City of Atlanta/Fulton County
Pre-Arrest Diversion Initiative Program Evaluation:
Reporting Social Service Effects in Their Own Words

Marla Cineas, MA
Contract Liberation LLC

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This report was written and prepared by Marla Cineas of Contract Liberation and informed by the independently contracted evaluation team selected by the City of Atlanta/Fulton County Pre-Arrest Diversion Initiative Program.

Additional Members:
Kevin Jefferson | Independent Program Evaluator
Brian McGregor | Morehouse School of Medicine
Sean Saifa Wall | Independent Program Evaluator

SOCIAL SERVICES SUMMARY

BACKGROUND

The City of Atlanta/Fulton County Pre-Arrest Diversion (PAD) Initiative program developed because of the discrimination that queer, trans, gender non-conforming, and non-binary people were experiencing on a day-to-day basis. Social problems such as racism and transphobia contribute to housing, employment, and healthcare discrimination, along with violence and harassment.[i] The racism and transphobia that was blatantly occurring in 2014 prompted many social justice organizations to come together and call out the City of Atlanta and other Atlanta Metropolitan areas around their discriminating proposals and that work prompted PAD to provide resources for queer and trans populations that are trying to survive. Currently, PAD offers people who are committing low-level offenses, such as survival sex work, substance use, and panhandling, a chance to better their opportunities for change by linking them to resources. In order to get these participants, the program has involved the work of the Atlanta Police Department to get officers to use their discretion and divert people who would otherwise be arrested for mental health issues, drug use, or other survival economy activity. The PAD program is a modification of the nation's Law Enforcement Assisted Diversion (LEAD) program, which has proved to been successful in 36 cities and 73 cities are either exploring, developing, or launching LEAD or a program that is aligned with LEAD.[1]

PURPOSE

This report documents and analyzes active PAD participants', Care Navigators (PAD's case management system operators), social service connectors and leaders, and funders' experiences with and perceptions of the PAD program in their own words.

METHODS

PAD participants (N=20), social service connectors (N=12), Care Navigators (N=9), funders (N=2), were interviewed with regards to their relation to the social services rendered in January 2019 and October 2019. Semi-structured interviews were administered to gather data about the programs' strengths, weaknesses, opportunities, and threats. This included comparisons with other social service organizations, participants' relationships with PAD staff, social service connectors/leaders, and law enforcement, and overall perceptions of PAD's services.

FINDINGS

All participants reported having positive experiences with the PAD program, particularly with the Care Navigators and the linkages to resources and social services. Many participants had already been involved with social service providers but felt that PAD gave them the resources they needed to make positive changes in their lives. PAD can close the majority of social service gaps and stabilizing the program structure benefitted all parties involved with the PAD program. There was also an element of culture change that occurred with social service providers, as well as participants connections with law enforcement.

[1] https://www.leadbureau.org/

DISCUSSION

The PAD program's connections to social service organizations are primarily positive amongst all of the participants in the study. PAD participants felt they had a better chance at succeeding while engaged in the PAD program due to internal and external factors that influenced their decisions. PAD participants, Care Navigators, and social service connectors/leaders had recommendations for PAD program enhancement due to the program's nuanced approach to serving their targeted participant population.

INTRODUCTION TO PAD'S SOCIAL SERVICE CONNECTIONS

Background and Aim of PAD's Linkage Program

During this evaluation, the aim of the PAD program is to assess the program's service delivery, measure program fidelity, and identifying potential problems in implementing PAD and suggest solutions for program enhancement. The overall goal for PAD is to strengthen the social service infrastructure and improve cultural competency for partners and get them acclimated to their harm reduction-based standards of care. In their words, they'd like to "improve the quality, raise the standards, and increase connection[s] between social service providers in Atlanta/Fulton County to benefit [the] program participants and all residents." PAD's housing first services can be traced back to Partners For Home, which intends to eradicate homelessness by the end of 2020 by constant tracking of people who are utilizing the social services in the city of Atlanta and Fulton County through the various social service providers in the area.

PAD's initial intent to train social service providers around cultural competency, trauma-informed care, and specialized harm reduction strategies began in the first year and due to the progression of the program, PAD shifted its program to cater to the participants' needs which is PAD's main priority.

Social Service Leaders & Connectors

With the original intent for PAD services, PAD aimed at connecting and collaborating with various social service organizations that would be beneficial for its future participants. Because of some social service provider's reputations, PAD set out on helping organizations by training them on various cultural competency issues. For instance, The Salvation Army is largely known to be a homophobic and transphobic organization; however, because they have low barrier access to housing, it was vital that PAD get connected to them to attain their "housing first" policy for PAD participants. Training the social service connectors in cultural competency would allow some participants to feel relatively safe and welcomed at the facility if they identified as queer or trans. Social service connectors are the people who are contacted by the Care Navigators to get their participant the resources they need to get one step closer for their intended goal. Ideally, these would be the people that the participant first connects with at the organization; equivalent to the "front desk" person that energetically awaits the PAD participant. Training these people to be culturally competent was thought to be vital to the organization in hoping to establish PAD as a key service advocacy institution.

Care Navigators

Care Navigators (CareNavs) are the people in the PAD organization that work to link the participants with the resources they need to get closer to their goals. After APD makes the invitation for a PAD diversion, the CareNavs meet them at the diversion area, bring them into the PAD office, feed them, fill out paperwork, and then proceed to get them on a participant-centered plan that establishes their goals while they are in the program. All CareNavs have previously worked in this industry, and therefore, know the process of social service providers, as well as bringing their own connections to the PAD program. The CareNavs are diverse; they

have varying ethnicities, gender identities, as well as variance in sexual orientation. This was intentional when thinking about the original populations that were PAD-inspired.

They work in teams of 2, but often seek each other out when it comes to various resources. They also have shifts in rotation, which allow them to cover the hours when people are being the most diverted. After Year One, they expanded with an Outreach team, which was built on the rapport of the first active year of the CareNavs.

In other social service organizations, the CareNavs would be the equivalent of a case manager; however, the difference is that the CareNavs are advocating and leading them to the resources and uplifting the voices of the participants, as opposed to just keeping track of the participant while they do the work by themselves.

Participants

The PAD participants have common characteristics that lead them into the PAD program. Most of them come into the program homeless. Most of them come into the program with substance use or mental health issues and multiple arrests. Some of them are committing low level offenses because they are just trying to survive. Participants range in age, gender identity, and sexual orientation, with most participants being Black Americans. Most of the participants have already been in the social services system, the Homeless Management Information System (HMIS) databank and PAD used this system after the first year to do proper tracking in regards to the homelessness and other services that they may need.

Law Enforcement

The Atlanta Police Department (APD) has been working with PAD to implement the diversions. With little expectation of the connections between law enforcement and the social service providers, there were a few things that were extracted in the data to elude to citywide culture change and APD's responsibility towards social service providers and other stakeholders in the communities.

METHODS

Design

A qualitative data analysis was used to describe everyone's experiences with the PAD program. Data was collected and their own words were analyzed from the individual interviews and focus groups.

Setting

The setting for the data collection was primarily collected in the office of the PAD program in their conference room. The PAD participants, CareNavs, and a few of the social service connector interviews done over the phone were completed in the PAD office. In order to collect data from most of the social service connectors, data was collected at the social service providers' offices. This was out of convenience for the connectors and leaders because of their busy schedules.

Study Participants

A convenience sample (N=43) was picked from the larger group of program participants, accessible social service connectors, and Care Navigators (including management).

Year One

- 10 PAD Program Participants
- 4 Care Navigators
- 1 Care Navigator Supervisor
- 1 Care Navigator Supervisor/Social Service Connector
- 5 Social Service Connectors

Year Two

- 10 PAD Program Participants
- 3 Care Navigators
- 1 Care Navigator Supervisory Support
- 6 Social Service Connectors
- 2 PAD Funders

PAD Participants

Ten participants were picked in Year One and ten different participants were picked in Year Two. Most participants were eligible for the PAD program through APD diversion. There were three participants that had social referrals to PAD, with one of those participants being referred from Grady Hospital.

Care Navigators

In Year One, there were four Care Navigators that were interviewed, with one of them no longer working for PAD. In Year Two, three new Care Navigators were interviewed and there were two short follow-ups with active Care Navigators from Year One. There were not any Care Navigator Supervisors during the data collection periods. In Year One, an interview was conducted with the last Care Navigator who no longer worked for PAD. One additional interview was conducted with the new Care Navigation Supervisor shortly after the main data collection to gain insight on current Care Navigation management, as well as their perspective with regards to their close connection with PAD working with them as a social service connector. Year Two, an interview was conducted with a local therapist who was conducting PAD participant support groups and acting as an interim supervisory support for the PAD Care Navigators.

Social Service Connectors/Leaders & Funders

There were five social service connectors interviewed in Year One with the goal of having at least 10. These social service connectors came from the current organizations that PAD staff were working with and had current Memorandum Of Understanding (MOU) paperwork completed. Year Two collection also had a goal of 10 social service connectors; six were social service connectors and two were funders. The conflation of the term “partners” provided some misguidance when data was being collected. The PAD program names the collaborative social service organizations as “partners” and also refers to funders (organizations that have granted PAD monies for the project), also as “partners.”

Interviewers and Interview Materials

Interviews were solely conducted by Marla Cineas of Contract Liberation of the PAD Evaluation Team.

Semi-structured interview guides were designed by Contract Liberation in collaboration with the PAD Evaluation Team for the purposes of exploring the larger qualitative experiences of all the people involved in the data collection. Interviews primarily consisted of open-ended questions to assess the participants' perceptions on their connections to the CareNavs (including management), the social service providers, and law enforcement (Appendix A).

Procedures & Data Management

PAD Participants

In Year One, PAD participants were randomly engaged and called into the PAD office to be interviewed. The PAD staff were aware of the interviews being conducted in their conference room and the Care Navigators helped to recruit PAD participants. The PAD participants had to fill out a consent and demographic form[2] (Appendix B); they were also compensated $25 for their time. In Year Two, the CareNavs were given instruction to provide the data collector with at least two participants from their caseload to be interviewed. Again, they were required to fill out the consent and demographic form and compensated $25 for their time. All interviews were audio-recorded and transcribed and lasted from 11-50 minutes.

Social Service Connectors & Funders

In Year One, the social service connectors were chosen by Marla from the current organizations PAD was working with. In Year Two, the Executive Director and the PAD staff supplied a list of social service connectors to be interviewed. Social service connectors were either interviewed at their place of service or over the phone. Funders were interviewed over the phone. Connectors and Funders also filled out the consent/demographic form and were not compensated for their time. All interviews were audio-recorded and transcribed and the social service connector interviews lasted from 8-43 minutes and the funder interviews lasted from 12-26 minutes.

Care Navigators

In Year One, there were four Care Navigators interviewed separately, with one person no longer working as a Care Navigator for PAD. The additional three CareNavs also did a Focus Group together. In Year Two, three new CareNavs were interviewed, but because of their hectic schedules, interviews had to be conducted at their convenience. This became partial interviews and partial focus groups. They also filled out the consent/demographic form and were not compensated for their time. All interviews and focus groups were audio-recorded and transcribed.

All transcripts were stripped of personally identifiable information and all participants of the study were given or chose their own pseudonym to be used during the interview process.

[2] Demographics were important to capture due to the background and the reasons behind the birth of the PAD program.

Data Analysis Plan

For this particular PAD goal of strengthening social service infrastructure, there were some evaluation questions that aimed for answers (Appendix C):

- What are the processes through which PAD Participants are interacting with the social service infrastructure? What are the gaps and weaknesses, strengths, and opportunities?
    - For a landscape/process analysis: who is doing what and how well?
- Did the training lay the groundwork for what they needed to know? How could it be improved?
- Do the service providers have the resources needed to do their work?
- What are their relationships with the police?
- Is there change in social service providers in terms of cultural competency and harm reduction-based standard of care due to their interactions with PAD, trainings, coaching, and monthly partner meetings?
- Is there change in the infrastructure due to PAD suggestions or support?

In order to execute this plan, we anticipated to conduct the following:

- semi-structured interviews with the CareNavs, social service leadership, and a sample of PAD participants
- Focus group interviews with the CareNavs, social service staff, and PAD participants
- Content analysis of the social service organizations and what they offer, as well as the PAD training materials, and relevant documents that need to be reviewed due to PAD's modifications
- Survey measures to measure the application of harm reduction techniques, trauma-informed care, culturally relevant care, linkage to care (case management), and intervention fidelity
- SWOT Analyses of all aspects of the program that are connected to the social services

Because of time and budget constraints, the amount of data collection was limited to the interviews, focus groups with only the CareNavs, CareNav participant observation, brief content analysis comparing Year One and Year Two, and the SWOT analysis (Appendix D) informed by all of the above.

SAMPLE DESCRIPTION

Year One

PAD participants (N=10) age ranged from 31-56 with a median age of 45.8 years. Seven participants are Black, one is Latinx, one is White, and one is bi-racial. In this sample, there were three trans people, three cisgender women, and four cisgender men. Within the first year total sample (N=55), there were three people (5%) who identified as trans, 22 identified as women (41%) 32 identified as men (58%), and 1 non-binary person (<1%). One participant

identified as being bisexual, one participant identified as being gay and all other participants identified as heterosexual. Three participants had college experience, two participants had a General Education Degrees (GED), and five participants had the educational level of high school or middle school.

The Social Service Connectors (N=6) age ranged from 30 to 65 years with a median age of 45.3 years. There were two cisgender women and four cisgender men: two Black people, two Hispanic people (1 of mixed heritage) and two White people. Three people identified as being a part of the LGBTQ communities, and three people identified as heterosexual. One connector had a high school diploma, one had a bachelor's degree, and four connectors had master's degrees or higher.

The Care Navigators and Care Navigator management (N=6) age ranged from 26-51 years with a median age of 35.5 years. There were two transwomen, one cisgender man, and the 3 cisgender women. One Care Navigator was white, one mixed Hispanic, and the other four people were Black. One Care Navigator identified as a lesbian and the other five identified as heterosexual. Two participants had some college experience and four participants had master's degrees.

Year Two

PAD participants (N=10) age ranged from 24 to 57 years with a median age of 37.6 years. There was one trans participant, three cisgender women, and six cisgender men. In the total sample (N=150), 10 people identified as trans (7%), 1 non-binary person (<1%), 48 women (8%), and 101 men (91%). One participant identified as Haitian and the other nine participants identified as Black. All participants identified as heterosexual and there was one person who had a master's degree, five participants who graduated high school, and four participants who did not complete high school.

The Social Service Connectors (N=6) age ranged from 28 to 49 years with a median age of 36.8 years. There were three cisgender women and three cisgender men with all participants identifying as heterosexual, except for one. There were three Black participants, one Hispanic participant, and two white participants. One participant did not graduate high school, two participants graduated high school and three participants had a master's degrees.

With the funders (N=2), one was aged 32 and the other was aged 40. Both were cisgender women, heterosexual, with master's degrees. One was Black and the other one was white.

The Care Navigation team (including management) participants (N=4) age ranged from 29-49 with a median age of 41.25 years. Two of them identified as genderqueer/genderfluid and two of the participants were cisgender women. Three participants identified as being part of the LGBTQ communities and one participant was heterosexual. There was one Black participant, one mixed race (Black/Dominican/Haitian) participant, and two white participants. Two participants had bachelor's degrees and two participants had master's degrees. There were two quick follow-ups from two of the Year One Care Navigators.

PRIMARY FINDINGS

In the analysis of all of the data, which was primarily to see PAD's relationship to social services, there were several themes that emerged about the PAD program itself, which will be highlighted in the Final Executive Report.

"Everybody deserves another chance."
– Joe, Social Service Connector

SOCIAL SERVICES SUMMARY

The social services that PAD sought out had quite a bit of range. Because they had participants in the program coming from various experiences, there were a lot of services that were needed in order for them to engage in the process of moving forward in their life. Social services included:

- Classes/Education
- Clothing assistance
- Counseling
- Crime victim's services
- Disability/SSI assistance
- Food/Food Stamp assistance
- Housing
- Hygiene assistance
- Identification assistance
- Job assistance
- Law assistance
- Medical assistance
- Medication assistance
- Substance use assistance
- Support Groups
- Transportation

Although there is a plethora of organizations that assist and give all these resources, there were a number of organizations that were named as the most dependable. These were the organizations that participants and Care Navigators felt comfortable with and consistently gave them the things that they needed. The opposite goes for the least dependable.

Most Dependable Organizations Named

- Allen & Allen
- Atlanta Recovery Center
- Caring Works/Hope House
- Central Presbyterian Outreach & Advocacy Center
- Community Friendship
- Community Service Boards
- Covenant House
- Essence of Hope
- First Presbyterian
- Gateway
- Georgia Division of Family & Children Services
- Georgia Works
- Goodwill
- Grady
- Living Room
- Making A Way
- Mary Hall Freedom House
- Mercy Care
- Midtown Assistance Center
- Motel 6
- MUST Ministries
- My Sister House
- Numerous Hotels
- Public Defender's Office
- Recovery Consultants of Atlanta
- River's Edge
- Salvation Army
- Sober Living America
- Social Security Office

- St. Joseph Mercy Care
- Supportive Services for Veteran Families
- Traveler's Aid
- United Way
- Veteran's Affairs
- Vocational Rehabilitation
- Welcome House
- Workforce Development

Least Dependable Organizations Named

- Georgia Division of Family & Children Services
- Georgia Food Stamp Program
- Grady Hospital
- Office For Medicaid

Key Characterizations:

- Social service connectors and leaders were motivated by participants and viewed the participants' success as inspiring.
- Social service leaders rarely met participants and did not feel relatable to the participants; however social service connectors did feel relatable to the participants.
- Some organizations changed their culture and policies because of the PAD program.
- Social service organizations were able to fill their spaces due to PAD's connections and organizational rapport.
- Several rules and barriers prevented many participants' from receiving services depending on the social service provider.
- There are social service gaps, which include emergency assistance, housing, and more help for people with children.

In the first year, the social service connectors and leaders were impressed with the PAD program goals and looked forward to working with them. Most of the social service connectors felt that the interconnections that PAD was making was nuanced and important when it comes to an alternative to the Atlanta Police Department:

> I love that the PAD program is just a different take on the criminal justice system and how we look at it and how we look at the people who are involved in the criminal justice system. I love that it's a different option for police officers. I love that. You know, they only have one choice previously, well, two choices. So they could either arrest a person or they could just say walk along. And that was kind of it. And so now we're giving them a third option, which is more holistic. I think that the more options people have, the better.
>
> – April, Social Service Leader/Care Navigation Supervisor

The fact that the PAD program is seen by the social service connectors and leaders as a program that will be all-encompassing plants the seed that PAD has a perspective that other social service providers lack.

By the second year, PAD had a great reputation about what they were doing, even though the connectors and leaders didn't attend any network meetings. Them knowing what the PAD program was doing is proof that PAD's organizational outreach was effective:

> I don't know as much as I would like, but what I understand and really like about PAD is the way that it's moving. People who should not be incarcerated kind of out of that track. Getting people to the services and the assistance that they need rather than continuing to overcrowd jails and put people behind bars who are not dangerous, violent offenders.
>
> – Michael, Social Service Leader

Having a program for participants to aid them in their progress was also inspiring to the social service connectors. Some of the social service connectors attended PAD meetings (advisory and network meetings) and were regularly updated on who the participants were (anonymously, of course) and how they were doing in the program:

> Hearing the stories, you know, when we were at the advisory board meetings and that kind of thing and just kind of hearing how folks have really turned some things around is just really inspiring.
>
> – Taylor, Social Service Leader

However, in the first year, despite being inspired by the participants and their progress, many social service leaders rarely came into contact with the participants they were serving and most social service leaders did not feel they could relate to the participants. Because of the sporadic communication that the social service leaders/connectors had with the CareNavs (mostly because they only talked with the social service leaders when they needed their services which ranged from once every two to three months), allowed them to not spend as much time communicating with participants; therefore not having the possibility for them to be relatable. Race, educational, and class disparities, were the most prominent when it came to possible factors of relatability:

> I mean there's, you know, the, the barriers of race and class and sort of, you know, experience and that kind of thing are very much in place.
>
> – Taylor, Social Service Leader

> Sometimes with some of them, there are definitely pieces that I cannot relate to.
>
> – Cameron, Social Service Leader

By the second year, there was a split when it came to the leaders and the connectors. The social service leaders had the same relatability factors as in year one, but the connectors (those social service persons who come in contact directly with the PAD participants) related directly with the participants, while continuing to be inspired by them:

"I love the program. I can't believe that there's stuff like that out there 'cause I never had that kind of help when I was in my active addiction." – Charlie, Social Service Connector

> It helps me stay clean and sober and it's a very, it's a gratifying feeling to watch someone come in broken and grow and get their life together and, and just, you know, all kind of doors open up for him. It's really self-fulfilling for myself.
>
> – Charlie, Social Service Connector

Some of the connectors even felt that they could have also benefitted from the program if was in existence at the time that they needed the help:

> I mean, I'm wondering myself, where was y'all at when I was out there, you know what I mean? …'cause I've been through some things and life on life's terms seemed to be there regardless, you know, but when you're in addiction, like I said, you get stuck, you can't find a peaceful solution, you know. Some of us are lost and have no clue.
>
> – Joe, Social Service Connector

The social service connectors and the leaders are both inspired and as PAD continues to evolve, there will be more of an opportunity for more social service connectors to promote the benefits of the program.

Another inspirational aspect in the first year, was that there were several organizations who changed what they did in the organization because of their relationship with PAD. One organization changed how they proceeded with their Memorandum of Understanding (MOU) with other organizations so they could keep their beds full:

> …Because of the agreement that we have, I'm looking to do similar agreements because of the benefits of being able to keep their rooms full. So I spoke with some people at PAD about expanding that MOU to include more rooms, but they do have that kind of arrangement even with other organizations. So yes [we have changed] 'cause of my relationship with PAD.
>
> – Ryan, Social Service Leader

Because PAD's priority is to get their participants housing first, creating MOU's with organizations that specialize in housing is necessary. Other social service organizations have also reserved housing strictly for PAD use:

> The only thing actually, we normally don't count like hold beds, like hold things like, reservation stuff. Like, we normally don't do that. But we do that for PAD. We're now trying to keep, at all times, we try to keep at least one bed open every day for them because, if we have somebody we want to get them in right away. Right away. And then, as soon as I, once I get rid of that one, I'm immediately trying to get another one. I'm going to keep at least one bed at all times over for them….Well, it's because you know we are staying so full these days and it gets your day. They got

> somebody and then I may not have a bed, and see and this is what we want to do. At least, that person, they got somebody. At least we can get them to help right then. And then at least by the next day I have another bed open, waiting on them and it don't matter. I'll hold that bed all weekend if I have to. It's more like reserved just for them.
>
> – Fred, Social Service Leader

The way that the organizations are changing their policies can speak to PAD's goal of changing the culture of social service organizations.

Even typically homophobic and transphobic social service organizations have changed how they interact with PAD's participants. In year one, Morgan, a Care Navigator, states, "Transgender women have lost their lives [in this shelter]. You owe me." In this instance, they were talking about a transwoman who committed suicide because of the way they treated her at the shelter and Morgan was no longer going to tolerate their discrimination. Because of this backstory, and the persistence of a Care Navigator to get a person into this low barrier emergency shelter, PAD staff has been able to get this shelter to be more accessible for LGBTQ participants.

However, in year two, none of the social service leaders or connectors changed what they previously did in the organization because of PAD's work. There could be many factors for this, including the changing of PAD's organizational procedures, or previously established connections that have already modified their policies due to the MOU's they have with PAD.

Even though PAD changed the culture at some of these social service organizations, there were still barriers that prevented some PAD participants from accessing resources:

> A background check is really just so that we have it on file. We take everything from registered sex offenders. I think the only thing that disqualifies somebody is a recent and violent felony. So that's within the past three years just a violent felony. Other than that, sometimes meth convictions will be a red flag.
>
> – Ryan, Social Service Leader

So, in addition to being anti-LGBTQ, accessing resources might have been limited for a variety of reasons. Participants' background, faith-based affiliations, or the rules of the social service organization, were unveiled as barriers in the first year, while organizations at max capacity, the social service organization discretion, and not having identification were the additional reasons why participants had barriers in these social service organizations in year two.

The social service organizational barriers are prevalent; however, what was also revealed were the gaps. The lack of emergency housing for PAD's participants who are coming in from diversion is a major gap that needs to be filled for PAD's 'housing first' organizational value. When interviewing the participants in the study for the first year, many people named the lack of housing that exists for people in the City of Atlanta and Fulton County and the lack of government funding to help with housing:

> I think in Atlanta, in our area there is a lack of housing resources for individuals and there's a lack of funding for housing resources. So that really impacts our ability to sort of help people transition if they're homeless into housing. Our process is extremely laborious to try to help people get on a state-funded voucher or try to get them at a shelter services, things like that. There's just not enough capacity to help people with the housing piece.
>
> – Paul, Social Service Leader

In year two, it was also revealed that a major gap in services had to do with organizational help for people who are pregnant or who have children. Two PAD participants had this particular experience and there were no social service organizations that PAD could connect them to besides the Department of Family and Children Services (DFACS). The result of this, is that those two PAD participants were separated from their children for them to remain in the PAD program. Although they still had access to their children, the reality is that they had to prioritize their personal goals without parental responsibility.

THE PAD PROGRAM FROM A SOCIAL SERVICE PERSPECTIVE

Being that PAD is a new organization that aims to fill social service gaps and moves to remove barriers that people experience trying to get their basic needs met, it is logical that they would look to partner with other organizations that can contribute towards the resources they would find useful for their potential participants. PAD's nuanced angles have the ability to recruit and convert social service organizations and shift the culture to one that has a true caring attitude about the people they serve.

Key Characterizations:

- PAD grew their partner network by providing more MOU's with more social service organizations and keeping up with various social services through HMIS.
- PAD is closing social service gaps, including housing, clothing, food, support groups, and classes.
- Social service organizations would benefit from PAD informational trainings, as well as more collaborations with the PAD program.

PAD's connections to social service providers grew tremendously between year one and year two. Through the content analysis, the first year named a vast amount of organizations (181 connectors belonging to 136 organizations) and having MOU's with 30 of those organizations. By the second year, PAD had an incredible amount of resource lists that surpassed the 136 organizations listed in the previous year, with at least 37 housing organizations (compared to 18 housing organizations in year one).

In the first year, PAD lacked connections to housing organizations and therefore, when diversions occurred, PAD often provided hotel/motel stays for participants. PAD also provided food and clothing if they weren't able to contact a social service provider to accommodate their needs. As they slowly developed relationships with more social service providers in year two,

less money was spent on hotels/motels, clothing, and food due to PAD's connections with more housing organizations, clothing closets (as well as having their own available in the office), and leading participants to food pantries or helping them to receive food stamps.

In year one and in year two, PAD also provided participants with transportation, either through MARTA cards or giving them a ride in their mobile transport vehicle. All other services were outsourced to other social service organizations, as PAD provided the link to care.

There were a few suggestions that came about when it came to PAD's offerings that related to social services in the first year:

- An option for social service connectors/leaders to shadow CareNavs with a diversion
- Informational trainings for social service providers who partner with PAD
- Screening PAD participants to ensure they are a good fit with the social service organization

The PAD program also had hopes for a Diversion Center that would be open 24 hours a day, 7 days a week that would take diversions, as well as social referrals. One participant felt the brunt of this because of PAD's limited hours:

> Well, I was saying I was here for about a week or two and I missed one or two of my appointments and, to be honest, they didn't want to deal with me and told me come back on Tuesday. No, what was it? Thursday? You know, it was a legal meeting and they didn't have time to handle it. So they gave me some clothes, gave me a list of food shelters and said, come back Tuesday and you know, we'll try and get you back here. I mean, it was my fault being late into my appointment. I'm 31, I shouldn't miss appointments, but five days back outside changes your life again. And I got caught back up in the cycle, which I did get locked up one more time and they had already helped me solve my legal issues, which they was supposed to do and I felt kind of upset that they did that to me.
>
> – Vanessa, PAD Participant

This is to be expected, especially in the first year, as PAD adjusts and figures out what would be the best course of action. The suggestion about being in partnership with other diversion services already in existence was also recommended in year two.

One of the biggest threats that PAD has with other social service organizations is the fact that other social service organizations are also doing wrap-around services. During the first year, social services tracking was suggested by the evaluation team, but was not implemented. Once PAD was informed about the Homeless Management Information System (HMIS) database, this allowed the CareNavs to keep track of their participants in the system to see what kind of social services they had been receiving. This was to help with limiting the amount of work the CareNavs were doing when their participants had other case managers helping them throughout the city. They continued to use the HMIS databank in the second year.

In the second year, there were some additional suggestions to that of the first year:

- Maximizing HMIS data
- More collaborations with social service organizations, especially mental health and medical needs
- More options for social referrals
- Utilizing the PAD staff for more support, such as anger management classes, substance use support, and other classes that help participants navigate social services on their own

All of these suggestions between the first and second year should be taken into consideration as the PAD program evolves.

One theme that emerged is the possibility that participants who love the services they are being connected to might have a problem being weaned off the program and continuing their social service connections without PAD's assistance. The change they made in their structure in the second year allows them to be flexible with their "we'll leave the light on" policy[3], where they have intensive case management for the first 90 days, while they wean the participant off the program in the next 90 days.

CARE NAVIGATORS AND THEIR RELATIONSHIP TO SOCIAL SERVICES

Care Navigators are integral to the PAD program and it's functioning. Their connections with the social service providers and the participants make them key witnesses to the structure of the PAD program and its effects on the participants themselves.

Key Characterizations

- Care Navigators had built rapport and strong connections with social service connectors and leaders.
- Care Navigators encountered service tension because of the characteristics of the PAD participants.
- Participants exploited Care Navigators in the first year, but the Care Navigators overcame that exploitation with participant-led resource access in year two.

> *"Whereas when they're coming in here, a lot of them are confused. That mental health issue, that substance abuse issues, social service issues, and they just want everything done at one time and it's so cluttered. Also they might not know how to navigate the different systems, the justice system, the social service system, the healthcare system, and sometimes it all, if you put it right, it all works together holistically. So just getting them to a place where they're able to navigate through the systems."*
> *– Diva, Care Navigator*

Care Navigators essentially lead their participants into getting the services they need, as well as advocating for them within the criminal justice system. The CareNavs get in contact with social service organizations in various ways. There were email introductions and phone calls to let the social service leaders and connectors get information about the PAD

[3] Based off of Motel 6's slogan, CareNavs provided reassurance to the participants in the first year that no matter what happened, they are always welcome to come back to PAD to get the help they needed.

participants and what services they would be needing from that particular organization. All the CareNavs indicated that meeting people in person was the best way to advocate for their participants to develop rapport and found it to be more effective than a phone call or through email.

When the CareNavs are in constant contact with the social service connectors/leaders, they learned that seeing the same people repeatedly helps to foster kindness and connection. Many of the connections that the CareNavs established became stronger connections over time. With more MOU's and partnerships, this is to be expected, especially in year two.

However, the CareNavs found that working with some of the social service organizations were frustrating, particularly in the first year, because there were so many barriers to get care. When social service organizations primarily exist to break down those barriers, to have so many barriers within these social service organizations that the CareNavs need to direct their participants, leads to elusive care within the system.

> *"And I try to stick with organizations that were geared towards the LGBT communities, but then that was also hard because most of the LGBT organizations I find, they are HIV organizations and I'm negative. So it was just like when they found out I was negative, they would automatically close the door...So it was just like, it also have felt like it's a curse being healthy and being homeless. They was like, I couldn't get no help or assistance because I wasn't HIV positive."*
> *– Janet, PAD Participant*

In the first year, some CareNavs indicated that those social service connectors won't "misbehave" (act rude), as long as the CareNavs called ahead of time and told them when they were going to come to the establishment. Morgan, one of the CareNavs in year one, mentioned they often demanded what the participant needed in order for them to be an effective CareNav. These partnerships weren't favorable, as described by Sonny:

> It just goes back to those bridges being burned because again, everybody is on the same journey, the same journey. So like, let's use a hotel for example. Hotel may have been like all for it 'cause all they seen is the cash flow and opportunities to get their rooms filled or whatever. But being that we work with the populations that we do, everybody doesn't come to that hotel just perfect. Right? So they like the money but then when they see what may come with the money, which may be the drugs or the prostitution or the arguments or talking to the wall or whatever, it may be. Over time, that front desk experience might not be the best because at this point they're over it and they don't, want our people there because they just bring them issues - money, but issues.
>
> – Sonny, Care Navigator

Because of their limited social service organization connections, the CareNavs were forced to go to organizations and businesses where there was service tension.

However, in the second year, PAD helped with the accountability of those negatively influential partnerships and resolved to connect their participants to other social service organizations that were a better fit. The CareNavs were able to bypass these partnerships because of their ability to use more resources that were already existent in the communities. In turn, this also took some of the weight off the CareNavs when it came to connecting participants to the social services they needed.

Despite having HMIS access, one of the disadvantages that the CareNavs might not have been aware, was the fact that if a PAD participant had another case manager at a different social service organization, they might be working on the same thing for one participant. Having two managers for one participant with an overwhelming amount of participants that still need the help might hinder the work of the CareNavs. One participant admitted that they had asked both their CareNav and another case manager at another organization to solve their housing issue at the same time. This is a clear waste of time and resources for either the CareNav or case manager.

CareNavs have also had their share of being taken advantage of when it came to the acquisition of resources by PAD participants. Because some of the PAD participants were used to lying to social service organizations to get the resources they need, they sometimes treated PAD in the same way; often lying to them to get things such as groceries and MARTA cards from their CareNavs. In the first year, the CareNavs realized they were being taken advantage of when their participants were having parties in their hotel room, letting other people eat their food, breaking things, or not going to their job that their CareNavs had helped them to get. By the second year, the CareNavs "got wiser" and held their participants more accountable for the resources they were giving them. When a participant pulled back from the program by not completing the things they needed to do to get closer to their goals, the CareNavs also pulled their resources from the participants.

> *"Because I'm your champion right now. But eventually my goal is to get it to where you take two steps and not take one that give you a little push. But to start, I'm going to take two friends that you can take, right? And we're going to do this together and I let them know we're a team, but I'm also not nothing to play with. You're not going to play no games. I'm going to be forthright with you. I want you to be as honest with me. Even if you're telling me, look, I'm not ready to stop doing drugs. That's fine. We're going to work around harm reduction. Then, Oh, we're going to do this or whatever. Wherever you're at, I want you to be honest. We gonna work together. And guess what? If you're not honest down the line and like you said, you want to come clean three months later, eight months later, I'm still going to feel the same way about you and I respect you for it."*
> *– RRR, Care Navigator*

PAD PARTICIPANTS' CONNECTIONS TO SOCIAL SERVICES & THE PAD PROGRAM

The participants in the PAD program have complicated relationships with social service providers, ranging from the resources to the people who run the organization. This section highlights those relationships and makes comparisons and connections with the PAD program.

Key Characteristics

- PAD participants lacked trust with social service organizations prior to working with PAD.
- The CareNavs and the PAD program helped participants to have more faith in the PAD program and its connections to social service providers.
- PAD participants had an abundance of benefits by being in the program.
- PAD participants' successes were dependent on participant-led goals, as well internal and external factors.
- The PAD program's reputation helps and hinders their programmatic goals.

As indicated above, many of the PAD program participants were familiar with many of the social service organizations and the resources they have for individuals. Through these organizations, they can alleviate resource stress by getting the resources they need. As stated earlier, many of these participants lie to social service organizations to get the resources they want and need, including the PAD Care Navigators. Quavo, a PAD participant stated, "I felt bad that the people had so much faith in me and I was just really slapping them in the face."

As the PAD participants get more and more involved with the program, and as the CareNavs continue to build rapport with the participants, eventually, the participants open up, share their struggles, and put more trust into the CareNavs. In the first year, Vanessa stated, "[The Care Navigator is] easy to talk to and she's the only one I feel, you know, really comfortable with. She seems to have a around the world view and understands the streets and understands what we go through." This faith in the participants resonated in year two, as well:

> They were pretty patient with me and they gave me more chances than, than I would've given myself anyway. I mean, I think it's very positive. I mean, I turned it all around, they helped me just change. I mean, they became more than just a program to me cause they, they, they loved me and believed in me 'til I was able to believe in myself. So now it's shining.
> – Quavo, PAD Participant

Having faith in the participants is different; many social service organizations and the Atlanta Police Department expressed not having faith in the participants to change, so this perspective gives the CareNavs and the PAD program an advantage when it comes to maintaining connections with the PAD participants.

All the participants felt happy and appreciative that they were being connected to services through PAD. It can further be highlighted that there were an abundance of additional benefits that the participants gained from by being in the program. In year one, the benefits included:

- Access to classes
- Being treated well
- Cigarettes
- Comfortable office atmosphere

"Yeah, and the way you're received into the space at the beginning. I think that makes a big difference. It sets the tone for the whole experience."
– Ruby, Care Navigation Supervisory Support

- Communicating better
- Experiencing success
- Having housing stability
- Help with social skills
- Paying off bills
- Reconnecting with family
- Renewed faith in self
- Saving money
- Seeing other participants' success
- Self-esteem boost
- Speaking opportunities
- Staying sober
- Substance use support groups
- Working relationship with PAD

The second year included these benefits, with the exception of the cigarettes. Cigarettes had transitioned out as a benefit in second year because the program wanted to contribute to the health of their participants and cigarettes weren't a part of that solution. Additional benefits mentioned in the second year were:

- Access to other CareNavs and staff when regular CareNav is not there
- Being seen as a role model and motivating for other participants
- Getting away from negative environments
- Helped with baby issues
- Nuanced problem-solving

"This is the only home I've ever known."
– Tracy, PAD Participant

In both year one and year two, the PAD participants' experiences with the Care Navigators and the PAD program were positive. Additionally, to the above-aforementioned items, the participants felt like the PAD staff was family. In year one, Reno mentions, "We like brothers…I wish he was my brother." In year two, Ashely stated:

> I was at the point where I wanted to just give up and I was like, "there's no point on just keep on trying to do this stuff." But talking to my care navigator, she's like a second mom to me. So whenever I need someone to talk to, I'd come to her and she'd give me advice.
>
> – Ashely, PAD participant

The PAD participants experiencing this attachment were also experiencing consistency in their life. In both years, the participants felt that the CareNavs always "did what they said they were going to do." The CareNavs offered advice, listened to the participants, and felt that the CareNavs could relate to them and their experiences. Many participants were happy about their inclusivity and understanding of the LGBTQ communities, as well.

"They take the time to care…They go above the call of duty."
– Hussan, PAD Participant

In year two, participants experienced having the CareNavs push them more towards their goals. Some of the participants experienced bargaining with their CareNavs in order to achieve their participant-led goals:

> Honestly. I mean, because what they said, they never renege. They never went back on it. It never did fail. Everything came through. She said, "You going to have housing. You going to have food. You'll get clothes. But you're going to get a job. You're going to have to get goals. You're going to have to motivate yourself. You're going to have to turn all this anger and bitter that you have in you and turn it into something positive and do something with it." And I can honestly say, it really works.
>
> – Kiki, PAD participant

Unfortunately, most of the sample participants in year one did not achieve success. Two participants stopped being in the program once they became ineligible for the benefits and three participants had partial success with their goals. In year two, six of the participants were able to achieve all of their goals.

Participants' successes are influenced by internal and external factors. Internal factors include:

- Addictions
- Medication adherence
- Mental health regulation
- Patience
- Restlessness
- Strength/Willpower
- Substance use
- Willingness to change

"They'll kind of guide me. It's more so of me putting in the effort."
– Baby, PAD Participant

These are all the factors in which the participant has control. In which the participants do not have control, these external factors include:

- Care Navigator relationships
- PAD programmatic structure
- Social Service (partner) connections

The connections to the social service providers were influential pre- and post-PAD induction. Some participants found that the organizations they were being connected to were not a good fit for them. While working with one of the social service organizations, Baby describes, "[there was] Too much going on. They don't help you. I don't feel welcome. The people are nice, but they just don't really care." Having this perception that the organizations will help you, but they do not care makes the participants feel unimportant and not a priority. In the first and second year, many participants felt that they couldn't trust a lot of the social service organizations and when entering the PAD program felt hesitant around working with the social service organizations because of their previous

"And, you know, they don't just do the temporary stuff there. When you are on the long haul to get back whatever it takes to get you back to being self-sufficient, productive member of society again."
– Jade, PAD Participant

experiences (whether they were previously connected to the same organizations or not). For instance, one participant discussed how they could not work with one social service organization because the organization saw that they were working with another social service organization in the HMIS databank. This is perceived as a barrier for the participant, while the organizational network perceives this as a regulation of resources allocated for individuals. This is another source of service tension.

As PAD participants get acclimated to the PAD program and its resources, some of the participants expressed their appreciation and were excited to be connected to services, especially if they were never connected to services prior to working with PAD:

> I mean, I feel like I'm in debt to them. I really do because I mean, they lifted a great, great, great burden off me of having housing, of having options of what food I could eat, or having the privilege of going and getting clothes from the corner closet or just in general, anywhere or whatever. Just because once upon a time, there was a point I didn't know what I was going to wear tomorrow, and I had this on for two weeks. So, I mean, it takes a lot off you.
>
> – Kiki, PAD participant

At the same time, people who lived on the streets of Atlanta were hearing about PAD's services and their reputation also had some participants feeling like PAD was not doing enough. For instance, when a participant entered the program and had received a hotel room and groceries from PAD, they did not want to go to a shelter or a food pantry after that experience and felt disappointment around the program. There were also some instances where the program that PAD had put them in was not a good fit for the participant, which resulted in short stays in housing and employment.

With that said, being in the program helps PAD's participants get them an abundance of resources and benefits, but it may be short-lived depending on the internal factors of each participant and their life experience.

LAW ENFORCEMENT & SOCIAL SERVICES

PAD participants would enter the diversion program based on the officer's discretion and whether it was a low-level offense stemming from lack of resources. In this small sample the Atlanta Police Department diverted from these possible arrests:

"As we're working with a lot of folks who are oftentimes agitated, sometimes there's mental health and addiction issues in the mix and they've been out all night. They're trying to get their services and it's just, it can lead to agitation. So sometimes we do call the police in when people are unwilling to leave. When there's a situation, our security guard is not able to handle safely and we are very pleased ... They've always been, at least that I have seen very respectful to our guests and willing to work with us and talk to us and want us to feel safe and supported."

– Michael, Social Service Leader

- Drug Paraphernalia
- Drug possession
- Jaywalking
- Littering
- Panhandling
- Pedestrian on the Roadway
- Prostitution
- Public Intoxication
- Public Urination
- Shoplifting
- Trespassing
- Urban Camping

Key Characteristics

- Law enforcement used by social services for various services.
- Law enforcement knows members of the communities that may have received social services and have had multiple arrests.
- PAD participants trusted police officers more after entering the PAD program.

There were a few connections with regards to the Atlanta Police Department and their interactions with social service providers and participants. Generally, law enforcement was used by the social service providers to:

- Keep their facilities secure
- Evacuate people from their premises
- Transport and link people to services

When a person has mental health or addiction issues, law enforcement is typically called out to transport them to a hospital or other service facility. Many times, law enforcement is familiar with the people in the areas that they patrol and have often arrested people repeatedly. In year one's sample, at least three participants were arrested over 10 times in their lifetime (one person at 10 arrests, one person with 27 felonies, and one person with 54 arrests). In year two's sample, there were at least three people who were arrested after already being inducted into the PAD program.

> *"I was at the mall or whatever, and, um, I ended up using the restroom or whatever and I guess someone got a call, the radio that I was, um, taking a wash in the restaurant and it wasn't even like that, you know, it was that, it was that time of month for me and I was using the restroom."*
> *– CC, PAD participant*

With the PAD participants, some of the officers were already familiar with some of the participants, and because of PAD's trainings with the police officers, this enabled some officers to get them into the program to try and get help. In year one, three participants were already familiar with the police officer who had referred them into the PAD program. In year two, two of the participants were familiar with the officer who referred them into the program.

Some participants were hesitant about the program at first because the information was coming from a police officer. After realizing that the officer did not handcuff them and having them enter the program, there was relief and trust gained in the justice system. This was further highlighted in year two when two different participants saw the officers in the building

again. One officer stopped by to check up on the PAD participant and the other officer told another participant to "Keep up the good work." These interactions help to reify not only the participant's trust in law enforcement, but the law enforcement's trust in the PAD program. This can lead to officers who have relied on a punitive lens to redirect their focus to a social service lens, which is more compatible to PAD's programmatic goals.

DISCUSSION

The objective of this report was to provide a thematic characterization of all those involved with the social service organizations and the perceptions of the PAD program and its connections to those social service organizations in their own words. Because of the participants' primary point-of-contact being the PAD Care Navigators, this report heavily focused on this aspect.

The PAD program's connections to social service organizations are primarily positive.

With the increased amount of social service organizations that PAD is connected to, this gives the Care Navigators more choices when it comes to connecting their participants to the kind of care they need while they are in the program and beyond. Being connected to more organizations that support the population's needs, such as mental health facilities, rehabilitation and sober living facilities, housing networks, and access to food, clothing, and medical needs will ultimately share the workload amongst all the social service organizations. In turn, this can help the Care Navigators to operate within the various organizational barriers to resources. Advocating for the participants and gaining access to these social service organizations provided trust in the Care Navigators to get what the participants needed and restore trust back into the social service organizations.

PAD participants felt they had a better chance at succeeding while engaged in the PAD program.

The PAD program enriched the participants' lives by providing clear, participant-led goals that felt achievable in the amount of the programmatic structured time. Although internal factors are important when it comes to the participant achieving their goals, the external factors proved to be quite significant to their success. Not only do the participants feel cared and advocated for by the Care Navigators and PAD staff, but they reap a tremendous amount of additional benefits that they would not normally get when working with the individual social service organizations by themselves. This reinforcement, along with law enforcement support allowed the participants to envision themselves to be successful beings and boosted their self-esteem so much so that some participants felt they could also be an example of success and motivate others who may have gone through similar situations.

> *"PAD is saving people's lives."*
> *– Quavo, PAD Participant*

PAD participants, Care Navigators, and social service connectors/leaders had recommendations for PAD program enhancement.

The sample participants that were invested in the PAD program, also had many recommendations for the PAD program. They felt that since the PAD program had offered such a nuanced stance when it came to social service goals (more social service collaborative networks, participant-led models of success, harm reduction outlook and strategies, and trauma-informed care), their contributions could help them to become an even greater source for participant success.

Sample Participant Recommendations

Group	Recommendations
Social Service Leaders/Connectors	• Offer continuing education credits for PAD trainings • Shadowing the CareNavs for knowledge reference • PAD trainings for social service providers ○ Informational, policy advocacy, mental health, cultural competency, criminal justice • Screen Participant • Prioritizing identification needs • More collaborations with social service organizations

Care Navigators	• Increase the number of Care Navigators
	• Additional PAD vehicle for transporting participants
	• Care Navigation management stability
	• Attain PAD Housing
	• Care Navigators at the jail and with officers
	• More cisgender men and older people as Care Navigators (to be reflective of the population they are currently serving)
	• Increase decision-making power
	• Utilize the living room space in the office in different capacities
	• Have an option for social referrals
	• Implement pre-trial diversion
	• More trainings about harm reduction and PAD's program
	• Police academy training about the PAD program
	• Get resource staff
	  ○ staff to gather different resources, get better connections in the community, and find different places that have the resources and understand referrals in how to get those resources
	• Use a multisystemic approach
	• Program protocols to revisit participant-led goal plan
	• Get certifications to run classes and support groups at the PAD facility
	  ○ Anger management, substance use, resume building, finance, communication/social skills
	  ○ Bring a friend policy to see what PAD is doing
	• Clarification on funds being allotted
	• PAD training hosted by other social service organizations
	• Work more with the At Promise Program (a youth diversion program)

Participants	• Open PAD 7 days a week, 24 hours a day • Outreach to possible participants • Help more trans people who come in from out of town

	• Expand the program and have it in other parts of Atlanta • More emergency assistance for people who were in a gang or coming from domestic violence • Have a program that helps people with children • Have more support groups and classes • Have more walk-ins and social referrals who qualify • More advertising • More housing and clothing resources
Funders	• Diversion Center as a one-stop shop for resources • Use the ACT (Acceptance & Commitment Therapy) Model • Attain more doctors, more mental health partners • Knowledge on how to better use the coordinated entry system (HMIS) • To be more hands-on during the diversion process

As you can see, a lot of these recommendations overlap with one another. Because of this saliency, we can gather that these suggestions might prove useful for PAD's programmatic future.

LIMITATIONS

Most of the limitations that had to do with the evaluation had to do with the evaluation design. At the beginning of starting this evaluation, documents were formed to capture social service data through the Care Navigators. This would have ultimately helped with the content analysis and keeping an accurate track of participants and the services they used (especially since this could have been done while they moved toward implementing HMIS data). However, it was not implemented and much data has not been able to be recovered or analyzed. When the team was given access to HMIS data, there was also limited data that could be used to show the participants' connections to social services.

There was also another limitation that had to do with evaluation design. Originally, there was hopes to do surveys and correlate them with the trainings that PAD was supposed to do with their social service partners. However, due to budgetary constraints, this evaluative measure was not possible. This could have been helpful to evaluate PAD's trainings and their resonance with social service providers.

Another limitation of the study had to do with the fact that the interviews for the PAD participants took place in the PAD office. This means that the data may be skewed towards people who were highly engaged in the program and possibly had more positive perceptions of the program. Future studies should also include participants who are less engaged or who have dropped out of the PAD program to document their perspective.

Despite these limitations, this report provides suitable information about the PAD program and its experiences with all the essential components connected to the social service providers. This can also be used to consider any program enhancements or replications.

CONCLUSION

This evaluation characterizes the PAD program as a positive experience for the PAD participants, the Care Navigators, Funders, and the social service connectors and leaders. PAD's harm reductive, trauma-informed, and participant-led approach is appreciated and resonated throughout all of these interviews and focus groups. PAD participants reported their commitment to the program helped them with not only resources that met their basic needs, but also with benefits that improve their lives, mend broken relationships, and changed their perceptions about social service providers and law enforcement. The key to these connections lie in the participants' connections with their Care Navigators. Their abilities to foster relationships with the participants and the social service providers, along with their abilities to help the participants feel safe and stable, largely contribute to the program's and participant's successes. As Ruby, Care Navigation supervisory support, concluded:

> Oh, well I'll say that the staff are so kind. Everybody wants to give you a hug and say hi and there's a genuine warmth that I haven't always seen in social service agencies. You really get the sense that there's something deeper going on. I believe everybody there deeply cares and deeply wants to not just change people's arrest records, but like get at the root causes of what are making these arrests happen in the first place.

"They got everything you need. It's the best program in Georgia."
– Cocoa, PAD Participant

RECOMMENDATIONS

By the second year of the PAD program, PAD was able to implement more structure into the program that would best serve its participants. One of the themes that was revealed was the fact that the participants thrived with stability. Having PAD staff feel like family, seeing the same officer, reporting to the office at the same time each week all contribute to participant stability. With that said, many of the participants cycled through two and three Care Navigators. Incentivizing Care Navigators might prevent turnover and help with the stability for the participants. This way, they will be able to build a solid relationship with one Care Navigator, who in turn, can be dependable to know everything about them and their file and what resources they need. The Care Navigator can also help to create stability by helping participants with the creation of habits and getting them into a routine. It's been shown that folks who engage in criminal activity do so because of the lack of routine and engagement with particular subcultures.[ii] Creating and sustaining routines and habits will help ensure participant stability and program fidelity.

During the participant observation data collection, it was noted that entire diversion process was long and repetitive. There are several things that the Care Navigators could benefit from including an efficient intake process, another mobile vehicle, more Care Navigators for expansion, and more teams – a resource connection team to foster connections with social service providers and an outreach team to find PAD participants who wish to get engaged back into the program. These changes should be implemented within a year, provided that there is sufficient financial possibility.

Having the Care Navigators invest their time into certifications so they can provide support groups and classes at the PAD office (or in the possible one-stop shop Diversion Center) can also positively influence participants, as well as the Care Navigators. In addition to the positive influence, the classes can also contribute to the PAD program stability. PAD trainings should also be considered at least once a quarter so that they can continue to build rapport and organizational knowledge with their partners.

Getting the participants to be honest is going to continue to be a challenge for the CareNavs. It is recommended that CareNavs be direct with the participant and ask them if they really want to be in the program and are ready for possible change or if they decided to come to PAD because they wanted to avoid jail time. Painting a picture of what it is like to be in the PAD program (and being honest about the benefits and challenges) and honing in how being a part of the PAD program means that you are potentially entering into a family dynamic where people love and care for each other, will help get the participants a more complete understanding of what it is like to participate in the program. Although this will prove challenging, being direct will help ground the participants and help them understand if they want to be a part of this dynamic or continue with how they are living their life.

APPENDIX A

PAD PARTICIPANT INTERVIEW QUESTIONS

1. Tell me about how you became a participant in PAD.
    a. How long have you been in the program?
    b. What enticed you to be in the program?
    c. What don't you like about being in the program?
2. What are your goals?
    a. How is PAD helping you with your goals?
    b. What have you requested from PAD?
    c. Has PAD affected your life? Why or why not?
    d. Does the PAD staff feel relatable? Why or why not?
        i. Tell me about your Care Navigator. What impact have they had on your life?
3. Which social service providers or organizations have helped you?
    a. What have they done for you?
    b. Do you like the organizations? Why or why not?
    c. How do you feel about being connected to these social service providers? Are you excited? Hesitant?
4. How often are you getting into contact with your social service providers?
    a. Are you seeing the same social service providers or do they change daily/weekly/monthly?
    b. Are you usually at the PAD office when you are in contact with them? Why or why not?
5. Which social service providers can you depend on the most? Why?
    a. Are there any social service providers that you feel make the most impact on you?
    b. What social service providers are you least dependent on?
    c. How many social service providers do you consistently work with? Why?
6. What kind of changes have you seen in PAD from the time you began until now?
    a. What kind of changes would you personally make with PAD Care Navigator program?
    b. What do/did you like about the program? Dislike?
7. Is there any other information that we should know about as evaluators?

SOCIAL SERVICE CONNECTOR/LEADER INTERVIEW QUESTIONS

8. Tell me about your role as a social service connector.
    a. Tell me about a typical day when you have interactions with a PAD Care Navigator.
    b. Tell me about an atypical day when you have interactions with a PAD Care Navigator.
    c. What do you like about the PAD program? Dislike?

9. How do you think you are helping participants with their goals?
    a. What are the benefits of having a Care Navigator for your participants?
    b. What do participants typically need from you? From the organization?
    c. Do these participants affect your life? Why or why not?
    d. Do your participants feel relatable? Why or why not?
10. Do you feel your organization has the resources it needs for the PAD participants?
    a. How do participants feel about being connected to your organization's services? Are they excited? Hesitant?
    b. Do you feel that the PAD program gives you everything you need in regards to the participant? Why or why not?
    c. Have you changed anything in your program/organization because of PAD or PAD's participants? If so, what have you changed? Why did you change it?
11. How often is a PAD Care Navigator contacting you?
    a. Are you seeing the same Care Navigators or do they change daily/weekly/monthly?
    b. Do you think your interactions with the Care Navigators have changed over time?
    c. Did you or any person at your organization go to any of the trainings or network meetings that PAD had? If so, who attended?
        i. Tell me about the training(s) or meeting(s).
        ii. What did you learn?
        iii. Which trainings or network meetings were the most helpful to you? Why?
        iv. Would you recommend for PAD to train social service connectors, like you? Why or why not?
            1. What kind of trainings would you recommend?
12. From your perspective, is there any connection between law enforcement and the social service providers?
13. What kind of changes have you seen in PAD from the time you have been in contact with PAD until now?
    a. What kind of changes would you personally make with PAD Care Navigator program?
14. Is there any other information that we should know about as evaluators?

CARE NAVIGATOR INTERVIEW QUESTIONS

1. What is/was your role as a PAD Care Navigator?
    a. Tell me about a typical day as a PAD Care Navigator.
    b. Tell me about an atypical day as a Care Navigator.
    c. What do you like about being a Care Navigator? Dislike?
2. How do you think you are helping participants with their goals?
    a. What are the benefits of having a Care Navigator for your participants?
    b. What do participants typically need from you?
    c. Do these participants affect your life? Why or why not?

   d. Do your participants feel relatable? Why or why not?
3. How do you know which social service providers to contact for your participants?
   a. How do the participants connect to these social service providers?
   b. How do participants feel about being connected to these social service providers? Are they excited? Hesitant?
4. How often are you getting into contact with social service providers?
   a. Are you seeing the same social service providers or do they change daily/weekly/monthly?
   b. Do you think your interactions with the social service providers, particularly the connectors, have changed over time because of you or PAD's presence?
   c. Did any of the social service providers that you were in contact with go to any of the trainings or network meetings that you had? If so, which providers attended?
      i. What role did you have in the trainings?
      ii. Which trainings or network meetings were the most successful? Why?
      iii. Would you recommend for PAD to train social service connectors? Why or why not?
         1. What kind of trainings would you recommend?
5. Which social service providers can you depend on the most? Why?
   a. Are there any social service providers that you feel make the most impact on the participants?
   b. What social service providers are you least dependent on?
   c. How many social service providers do you consistently work with? Why?
6. From your perspective, is there any connection between law enforcement and the social service providers?
7. What kind of changes have you seen in PAD from the time you began until now?
   a. What kind of changes would you personally make with PAD Care Navigator program?
   b. What did you like about the program? Dislike?
   c. How do/did you feel about Care Navigation management/supervision? Are there any improvements to be made with management/supervision?
8. Is there any other information that we should know about as evaluators?

CARE NAVIGATOR FOCUS GROUP QUESTIONS

1. What is/was your role as a PAD Care Navigator?
   a. Tell me about a typical day as a PAD Care Navigator.
   b. Tell me about an atypical day as a Care Navigator.
   c. What do you like about being a Care Navigator? Dislike?
   d. How does your team normally function?
2. How do you think you are helping participants with their goals?
   a. What are the benefits of having a Care Navigator for your participants?
   b. What do participants typically need from you?
   c. Do these participants affect your life? Why or why not?
   d. Do your participants feel relatable? Why or why not?

3. How do you know which social service providers to contact for your participants?
    a. How do the participants connect to these social service providers?
    b. How do participants feel about being connected to these social service providers? Are they excited? Hesitant?
4. How often are you getting into contact with social service providers?
    a. Are you seeing the same social service providers or do they change daily/weekly/monthly?
    b. Do you think your interactions with the social service providers, particularly the connectors, have changed over time because of you or PAD's presence?
    c. Did any of the social service providers that you were in contact with go to any of the trainings or network meetings that you had? If so, which providers attended?
        i. What role did you have in the trainings?
        ii. Which trainings or network meetings were the most successful? Why?
        iii. Would you recommend for PAD to train social service connectors? Why or why not?
            1. What kind of trainings would you recommend?
5. Which social service providers can you depend on the most? Why?
    a. Are there any social service providers that you feel make the most impact on the participants?
    b. What social service providers are you least dependent on?
    c. How many social service providers do you consistently work with? Why?
6. From your perspective, is there any connection between law enforcement and the social service providers?
7. What kind of changes have you seen in PAD from the time you began until now?
    a. What kind of changes would you personally make with PAD Care Navigator program?
    b. What did you like about the program? Dislike?
    c. How do/did you feel about Care Navigation management/supervision? Are there any improvements to be made with management/supervision?
8. Is there any other information that we should know about as evaluators?

APPENDIX B

PRE-ARREST DIVERSION INITIATIVE CONSENT & DEMOGRAPHIC FORM

I, _____, understand that the,
[print name]

Pre-Arrest Diversion (or PAD) Initiative is a partnership between law enforcement and social service providers that allows police officers to divert people to services, instead of arresting them, when the activity is likely related to unmet mental health needs, substance use/misuse, and/or extreme poverty. This interview is part of PAD's comprehensive evaluation of the pilot initiative and your feedback will help PAD to improve their program.

I do not have to participate in this interview. I have the right to stop this interview at any time. These data are being collected by the Evaluation Research Team for PAD. If I am willing to speak on the record, the evaluation team will share my individual responses with PAD and in public facing reports and presentations in order to help PAD improve their programming and to help inform similar projects around the country.

The evaluators will not use my real name in the written analysis; I will have a pseudonym. My confidentiality will be protected as far as possible. Other people other than the Evaluation team, such as government agencies, PAD staff, and/or Morehouse School of Medicine, etc., may look at this inte35eview to ensure proper study conduct.

I agree to participate in this study conducted by the Evaluation Team for PAD.

I agree to the use of and release of the recording by the Evaluation Team. I understand that the information and recording is for research purposes and that my name and image will not be used for any other purpose. I relinquish any rights to the recording and understand the recording may be copied and used by the evaluators without permission.

_____ _____
Signature Date

DEMOGRAPHICS

Age_____ Race/Ethnicity_____

Gender Identity_____

Sexual Orientation_____

Highest Level of Education_____

PAD Role_____

APPENDIX C

PAD Goal #2: Strengthen Social Service Infrastructure

Research Question	Subjects	Methods & Tools	Timeline	Data Analysis
		Process		
What are the processes through which PAD participants are interacting with the social service infrastructure?	Participants Social service connectors PAD Care Navigators	At least 10 semi-structured interviews with interview guide & observer notes Content Analysis • SWOT Analyses on social service providers • PAD Care Navigation Training Materials • Social Service PAD Training Materials	1/19	Pull out qualitative data from the interviews and find common themes amongst them, as well as seeing the gaps in the content analysis to improve the program for Year 2.
Do the social service providers have the resources needed to do their work?	Social service connectors	Content analysis on the checklist of services provided and to whom; including organizational capacity Semi-structured interviews with interview guide and observer notes	3/18 before quarterly meetings; 1/19	Analyze what kind of resources the social service organizations have and then to see if the resources have changed or there is more resources needed after Year 1.
What are the social service relationships with the police?	Social service connectors PAD Care Navigators	Semi-structured interviews with interview guide and observer notes Focus groups with focus group guide and observer notes	1/19	Pull out qualitative data from the interviews and the focus groups to see what the relationships with police look like, how they were formed and how they continue to manifest

				throughout the program.
What are the social service relationships with the police?	Participants	Semi-structured interviews with interview guide and observer notes	1/19	Pull out common themes from the qualitative data to show what kinds of relationships the social service connectors had with the police from the lens of the participants.
Did the PAD training lay the groundwork for what the social service providers needed to know?	PAD Training Staff Social service connectors	Pre- & Post Training Surveys for social service connectors Observation of PAD Trainings along with observer notes; includes video and audio transcriptions Semi-structured interviews and focus group interviews with observer notes	Every quarter after trainings; 1/19	Pull out quantitative and qualitative data from surveys to see if the PAD trainings were successful in conveying the right knowledge to social service connectors
		Outcome		
Is there a change in social service providers in terms of cultural competency and harm reduction-based standard of care due to their interactions with PAD trainings and monthly partner meetings?	Social service connectors PAD Training Staff PAD Care Navigators	Evaluation of Daily Surveys provided by the PAD Care Navigators Semi-structured interviews with interview guide and observer notes Focus groups with focus group guide and observer notes	Given 1/19, 4/19, 7/19, 10,19	Pull out quantitative and qualitative data where we analyze the various trainings and how the social service connectors retain and implement the trainings into their organizations. Pull out qualitative data from PAD Care Navigator notes to see what kind of changes have been made over time.

Is there change in the infrastructure due to PAD suggestions or support?	Social service connectors PAD Care Navigators	2 Focus Groups with social service connectors and with PAD training staff	11/18 or 12/18 & 10/19	Pull out qualitative data that shows how social service organizations have changed from Year 1 and Year 2.

APPENDIX D

SWOT ANALYSIS

To provide information that would be pertinent to the future of PAD, the Evaluation team has put together a SWOT Analysis to help in this venture. This is a short bullet-point list. The longer explanations will be included in the final draft of the PAD Evaluation report.

PAD Component	STRENGTHS
Participants	• Viewed the Care Navigators as family • Were pushed towards their goals; many achieving those goals • Were accountable for their actions and behaviors • Can be themselves and be honest • Alleviation of [housing/food/clothing/justice system] stress • Getting reconnected to biological family members • Boost in self-esteem • Feel like they can be a source of motivation for others • Medication adherence • Gained strength and willpower • Help them to create and maintain a "normal" routine • Building positive relationships with police • Able to save money • Being able to keep clean and hygienic • The ability to have stability • Having hope and faith • They are resilient even while managing mental health and substance use problems
Social Services	• Variety of services that are available for participants • Provided immediate services and housing • Reserved housing/beds for PAD program • Collaborations with other social service organizations • Connectors serve as motivational for participants • Some Connectors feeling relatable to participants • Participants' success as rewarding • Organizational rapport • Changed positively because of PAD and it's participants • Keeps beds and housing full because of PAD • Excited to work with PAD
Care Navigators	• Do what they say they are going to do (are reliable) • Have faith and patience with their participants; don't give up on participants when they fail

	• Kept participants accountable for their actions and behaviors • Were attentive with participants' needs • Were motivational and inspiring • Participant advocacy with social services and the justice system • Were inclusive in whom they served • Great problem-solvers • Reliable staff and co-workers when assigned Care Navigator isn't there • Access to HMIS system to check in with other social service providers • Able to build rapport with ease • Ease of communication with social service providers • Have been in the place where participants are at now
Police	• Changing relationships with and to participants for the positive • Being previously connected to a social service provider through membership or experiences • Wanting to help participants and believing PAD can work • Buy-in from multiple levels of APD • Supervisors pushing PAD • Dedicated police liaison • Partnering to see where they can improve by looking at unsuccessful referrals
PAD Program	• Monday support group • The office as a place to rest or safe space • Helps participants to stay out of trouble • Participant-driven goals & what success looks like for them • Provided hotel/motel stays when housing was not available • Provided food and clothing if they weren't available elsewhere • Many connections to a lot of social service providers • Respectful of participants • Non-judgmental attitude towards participants • Changing culture of arrest • Getting participants' linked to care • Getting police officers on board for the PAD program • Positive reputation and awareness of PAD influences organizations to work with them
Partners and Community Members	• Residents asking for diversions • Partners feeling connected to PAD • Partners have relationships with each other through PAD that benefits participants

	• Partners stepping up to address PAD participant needs (e.g., legal clinic) • Understanding that funding for services needs to increase and relative agreement on what services they would like to see

PAD Component	WEAKNESSES
Participants	• The active struggle with sobriety; addiction •
Social Services	• Connectors rarely came into contact with participants • Sporadic communication with Care Navigators • Some Connectors not feeling relatable to the participants • Rules and barriers that prevent them from receiving services • Organizational rapport • Needing more connectors to help with participants' needs • Service confusion • Funding for services is fragmented and it creates barriers to effective collaboration • Not enough services to met need (e.g., housing)
Care Navigators	• Other case workers in different organizations working on the same things • Care Navigator turnover; change of Care Navigators • Turnover in Care Navigation management • Burnout and morale over constantly putting out fires • Seeing participants get services that they can't afford themselves might build resentment
Police	• Under-utilization of PAD • Zone 6 does not have a liaison and has to go out of zone to get to PAD • Arrest is familiar whereas PAD is not • Belief that some people do not deserve PAD and a lack of understanding about how behavior change occurs
PAD Program	• Weaning them off program • Slow communication with social service Connectors • Intake time • Meetings are boring

Partners and Community Members	• Unrealistic expectations for growth and scale-up • Lack of understanding about when what results may be seen • Unmet need to hear about PAD successes

PAD Component	OPPORTUNITIES
Participants	• Learn new adulting/coping/relationship skills
Social Services	• More social services that provide emergency assistance • More help for people with children • Increased data and service coordination between agencies • Repurposing jail space for social services
Care Navigators	• Contributed ideas to strengthening the program • Outreach to find potential participants
Police	• Increase referrals either by wider adoption of PAD and/or by increasing referrals from service-minded officers • Educate on harm reduction results and the need for re-referrals • Training for police that is adapted to high APD turn-over
PAD Program	• Provide social referrals • Marketing & recruiting methods for folks to enter into the program • Program expansion • More dynamic meetings • More help for people with children; child support • Offering CEU's to provide more help with participants • Get Connectors to experience ride-alongs to feel the PAD diversion experience • More trainings for social service providers about the program • Screening process for participants to see how/if they are a good fit for a program • Diversion Center to streamline services • Centered tracking of services • Get connected to more social service providers • More trainings (mental health, first aid, political advocacy, consequences of incarceration, etc.) • Meet any need for increased services from jail closure • Increase availability in terms of zones, locations, and participants

Partners and Community Members	• Educate residents and members of the judicial and legal systems on who PAD works with, harm reduction, PAD services, PAD success stories, and PAD's impact on community safety • Have PAD be seen as a viable service comparable to familiar emergency response services • Create structure for community members and founders to provide guidance

PAD Component	THREATS
Participants	• Participants who lie to take advantage of the program • Aren't ready for change • Only entering to avoid jail time • Mental health issues that plague them • Medical issues that may arise • Seeing the allocation of resources as unequal • Being re-arrested • Housing qualifications • Missing the quick money of the hustle, which might tempt them to return to old lifestyle • Being lazy
Social Services	• Limits to populations served • High entry barriers to resources • Not enough services for a growing PAD to utilize
Care Navigators	• Resentment over participants who receive services
Police	• Seeing past PAD participants committing more crimes or being out in the streets
PAD Program	• Other organizations that are doing wrap-around services • Organizations that run 24/7 or at times that PAD is closed
Partners and Community Members	• Pressure from residents to "clean up" an area leading to arrests • People have unrealistic results expectations • PAD needs a strong champion in an administrative or city government position

[i] Sugano, E., Nemoto, T., & Operario, D. 2006. "The Impact of Exposure to Transphobia on HIV Risk Behavior in a Sample of Transgendered Women of Color in San Francisco." AIDS and Behavior, 10(2):217-225.
[ii] Osgood, D., Wilson, J., O'Malley, P., Bachman, J., and Johnston, L. 1996. "Routine Activities and Individual Deviant Behavior." American Sociological Review, 61(4):635-655.