Mayor's Office of Criminal Justice. We are indebted to the Office of the Deputy Commissioner for Collaborative Policing and Deputy Commissioner Susan Herman for her support of this request.

Metis received de-identified arrest data for all individuals who were arrested on Staten Island with a top charge of §220.03 in 2017. Individual arrest records were provided for the period between January 1, 2016 and June 30, 2018. The dataset also included if a DAT was issued and the total number of historical arrests for each individual. The first arrest in 2017 with a top charge of §220.03 was defined as the "precipitating" arrest. This arrest was used to identify prior arrests and re-arrests through June 30, 2018.

Individuals who participated in the HOPE program during this time period and who consented to have their information shared for the evaluation were identified by a unique study ID. However, approximately half of the 2017 HOPE program participants did not consent to have their information shared and therefore could not be identified for this analysis. The analyses of HOPE participants are based on a population size of 152. The arrest that triggered their invitation to join the HOPE program was identified using program data provided by the District Attorney's Office and matched using the anonymous unique study ID. The remaining individuals included in the dataset represent a comparison group (N = 601). This group, however, also includes those HOPE participants who did not consent to

have their information shared for the evaluation—estimated at approximately one-third of the comparison population.

Program Documentation. A review of program documentation was conducted that included the program's protocol for determining eligibility, the form used to report meaningful engagement, and the workflow detailing the interactions between each initiative partner and a program participant.

Research Literature. A literature review was conducted to inform the evaluation design, data collection efforts, and data analyses.

Appendix B: Data Tables

Meaningful Engagement

Summary of Findings

- Rates of meaningful engagement are relatively similar across subgroups in the program and do not substantially differ by arrest date, arrest precinct, Resource and Recovery Center, gender, or race/ethnicity.
- Overall, 95% of meaningfully engaged individuals completed the program within 30 days.
- Length of time in the HOPE program differed by Resource and Recovery Center. Participants at the Staten Island YMCA Counseling Service were more likely to complete the program in two weeks or less compared to participants at the other Centers. Participants at Community Health Action of Staten Island (CHASI) were more likely to take longer than 30 days to complete the program compared to participants at the other Centers.
- Resource and Recovery Centers, when reporting to the District Attorney that a participant has meaningfully engaged, are asked to select the service(s) that comprised this engagement. The most prevalent services listed were: participation in an outpatient program, participation in recovery readiness, and participation in harm reduction programs or related counseling.
- The selection of outpatient programming—as the service through which a participant meaningfully engaged—declined over the course of 2017.
- Very few participants enrolled in detoxification programs as part of their meaningful engagement despite qualitative feedback about its importance to participants and staff.

Table B-1. Participants' meaningful engagement, overall and by subgroup

Subgroup		Total N	Percentage of having meaningfully engaged	
			No	Yes
Total		**166**	**10%**	**90%**
Arrest Date	Quarter One	28	4%	96%
	Quarter Two	49	8%	92%
	Quarter Three	46	17%	83%
	Quarter Four	43	7%	93%
Arrest Precinct	120	61	10%	90%
	121	30	13%	87%
	122	36	8%	92%
	123	39	8%	92%
Resource and Recovery	CHASI	113	11%	89%

Subgroup		Total N	Percentage of having meaningfully engaged	
			No	Yes
Center	Christopher's Reason	41	7%	93%
	SI YMCA Counseling Service	9	0%	100%
	Unknown	3	◦	◦
Gender	Female	37	19%	81%
	Male	129	7%	93%
Race	Asian	5	◦	◦
	Biracial	1	◦	◦
	Black	15	13%	87%
	Hispanic	21	10%	90%
	White	124	9%	91%

Source: RCDA data submission
Population: All individuals offered the program (excludes two that were offered but declined).
Note: the symbol "◦" signifies a value not reported due to the small number of cases.

Table B-2. Duration in program of participants who meaningfully engaged

Subgroup		Total N	Duration of program participation (days)		
			Mean	Min	Max
Total		**150**	**26**	**0**	**52**
Arrest Date	Quarter One	27	26	9	30
	Quarter Two	45	27	7	52
	Quarter Three	38	27	0	36
	Quarter Four	40	24	7	51
Arrest Precinct	120	55	26	7	52
	121	26	25	17	30
	122	33	26	7	49
	123	36	25	0	51
Resource and Recovery Center	CHASI	101	27	7	52
	Christopher's Reason	38	25	0	30
	SI YMCA Counseling Service	9	18	7	25
	Unknown	2	◦	◦	◦
Gender	Female	30	25	0	32
	Male	120	26	7	52
Race	Asian	5	◦	◦	◦
	Biracial	0	-	-	-
	Black	13	27	21	29
	Hispanic	19	24	7	30
	White	113	26	0	52

Source: RCDA data submission
Population: All individuals that meaningfully engaged in the HOPE program.
Note: the symbol "◦" signifies a value not reported due to low population size.

Table B-3. Services reported to the District Attorney's Office as reason for meaningful engagement

Service	Percentage of meaningfully engaged participants (N = 150)	Duration of program participation (days)		
		Mean	Min	Max
Outpatient program	35%	26.1	9	49
Recovery readiness	28%	25.6	7	51
Harm reduction or counseling	16%	27.8	20	52
Screening, brief intervention, and referral to treatment	7%	24.3	15	29
Inpatient program	5%	29.0	26	32
Detoxification program	4%	29.5	28	32
Methadone	4%	24.7	0	32
Assessment only	3%	14.6	7	27

Source: RCDA data submission
Population: All individuals that meaningfully engaged in the HOPE program.
Note: Three participants meaningfully engaged through two types of services.

Table B-4. Meaningful engagement service by arrest date and Resource and Recovery Center

Subgroup		Service indicated							
		Outpatient	Recovery readiness	Harm reduction or counseling	SBIRT	Inpatient	Detoxification	Methadone	Assessment only
Total		**35%**	**28%**	**16%**	**7%**	**5%**	**4%**	**4%**	**3%**
Arrest Date	Quarter One (N = 27)	46%	14%	14%	7%	7%	4%	4%	4%
	Quarter Two (N = 45)	47%	16%	14%	8%	-	-	2%	4%
	Quarter Three (N = 38)	15%	26%	17%	4%	7%	9%	7%	2%
	Quarter Four (N = 40)	22%	40%	11%	4%	4%	2%	2%	2%
Resource and Recovery Center	CHASI (N=101)	27%	35%	17%	-	5%	4%	3%	2%
	Christopher's Reason (N = 38)	39%	7%	7%	24%	2%	2%	5%	5%
	SI YMCA Counseling Service (N = 9)	67%	-	22%	-	-	-	-	11%

Source: RCDA data submission
Population: All individuals that meaningfully engaged in the HOPE program.
Note: Three participants meaningfully engaged through two services.

Table B-5. Meaningful engagement by substance used upon initial arrest

Meaningful engagement disposition	Substance at arrest						
	Amphetamines	Benzodiazepines	Cannabis	Addiction Medications	Opioids	Hallucinogens	Cocaine/Crack
Total	**18**	**50**	**189**	**51**	**174**	**16**	**134**
Yes	15	38	153	38	144	11	108
No	2	10	32	10	23	5	23
Case Dismissed	1	1	3	1	2	0	0
HOPE Revoked	0	1	1	2	3	0	3
Client Death	0	0	0	0	2	0	0

Source: RCDA data submission

Snapshot of Participants at One Resource and Recovery Center

Summary of Findings

- Participants were identified as having a breadth of needs, including substance use, counseling, and harm reduction. Over half of the participants had three or more needs identified in collaboration with Resource and Recovery Center staff.
- Almost two-thirds of the participants at this Center were served in-house. Recovery readiness and outpatient services were the two most prevalent referral choices.
- Three quarters of the participants had been arrested previously, primarily on substance-related charges.
- Participants varied considerably in their living situations, but 45% live with their parents and/or family members (not including their children or significant others).
- The largest percentage of participants reported using marijuana within 30 days of intake, followed by cocaine and heroin. In addition, at least 16 participants reported having overdosed at least once.
- At least 20% of participants at this Center did not have health insurance at time of intake.

Table B-6. Areas of need identified at intake

Areas of need	Percentage of participants with need indicated (N = 157)
Substance use	36%
Counseling	34%
Other	28%
Harm reduction	20%
Mental health	8%
Recovery	8%
Medical	4%
Entitlements/benefits	3%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-7. Number of needs identified at intake

Number of needs	Percentage of participants (N = 157)
None	3%
One area	4%
Two areas	35%
Three areas	58%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-8. Location of services

Location of services provided and source of referral	Percentage of participants (N = 157)
In-house	61%
External (referred directly)	17%
External (referred using SI Connect)	16%
Other/Unknown	6%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-9. Types of services selected by participants

Types of services	Percentage of participants (N = 157)
Recovery readiness	43%
Outpatient	34%
Harm reduction	20%
Inpatient	1%
Other/Unknown	3%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-10. Participants' living situations at intake

Current living situation	Percentage of participants (N = 157)
Parents/Family	45%
Alone	15%
Significant other	15%
Significant other with children	5%
Friends	6%
Alone with children	4%
Homeless	1%
Shelter/Treatment	1%
Unknown	9%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-11. Participants' health insurance status at intake

Health insurance status	Percentage of participants (N = 157)
Insured	64%
Uninsured	20%
Unknown	15%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-12. Participants' prior arrests at intake

Prior arrests	Percentage of participants (N = 157)
Yes	75%
No	20%
Unknown	5%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-13. Participants' types of prior arrests

Types of prior arrests	Percentage of participants arrested previously (N = 111)
Drug charges	73%
Crimes against persons	10%
Crimes against property	9%
Other	8%
DWI/DUI	7%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-14. Participants' history of mental health needs at intake

Ever diagnosed with a mental health condition	Percentage of participants (N = 157)
Yes	20%
No	67%
Unknown	13%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-15. Participants' mental health conditions

Mental health condition	Percentage of participants ever diagnosed (N = 31)
Depression	48%
Anxiety	45%
Bipolar disorder	32%
ADHD	16%
PTSD	16%
Other	16%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.

Table B-16. Participants' assessed level of depression and anxiety at intake

PHQ-4 result (Level of Depression and Anxiety)*	Percentage of participants with score (N = 132)
None	12%
Mild	11%
Moderate	73%
Severe	4%

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.
The 'Patient Health Questionnaire-4' (PHQ-4) is a 4-item inventory rated on a 4-point Likert-type scale. Items are drawn from the first two items of the 'Generalized Anxiety Disorder–7 scale' (GAD–7) and the 'Patient Health Questionnaire-8' (PHQ-8). The purpose is to allow for very brief and accurate measurement of depression and anxiety.
(Source: http://www.midss.org/content/patient-health-questionnaire-4-phq-4)

Table B-17. Participants' reported history of substance use

Substance use	Number of participants indicating			
	Within 30 days of intake	Between 31 and 180 days of intake	Between 181 and 365 days of intake	More than 365 days prior to intake
Marijuana	67	8	1	8
Cocaine	40	6	1	14

Substance use	Number of participants indicating			
	Within 30 days of intake	Between 31 and 180 days of intake	Between 181 and 365 days of intake	More than 365 days prior to intake
Heroin	28	0	3	9
Other opioids (Oxycodone, Oxymorphone, Percocet, Fentanyl, Suboxone)	9	6	2	15
Benzodiazepines	12	2	0	6
Buprenorphine	7	3	1	5
Ecstasy & Designer Substances	3	1	3	7
Amphetamines	4	0	3	6
Hallucinogens and PCP	5	3	1	2
Other (Barbituates, Synthetic Marijuana, Inhalants)	4	1	0	1

Source: Resource and Recovery Center data
Population: All evaluation participants at selected Center.
Note: Data on prior or current use of substances was unknown and or not available for a large percentage of individuals.

Table B-18. Participants' reported history having overdosed

History of overdose	Percentage of participants (N = 157)
Yes	10%
No	77%
Unknown	13%

Criminal Justice Outcome Findings

Table B-19. HOPE participants' charges issued on first re-arrest, ranked by occurrence

Charges with more than 5% occurrence*(N = 29)*	Top charge at first re-arrest	All charges at re-arrest
Criminal Possession Controlled Substance- 7th Degree	35%	48%
Petit Larceny	10%	14%
Criminal Possession Stolen Property-5th Degree	-	10%
Aggravated Unlicensed Operation Motor Vehicle-1st Degree	7%	7%
Unlawful Possession Of Marihuana	-	7%
Criminal Use Drug Paraphernalia-2nd Scales	-	7%
Criminal Possession Controlled Substance-5th Intent To Sell	3%	7%

Charges with more than 5% occurrence*(N = 29)*	Top charge at first re-arrest	All charges at re-arrest
Other charges issued on first arrest:		
- Robbery-2nd:Aided By Another - Resisting Arrest - Possession Hypodermic Instrument - Intent To Obtain Transportation Without Paying - Grand Larceny-4th:Credit Card - Grand Larceny 4th Degree: Firearms/Rifles/Shotguns - Criminal Sale Controlled Substance-3rd:Narcotic Drug - Criminal Possession Marihuana-3rd: Aggregate Weight More Than 8 Ounces - Criminal Possession Controlled Sub-5th:Narc - Criminal Possession Controlled Sub-3rd:Narc Drug Intent To Sell - Burglary-2nd Degree: Displays Firearm-Sexually Motivated - Assault 3rd Degree: With Intent To Cause Physical Injury - Assault 2nd Degree :Intent To Cause Physical Injury with Weapon/Instrument - Unlawful Possession Of Marihuana	- Criminal Use Drug Paraphernalia-2nd:Scales - Unsafe Turn Or Failure To Give Appropriate Signal - Trespass - Speed Not Reasonable And Prudent - Possession Controlled Substance In Non-Original Container - Obstruct Governmental Administration-2nd Degree - General Violation Of Local Law - Failed To Use Headlights With Windshield Wipers - Disorderly Conduct: Fight/Violent Behavior - Criminal Use Drug Paraphernalia-2nd:Package - Criminal Trespass 3rd: Property Fenced in or Enclosed - Criminal Possession Weapon-4th:Firearm/Weapon - Criminal Possession Stolen Property-4th:Property Value Exceeds $1000 - Criminal Possession Of Marihuana-5th Degree: In A Public Place - Criminal Possession Of A Weapon-2nd Degree: Disguised Gun - Criminal Possession Marihuana-5th: Aggregate Weight More Than 25 Grams - Criminal Possession Controlled Substance-4th:Hallucinogen	

Initial Arrest Data

Table B-20. Frequency of prior arrests at time of HOPE enrollment, participants and comparison

Frequency of prior arrests	Percentage of HOPE participants (N = 152)	Percentage of comparison population (N = 601)
No prior arrest	46%	15%
1 to 3 prior arrests	30%	19%
4 to 6 prior arrests	11%	15%
7 to 9 prior arrests	9%	11%
10 or more prior arrests	5%	40%

Source: NYPD