Supporting Treatment and Reducing Recidivism (STARR) Evaluation Plan

San Francisco Department of Public Health

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Project Background

Program Context

San Francisco is facing a public health crisis caused, in large part, by a rise in substance use disorder and mental health needs, against a landscape of a skyrocketing cost of living and gaps in support services. This crisis has developed into a homelessness epidemic and medical emergency - with an estimated homeless population of nearly 9,000 people and ever-increasing instances of staph infection, public intravenous drug injection, overdose, and drug-related deaths (Kendall, 2018). Among those who are experiencing homelessness in San Francisco, 41% self-reported having substance use disorder(s) (SUD) and 39% self-reported having a psychiatric condition (San Francisco Healthy Streets Operation Center, 2019).

The San Francisco Health Commission has warned that the criminalization of homelessness and poverty, substance use, and mental illness leads to incarceration, recognizing that jails and prisons are not healing or trauma-informed environments. In 2018, approximately 40% of individuals incarcerated in San Francisco County Jail (SFCJ) were homeless; 22% were diagnosed as seriously mentally ill (SMI); and 80% of bookings in SFCJ involved individuals who reported substance use. In addition, the average length of incarceration was longest for individuals with co-occurring substance use and SMI (City and County of San Francisco, March 2019).

Individuals living with moderate to severe dual diagnoses (co-occurring disorders) are often best served by comprehensive residential SUD treatment and outpatient mental health (MH) services, due to the complex risk factors they face (e.g., homelessness, family crises, overdose, infection, and criminal justice system involvement) (Center for Substance Abuse Treatment, 2006). The San Francisco Department of Public Health (DPH) is working to provide some of these services through a Harm Reduction-based approach to recovery and wellness, as supported by the implementation of three recent pilot programs - Promoting Recovery & Services for the Prevention of Recidivism (PRSPR), Law Enforcement Assisted Diversion (LEAD), and the Healthy Streets Intervention Program (HSIP). However, due to the shortage of SUD treatment beds, limited case management staff capacity, and restrictive program eligibility criteria, best practices are often not upheld. Lack of timely access to low threshold treatment options often leads to risky drug use, MH decline, continuing homelessness, criminal behavior, and recidivism. (Center for Substance Abuse Treatment, 2006).

Program Overview

The 2019 Proposition 47 Supporting Treatment & Reducing Recidivism program (STARR) is designed to meet one of the most critical community care needs in San Francisco – providing additional residential treatment beds, low threshold outpatient case management, and wraparound support services for adults with co-occurring substance use disorder and mental health needs who have had contact with the criminal justice system. The program will centralize intake, assessment, and triage at the Community Assessment Service Center (CASC), enabling individuals who are diverted or discharged from jail to immediately access SUD/MH treatment options, with multiple levels of engagement - a crucial and missing piece in serving this population, particularly for those who have high needs but are not yet "ready to engage" in traditional services.

The overall goal of STARR is to reduce incarceration and recidivism by strengthening city-wide initiatives focused on jail diversion, recovery, and community reentry for high-risk individuals with co-occurring disorders. Over the course of the grant, STARR will support: (1) 10 SUD social detox and 32 residential treatment beds; (2) outpatient case management with a Harm Reduction approach; and, (3) wraparound support services and referrals through the Community Assessment and Services Center (CASC), a one-

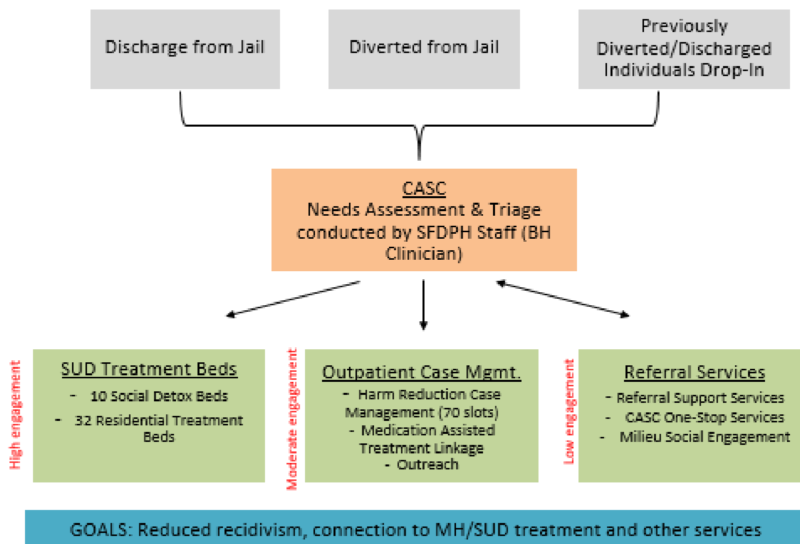
stop reentry center. SFDPH will partner with SF Adult Probation Department (APD) and Felton Institute to offer intake, assessment, and triage at the CASC during regular and extended evening hours.

As the STARR program builds on the 2017 Promoting Recovery and Services for the Prevention of Recidivism (PRSPR) program, funding would provide 5 SUD social detox beds in Y1-2, in addition to the 5 provided in Y1-2 by the 2017 PRSPR grant, and 10 beds in Y3. Funding would also provide 32 residential treatment beds in Y3, in addition to the 32 provided in Y1-2 by the 2017 PRSPR grant. Grant funds would also be used to provide direct support to clients, including emergency funds for short-term housing stays, document fees, or other as-needed one-time financial supports.

The STARR program design is based on the following evidence-based strategies: (1) Meet people where they are by providing extensive outreach to individuals on the street and flexible entries to engagement/treatment for those diverted/discharged from jail; (2) High touch, Harm Reduction case management increases the likelihood of stabilization and successful engagement; (3) Engagement focused on participants' own strengths, treatment goals and future plans allows for respectful and client-centered support; (4) Strengthening relationships between agencies and organizations throughout the system of care allows for information and resource sharing, and enhances service provision; and, (5) Collaboration throughout the system of care allows for the provision of individualized care and services and increases the likelihood of successful engagement (Harder & Co., 2018). In addition, all DPH programs and services are trauma-informed, client-centered, and based in principles of recovery and wellness.

DPH will serve as the lead agency and will be responsible for project coordination, grant administration, and facilitating connections to the DPH system of care. Grant-funded staff would include a Behavioral Health Clinician (1.0 FTE) to oversee service utilization, client intake/assessment, and triage/placements, and 2 SF Adult Probation Officers (1.4 FTE) to staff the CASC in extended evening hours.

Figure 1. STARR Program Flow Overview



Referral and Enrollment in STARR. Following an encounter with law enforcement, individuals who meet certain criteria may be diverted from jail and brought to the CASC, where a DPH Behavioral Health Clinician will conduct a client intake and needs assessment and triage to appropriate services. Individuals may also be brought to CASC by Jail Behavioral Health Services or may self-refer. Led by Adult Probation and UCSF Citywide, CASC is a one-stop, multi-service reentry center that specializes in reducing barriers to successful reintegration into the community for justice-involved people ages 18 and older. CASC

provides a client-centered, strengths-based, streamlined approach to a range of services, including: clinical and reentry case management; medication management and distribution; milieu social engagement; peer coaching; cognitive behavioral interventions and groups; substance dependency and recovery services; education and employment services; benefits enrollment assistance; and other outreach and engagement services. In Year 3, we can expect referral sources to the residential treatment beds to expand to additional organizations and agencies.

Depending on an individual's needs, as well as their threshold for engagement, the Clinician may direct the individual to (1) High Engagement STARR Enrollment: a social detox bed (for up to a 2 week stay) and/or a residential treatment bed (for up to a 6 month stay); (2) Moderate Engagement STARR Enrollment: outpatient case management services; or (3) Low Engagement: support services offered at the CASC.

High Engagement Services. DPH will contract with the Salvation Army (SA) Harbor Light facility to provide 10 SUD social detox and 32 residential treatment beds for eligible participants by year three. Participants will be able to stay in detox for up to two weeks for stabilization. Participants in SA's residential treatment program, which typically lasts up to 6 months, will co-develop an Individualized Intervention Plan (IIP) with their counselor, and will participate in individual and group counseling and therapy, case management, SUD and MH classes, and physical wellness activities. SA's client-centered social model program emphasizes accountability, mutual self-help, and relearning responses to challenges to build positive coping behaviors and social support systems. Participants are part of a healing community, based on restorative justice principles. Given that STARR will utilize resources from the existing PRSPR grant, 5 detox beds will be available to STARR participants in Years 1 and 2. In Year 3, an additional 5 detox beds and 32 residential beds will be available to participants.

Moderate Engagement Services. DPH will contract with Felton Institute to provide low threshold outpatient case management services - including linkage to medication assisted treatment, transportation and support to appointments, flexible funds, connection to shelters, and street outreach. Through this grant, Felton will assign four case managers who will provide a total of 70 client slots. Two case managers will work part time at the CASC to receive warm-handoffs from the DPH Clinician. Case Managers will co-develop an IIP with each client they meet. IIPs are based on Harm Reduction principles and connect clients to the city's extensive network of services, such as physical health services, transitional housing, employment, public benefits, and other services.

Low Engagement Services. All individuals who are assessed and triaged by the DPH Clinician will be informed of and/or linked to support services at CASC. For clients who are not ready to enroll in case management, detox, or residential treatment services, these linkages and referrals to milieu support services will be the only STARR activity that they engage in. Support services at the CASC include support groups conducted by UCSF Citywide Case Managers, vocational and employment skill development, educational classes, housing assessments, and benefits assistance. Individuals receiving these services will not be considered enrolled in STARR, but will be reported as assessed/engaged.

Program and Partner Goals & Objectives

Program Grant Goals and Objectives

(1) Goal:	Successfully triage individuals into appropriate Referral services.
Objectives:	**1.1** At least 200 individuals will be referred to the CASC for needs assessment and triage annually. **1.2** 40% of referred individuals will receive some resources (e.g., employment services, benefits assessments, support groups, housing assessments, etc.) through the CASC.
(2) Goal:	Successfully triage individuals into appropriate treatment services (SUD Treatment, Outpatient/Case Management services).
Objectives:	**2.1** At least 40% of individuals coming into the CASC for needs assessment/triage will be referred to outpatient case management[1] services annually. **2.2** At least 60% of individuals connected to grant-funded outpatient case management services will engage with a case manager at least one time. **2.3** 100% of participants who engage with a grant-funded case manager will receive an Individualized Intervention Plan (IIP). **2.4** Maintain at least 90% occupancy rate for social detox/residential treatment beds. **2.5** 50% of individuals enrolled in social detox will successfully complete their treatment by meeting their individualized treatment goals.
(3) Goal:	Program participants will demonstrate lower recidivism rates during and after program participation than they did during a similar period before participating in the program.
Objectives:	**3.1** As a cohort, 33% of individuals who have been assessed by this project will demonstrate lower recidivism rates than in a comparable period prior to admission. **3.2** As a cohort, individuals assessed by this project will utilize 50% fewer jail bed days per year than they did prior to program participation.

Partner Goals & Objectives

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

Partner 1: Citywide

C1.1. At least 40% of referred individuals will receive some resources (e.g., employment services, benefits assessments, support groups, housing assessments, etc.) through the CASC.

Partner 2: Salvation Army

SA1.1. By the end of the fiscal year, Salvation Army will have achieved at least a 90% occupancy rate in their detox program, as measured by program enrollment data documented by joint data collection efforts between DPH, HTA and Salvation Army and stored in Avatar.

SA1.2. By the end of the fiscal year, 50% of participants enrolled in social detox will successfully complete their treatment by meeting their individualized treatment goals, as measured by joint data collection efforts between DPH, HTA, and Salvation Army.

SA1.3. 100% of open clients will have zero errors on their CalOMS Admission Form.

SA1.4. 100% of clients discharged during each fiscal year will have the CalOMS Discharge Status field completed no later than 30 days after episode closing is entered into Avatar.

[1] It is assumed that this refers to **grant-funded** outpatient case management services.

SA1.5. STARTING IN FY21-22. By the end of the fiscal year, Salvation Army will have enrolled at least 64 individuals in residential treatment, as measured by program enrollment data documented by joint data collection efforts between DPH, HTA and Salvation Army and stored in Avatar.

SA1.6. STARTING IN FY21-22. By the end of the fiscal year, Salvation Army will have achieved at least a 90% occupancy rate in their residential program (starting in Year 3), as measured by program enrollment data documented by joint data collection efforts between DPH, HTA and Salvation Army and stored in Avatar.

Partner 3: Felton Institute

FI1.1. At least 60% of individuals connected to grant-funded outpatient case management services will engage with a case manager at least one time.

FI1.2. 100% of participants who engage with a grant-funded case manager will receive an Individualized Intervention Plan (IIP).

Evaluation Methods and Design

Hatchuel Tabernik & Associates (HTA) will conduct an independent evaluation of the Supporting Treatment and Reducing Recidivism (STARR) program. HTA will utilize a utilization-focused approach combining mixed methods of program data, interviews, and focus groups to address the impact of the Proposition 47 grant funds on STARR clients. Utilization-based evaluation is an approach whereby the evaluation activities *from beginning to end* are focused on the *intended use by the intended users* (Patton, 2012). Additionally, the evaluation will focus on both process and outcome elements. The process evaluation will be oriented towards providing continuous feedback on program revisions and improvements, as needed. The outcome evaluation will be focused on describing the program's outcomes cumulatively over the three-year period.

Data Collection Plan: Partner/Program Goals and Process/Outcome Evaluation

The evaluator, HTA, has participated in implementation team workgroup meetings and the planning process from the inception of this project. Representatives from each of the program partners are aware of reporting needs and expectations, and have agreed to provide data as needed. Additionally, data sharing agreements were addressed in the contracts between SFDPH and partner agencies. Simultaneous to developing the local evaluation plan, HTA will create partner-level data collection plans outlining all of the requested data from each of the partners along with a quarterly timeline for which data is to be submitted.

To the extent possible, the data collection plans will be designed to pull from existing partner instruments. However, the evaluator will also create new instruments and data entry spreadsheets to facilitate the collection of information that had not been captured in other forms. Outcome data will be tracked and collected separately for the three types of SUD treatment enrollment: outpatient case management, social detox, and residential treatment (FY 21/22 only). If individuals enroll in more than one type of SUD treatment under this program, it will be tracked and reported as a new encounter.

Table 1 presents a summary of the data that will be requested of program partners to measure performance and progress toward program and partner goals and objectives, and answer process and outcome evaluation questions (outlined in the sections following the table).

Table 1. Data Collection Plan for Program and Partner Goals and Guiding Evaluation Questions

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
P-1. **O-1.**	**1.1**	Meet referral targets	• # of individuals referred to CASC • Referral source (e.g. TAP, OTP, JBHS, Sherriff's Office, Law Enforcement, etc.). • Demographics and outcome variables (e.g. education, employment, and housing) of individuals referred to CASC • History of involvement with criminal justice system • Mental health/substance use history	• STARR SFDPH Case Log • STARR SFDPH Intake Form • APD Database	Quarterly
P-1. **O-1.**	**1.2** **C1.1**	Meet low engagement enrollment targets	• # of individuals enrolled in referral services (low engagement track) • # and types of resources received • Demographics and outcome variables (e.g. education, employment, and housing)	• STARR SFDPH Case Log • STARR SFDPH Intake Form	Quarterly
P-1. **O-1.**	**2.1**	Meet moderate engagement enrollment targets	• # of individuals referred to outpatient case management services (moderate engagement track) • # of individuals enrolled in outpatient case management services (moderate engagement track) • Date of referral • Date of enrollment • Demographics and status variables (e.g. education, employment, and housing) • Participation status (e.g. assessed/engaged but not enrolled, enrolled & active, enrolled & no contact, exit no completion, successful completion)	• STARR SFDPH Case Log • STARR SFDPH Referral Form • Felton Case Log	Quarterly
P-1.	**SA1.5**	Meet high engagement enrollment targets	• # of individuals referred to/enrolled in social detox at Salvation Army • # of individuals referred to/enrolled in residential treatment at Salvation Army *(FY21-22 only)* • Date of referral • Date of enrollment • Demographics and status variables (e.g. education, employment, and housing) • Participation status (e.g. assessed/engaged but not enrolled, enrolled & active, enrolled & no contact, exit no completion, successful completion)	• STARR SFDPH Case Log • STARR SFDPH Referral Form • Salvation Army Case Log • Avatar	Quarterly

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
P-1. **P-3** **O-3.**	**2.2**	Outpatient case management engagement	• # of participant meetings with case manager • Participation status (e.g. assessed/engaged but not enrolled, enrolled & active, enrolled & no contact, exit no completion, successful completion) • Date of completion • Demographics and status variables (e.g. education, employment, and housing) • # and type of support services provided • # of outreach encounters/warm handoffs at CASC	• Felton Case Log • Program completion form	Quarterly
No specified evaluation question	**2.3**	Individual Intervention Plans (IIPs)	• # of participants with an IIP • Needs identified on IIPs	• Felton Case Log • Salvation Army Case Log • IIPs	Quarterly
No specified evaluation question	**2.4** **SA1.1** **SA1.6**	High occupancy	• Occupancy rate (sum of daily beds used/sum of daily beds available)	• Avatar (daily census maintained by Salvation Army)	Quarterly
P.1. **P-2.** **O-1.** **O-2.**	**2.5** **SA1.2**	Successful completion of SUD treatment	• # of individuals enrolled in social detox/residential treatment at Salvation Army • Date of referral • Date of enrollment • Participation status (e.g. assessed/engaged but not enrolled, enrolled & active, enrolled & no contact, exit no completion, successful completion) • # of participants completing detox/residential treatment • Date of discharge from detox/residential treatment • Demographics and status variables (e.g. education, employment, and housing) • # and type of support services provided	• STARR SFDPH Case Log • STARR SFDPH Referral Form • Salvation Army Case Log • Program completion form	Quarterly
O-4.	**3.1**	Lower recidivism rates	• # of convictions for felony or misdemeanor in San Francisco for period prior to program admission (up to 3 years for each enrolled client) • # of convictions for felony or misdemeanor in San Francisco for comparable period after enrollment in program (up to 3 years for each enrolled client) • Types of convictions in both time periods • Dates of arrests, re-incarcerations, and new/prior offenses	• SF District Attorney database via a data sharing MOU	Annually

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
O-4.	**3.2**	Fewer days in jail (or reduced length of stay)	• # of jail bookings for felony or misdemeanor in San Francisco for period prior to program admission (up to 3 years for each enrolled client) • # of jail bookings for felony or misdemeanor in San Francisco for comparable period after enrollment in program (up to 3 years for each enrolled client) • LOS at SF jail after enrollment in program (up to 3 years for each enrolled client)	• SF Sherriff's Office	Annually
P-4.	*No specified program/partner objective*	Effective transition between levels of program engagement	• Dates of enrollment/exit in residential treatment • Date of enrollment in outpatient case management • Description of participant handoff between partners • Description of collaboration between partners	• Felton Case Log • Salvation Army Case Log • Implementation team meeting notes • Partner interview notes/transcripts • Participant focus groups notes/transcripts	Quarterly Annually
P-5.	*No specified program/partner objective*	Effective program implementation and partner collaboration	• Description of program successes, challenges and lessons learned • Description of collaborative process	• Implementation team meeting notes • Partner interview notes/transcripts	Quarterly Annually
P-6.	*No specified program/partner objective*	Identification of program entry and retention barriers	• Description of barriers • Description of strategies and solutions • Descriptions of any barriers that could not be overcome	• Quarterly Implementation Team Meeting Minutes • Partner Interview Notes/Transcripts	Quarterly Annually

Process Evaluation

The process evaluation includes a continuous improvement model to program implementation by addressing fidelity to the program plan and monitoring specific program goals (i.e., number assessed, number referred, services received, etc.). Process data will include: (1) Service utilization records (e.g., intake forms, assessments, IIPs, services, referrals, exits); (2) Minutes from meetings and check-in calls with project staff; (3) Annual interviews/focus groups with key staff and partners including SA, Felton, UCSF/Citywide and Adult Probation (CASC staff). Service utilization data will be entered into Avatar, DPH's Electronic Health Records system, to store clinical, service and billing information. Case logs will be developed for the DPH Clinician, Salvation Army and Felton to use in tracking clients who are assessed and/or enrolled and the services that they receive. Process data will be collected on individuals who are assessed, receive referral services, engage/enroll in SUD outpatient case management, engage/enroll in SUD detox treatment, and/or engage/enroll in SUD residential treatment. Data sharing will be conducted with informed consent from all participants and data MOUs as needed.

To monitor fidelity to the program plan, HTA will participate in quarterly workgroup meetings and conduct regular check-ins with project staff and interviews/focus groups with staff and partners to discuss program developments. Topics will include successes/challenges in recruitment and engagement, client progress, areas for improvement, and evidence-based best practices utilized.

To inform continuous program improvement, analyses will be conducted quarterly and findings folded into quarterly progress reports presented to administrative leadership and in clinical team meetings. Annual reports, including the required Two-Year and Final Local Evaluation Reports, will be presented to the Reentry Council to ensure the involvement of all stakeholders. These presentations will provide a forum to discuss interpretation of findings and direction for additional data collection and analysis.

Guiding Process Evaluation Questions

P-1. Is the target population being reached? What is the profile of individuals being referred to STARR program services (SUD treatment beds, outpatient case management, and referral services)?
P-2. What services are provided as a part of social detox and/or residential treatment ?
P-3. What services are provided as a part of outpatient case management?
P-4. What do transitions look like between engagement level
P-5. What are the successes and challenges that emerge throughout the implementation of the program?
P-6. Do any barriers emerge to program entry, connecting clients with services, and retention? If so, how were they overcome?

See Table 1 (above) for detailed overview of evaluation questions, program/partner objectives, indicators/outcomes, data sources, and frequency of collection.

Outcome Evaluation

As the Grantee Orientation was on September 6, 2019, the STARR program ramp-up period was changed to happen from September through December 2019. SFDPH anticipates beginning program enrollment in January 2020. Individuals will be eligible for the program if they have had contact with the criminal justice system and are experiencing behavioral health needs.

The local evaluation of the STARR program will use the following definitions as part of the outcome evaluation.

- **Outpatient SUD Case Management Program Completion**: Client successfully met all goals on their Individualized Intervention Plan. If there is no contact with the client for one year, their case will be

closed/client reported as exited without completing requirements, and they can be re-assessed and re-enrolled.

- **Detox SUD Program Completion:** Client successfully met detox program goals
- **Residential SUD Program Completion:** Client successfully met residential treatment goals
- **Recidivism:** Client was booked into jail within three years of release

It is stated in the grant that 200 individuals will be referred to the CASC for triage and assessment annually (600 individuals total over the three years, through June 30, 2022) (see Table 2). We anticipate that 100% of these individuals will receive a baseline assessment. We anticipate that 40% of these individuals will receive referral services, meaning they will receive some resources through CASC (240 individuals), though these individuals will not be considered enrolled in STARR. We anticipate that 40% of those assessed by the DPH Clinician will be referred to outpatient case management services, and 60% of those will engage in these services (96 individuals). This would be the sample from which we likely be able to pull our post discharge data for outpatient case management services.[2] The grant application specified that the program will achieve a 90% occupancy rate for detox beds, which indicates that we can expect at least 29 individuals to engage in detox during Years 1 and 2, and 58 individuals per quarter in Year 3. With 50% of those completing their treatment goals, we can expect that 203 individuals will successfully complete detox, and will contribute to post discharge data collection, over the 3-year program.[3] The grant application did not specify the number of individuals who will engage with residential treatment services. However, the partner objectives for Salvation Army specify that beginning in FY21-22, 64 individuals will be enrolled in residential treatment. Presuming that 50% of those will successfully complete, we anticipate to be able to collect post discharge data on 32 individuals.[4]

Table 2. Anticipated Outcome Data Collection Sample

Grant Quarter	Calendar Months	Avg. CASC Referrals/ Quarter	Anticipated Baseline N	Anticipated CM Engaged N	Anticipated Detox Discharge N	Anticipated Residential Discharge N
1/2	Sep – Dec 2019	--	--	--	--	--
3	Jan – Mar 2020	60	60	9	14	--
4	Apr – Jun 2020	60	60	9	14	--
5	Jul – Sep 2020	60	60	9	14	--
6	Oct – Dec 2020	60	60	9	15	--
7	Jan – Mar 2021	60	60	10	15	--
8	Apr – Jun 2021	60	60	10	15	--
9	Jul – Sep 2021	60	60	10	29	8
10	Oct – Dec 2021	60	60	10	29	8
11	Jan – Mar 2022	60	60	10	29	8
12	Apr – Jun 2022	60	60	10	29	8
Total		**600**	**600**	**96**	**203**	**32**

The outcome evaluation, utilizing a pre-post design, will study whether the program achieved its stated outcomes (i.e., engagement with services, successful completion of individualized treatment plan goals, lower recidivism rates, etc.). We will collect information from program participants during two time

[2] The N will be greater if higher percentages of participants successfully complete programming.
[3] ibid.
[4] ibid.

periods: once before participants receive treatment at their time of enrollment (baseline) and once to measure outcomes immediately after treatment has concluded. For the first two years of the grant, outcome data will be collected only on those participants who engage social detox and outpatient case management. In year three, data will also be collected on individuals engaged in residential treatment.

We will compare baseline indicators with post-treatment outcomes to see if changes in individual-level outcomes are not only accomplished, but maintained over time. Client outcome data will be stored in and pulled from secure and long-established DPH and partner databases including Avatar and CIRCE. We will use partner databases and tracking spreadsheets to collect baseline demographics (e.g., age, gender, race/ethnicity) and outcome data. Additionally, data sources will include client assessments, intakes, referral forms, and program completion forms. HTA will facilitate focus groups with participants to explore changes in mental health, substance use, housing, income, and sense of well-being, as well as perceived program impact and satisfaction. Recidivism data will be sourced from the District Attorney's Office and the Sherriff's Office, with whom HTA has current MOUs. Analysis of these data will include the exploration of differences in outcomes by populations of interest.

Guiding Outcome Evaluation Questions

O-1. What are the baseline characteristics of individuals on key outcomes when they start the program? Do these characteristics differ by level of engagement?
O-2. What is the profile of clients who successfully complete detox/residential SUD treatment?
O-3. What is the profile of clients who successfully complete outpatient case management?
O-4. Do clients recidivate?

See Table 1 (above) for detailed overview of evaluation questions, program/partner objectives, indicators/outcomes, data sources, and frequency of collection.

Measuring Recidivism

Because recidivism is of particular interest for this grant, this outcome will be a highlight of the evaluation. For this study, two definitions of recidivism will be used: 1) the conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction, and 2) booked into jail within three years of release. We will be exploring recidivism within the SF Jail system specifically for each individual for up to three years prior and up to three years after enrollment in the STARR program. Because admission to the program is rolling, it will be most useful to conduct this study using a cohort model, taking into account the length of time an individual is involved with the STARR program. For example, an individual who enrolls at the start of the first year of programming cannot be compared equally to an individual who enrolls toward the end of the third year. More time will have passed for the first individual since discharge from treatment, allowing for more time to recidivate. Therefore, recidivism for this study will be calculated as if they were follow-up rates, calculating pre-post recidivism rates for each individual at 6-month intervals following their enrollment in STARR.

We plan to analyze convictions and bookings for clients pre- and post- enrollment in STARR in order to determine whether the program had an effect on recidivism, though causation will not be able to be inferred. Given that the San Francisco District Attorney's office is currently undergoing a change in leadership that will likely affect prosecution in the City and County, it may be challenging to truly disengage the recidivism outcomes seen among STARR participants from outside factors. In addition, this program is considered to be part of a collaborative system of care and collection of programs in San Francisco that are aimed at reducing recidivism, especially among residents with SUD and MH needs.

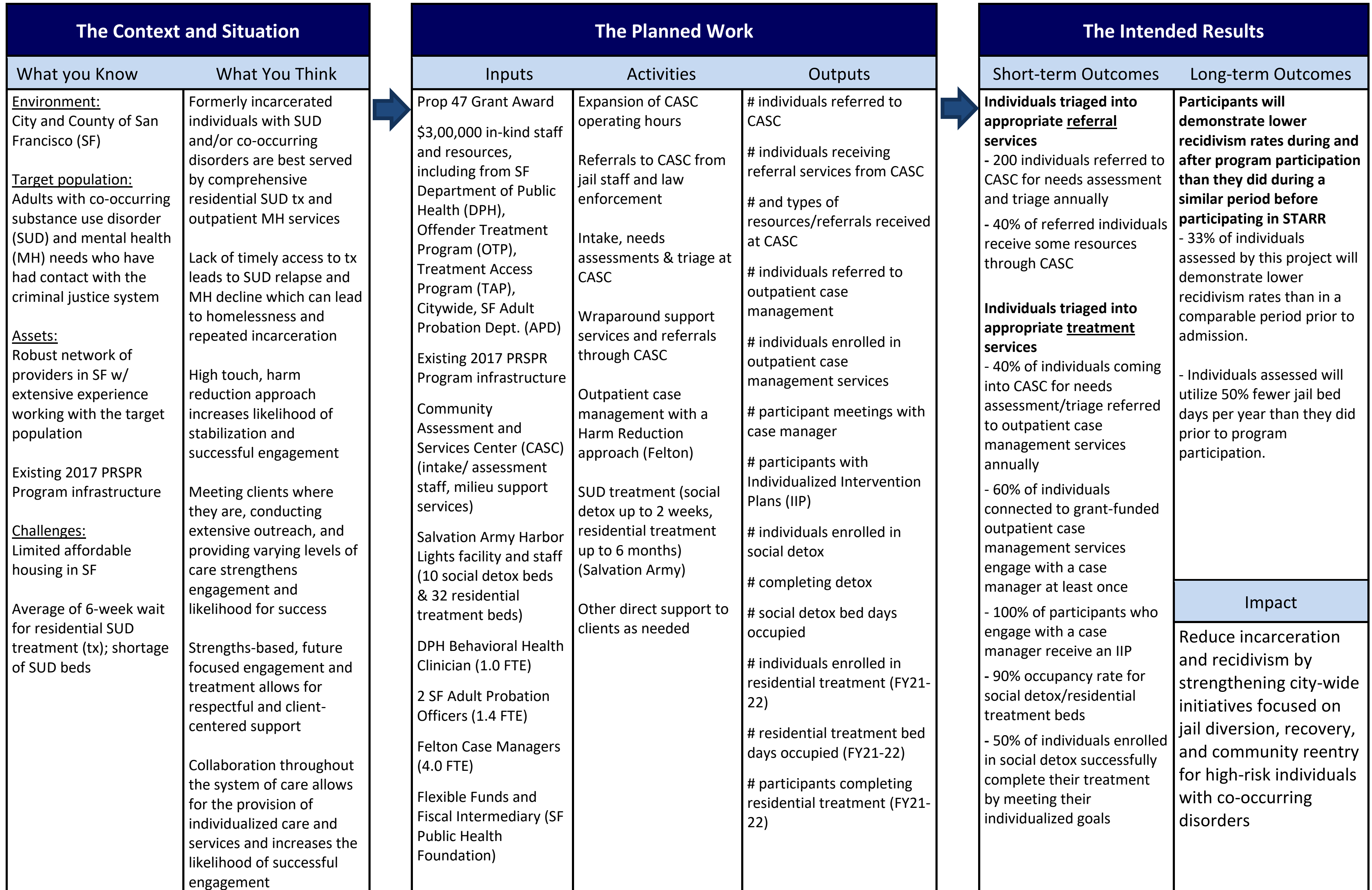
Therefore, we are looking at the contribution of this program to that wider system, rather than individual attribution. If appropriate, and with available data, we will do our best to compare the recidivism rates seen among participants to City and County-wide rates to compare trends over time.

Table 3 outlines each cohort, or group of participants, who enroll during the same time span, and what recidivism rates will be calculated. For example, for clients who enroll in the second and third quarters, recidivism rates can be calculated at 6-months post-intake, at 1-year post-intake and so on.

Table 3. Recidivism Rates that Can Be Calculated for Each Program Cohort

Grant Quarter	Calendar Months	6-m	1-yr	1.5-yr	2-yr	2.5-yr
1/2	Sep – Dec 2019					
3/4	Jan – Jun 2020	☑	☑	☑	☑	☑
5/6	Jul – Dec 2020	☑	☑	☑	☑	
7/8	Jan – Jun 2021	☑	☑	☑		
9/10	Jul – Dec 2021	☑	☑			
11/12	Jan – Jun 2022	☑				

Logic Model



The Context and Situation

What you Know

Environment:
City and County of San Francisco (SF)

Target population:
Adults with co-occurring substance use disorder (SUD) and mental health (MH) needs who have had contact with the criminal justice system

Assets:
Robust network of providers in SF w/ extensive experience working with the target population

Existing 2017 PRSPR Program infrastructure

Challenges:
Limited affordable housing in SF

Average of 6-week wait for residential SUD treatment (tx); shortage of SUD beds

What You Think

Formerly incarcerated individuals with SUD and/or co-occurring disorders are best served by comprehensive residential SUD tx and outpatient MH services

Lack of timely access to tx leads to SUD relapse and MH decline which can lead to homelessness and repeated incarceration

High touch, harm reduction approach increases likelihood of stabilization and successful engagement

Meeting clients where they are, conducting extensive outreach, and providing varying levels of care strengthens engagement and likelihood for success

Strengths-based, future focused engagement and treatment allows for respectful and client-centered support

Collaboration throughout the system of care allows for the provision of individualized care and services and increases the likelihood of successful engagement

The Planned Work

Inputs

Prop 47 Grant Award

$3,00,000 in-kind staff and resources, including from SF Department of Public Health (DPH), Offender Treatment Program (OTP), Treatment Access Program (TAP), Citywide, SF Adult Probation Dept. (APD)

Existing 2017 PRSPR Program infrastructure

Community Assessment and Services Center (CASC) (intake/ assessment staff, milieu support services)

Salvation Army Harbor Lights facility and staff (10 social detox beds & 32 residential treatment beds)

DPH Behavioral Health Clinician (1.0 FTE)

2 SF Adult Probation Officers (1.4 FTE)

Felton Case Managers (4.0 FTE)

Flexible Funds and Fiscal Intermediary (SF Public Health Foundation)

Activities

Expansion of CASC operating hours

Referrals to CASC from jail staff and law enforcement

Intake, needs assessments & triage at CASC

Wraparound support services and referrals through CASC

Outpatient case management with a Harm Reduction approach (Felton)

SUD treatment (social detox up to 2 weeks, residential treatment up to 6 months) (Salvation Army)

Other direct support to clients as needed

Outputs

individuals referred to CASC

individuals receiving referral services from CASC

and types of resources/referrals received at CASC

individuals referred to outpatient case management

individuals enrolled in outpatient case management services

participant meetings with case manager

participants with Individualized Intervention Plans (IIP)

individuals enrolled in social detox

completing detox

social detox bed days occupied

individuals enrolled in residential treatment (FY21-22)

residential treatment bed days occupied (FY21-22)

participants completing residential treatment (FY21-22)

The Intended Results

Short-term Outcomes

Individuals triaged into appropriate referral services
- 200 individuals referred to CASC for needs assessment and triage annually
- 40% of referred individuals receive some resources through CASC

Individuals triaged into appropriate treatment services
- 40% of individuals coming into CASC for needs assessment/triage referred to outpatient case management services annually
- 60% of individuals connected to grant-funded outpatient case management services engage with a case manager at least once
- 100% of participants who engage with a case manager receive an IIP
- 90% occupancy rate for social detox/residential treatment beds
- 50% of individuals enrolled in social detox successfully complete their treatment by meeting their individualized goals

Long-term Outcomes

Participants will demonstrate lower recidivism rates during and after program participation than they did during a similar period before participating in STARR
- 33% of individuals assessed by this project will demonstrate lower recidivism rates than in a comparable period prior to admission.

- Individuals assessed will utilize 50% fewer jail bed days per year than they did prior to program participation.

Impact

Reduce incarceration and recidivism by strengthening city-wide initiatives focused on jail diversion, recovery, and community reentry for high-risk individuals with co-occurring disorders

Timeline

Activity	Year 1			Year 2				Year 3			
	Q1/2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Planning and Development											
Project launch/grantee orientation											
Project planning											
Evaluation and data collection plan developed											
Instrument and data collection tool development											
Implementation											
Data collection: partner case logs, IIPs, program completion forms, and other program instruments *(Referral Services, SUD Outpatient Case Management, SUD Social Detox)*											
Data collection: partner case logs, IIPs, program completion forms, and other program instruments *(SUD Residential Treatment)*											
Data collection: Sherriff's Office											
Data collection: District Attorney's Office											
Data collection: staff interviews											
Data collection: focus groups											
Analysis and Reporting											
Analysis of data (ongoing)											
Quarterly data reports to BSCC											
Year 1 formative report draft											
Year 1 formative report final											
Year 2 formative report draft											
Year 2 formative report final											
Year 3 summative report draft											
Year 3 summative report final											

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