Supporting Treatment and Reducing Recidivism (STARR II) 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 18,000 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). An analysis by San Francisco's Mental Health Reform team found that among adults experiencing homelessness in 2018-19, 22% (or 4,000 individuals) also suffered co-occurring mental health and substance use disorders (Bland, 2020).

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 recent pilot programs – Supporting Treatment & Reducing Recidivism (STARR), Promoting Recovery & Services for the Prevention of Recidivism (PRSPR), Law Enforcement Assisted Diversion (LEAD), and the Healthy Streets Intervention Program (HSIP). Additionally, in December 2021, SF Mayor London Breed responded to the City's epidemic of overdose-related deaths by launching the Tenderloin Emergency Initiative, building on the citywide effort to build a collective response to the crisis of homelessness, crime and drug-related overdoses and deaths. 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

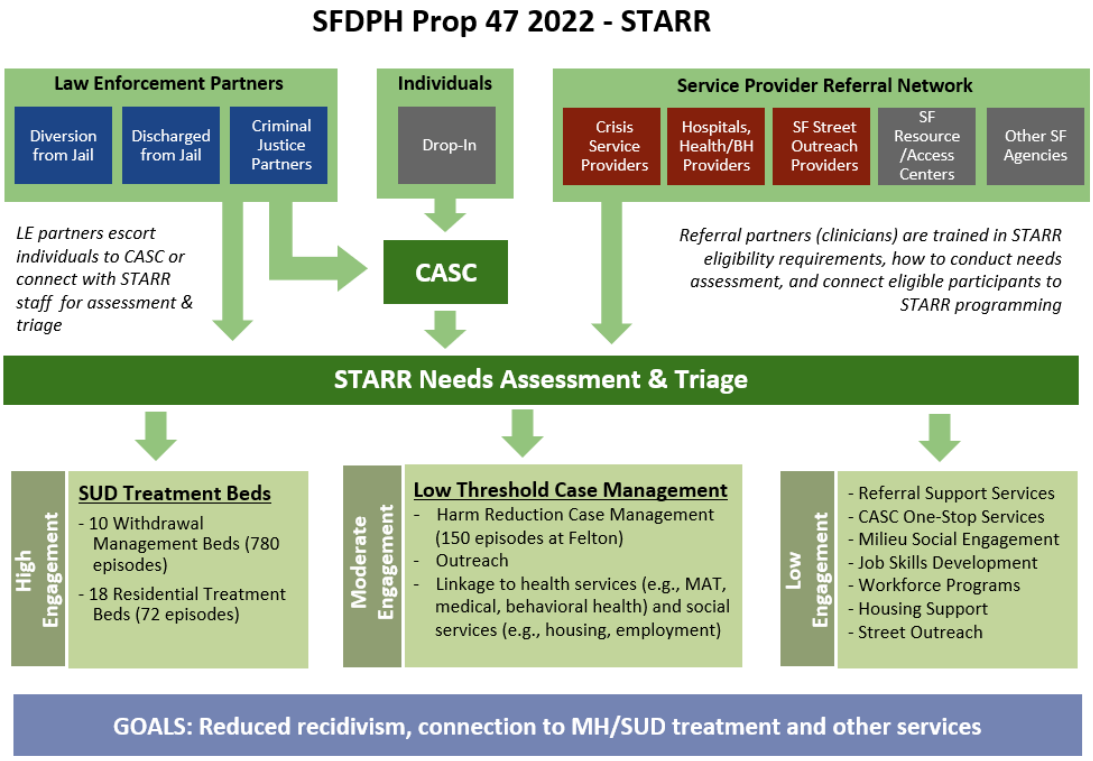
The Proposition 47 Supporting Treatment & Reducing Recidivism II program (STARR II) is designed to meet one of the most critical community care needs in San Francisco – providing additional residential treatment beds, low threshold outpatient case management, and wraparound support services for adults with co-occurring substance use disorder and mental health needs who have had contact with the criminal justice system. The program will decentralize intake, assessment, and triage, allowing providers to meet individuals "wherever and whenever" they need to 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 II 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 18 residential treatment beds, for at least 72 episodes, at Salvation Army; (2) outpatient case management with a Harm Reduction approach; and, (3) wraparound support services, referrals, and low engagement care, including employment support from SA and assessment by STARR staff and other partners, including the Community Assessment and Services Center (CASC).

The STARR II 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 Health Worker (.48 FTE) to oversee service utilization, client intake/assessment, and triage/placements.

Figure 1. STARR Program Flow Overview



Referral and Enrollment in STARR II. While the previous STARR program focused on centralizing intake, assessment and triage at the Community Assessment Service Center (CASC), STARR II will take a decentralized approach, leveraging connections between STARR II and key service providers in the City. A network of providers, including crisis service agencies, hospitals, street outreach providers, access centers and the Jail Behavioral Health Services have been trained in STARR II eligibility requirements and may now conduct needs assessments and directly connect individuals with the beds and case management that STARR offers, or may reach out to STARR staff for triage and referral. This decentralized approach will expand the potential pool of individuals who will be served and reduce barriers by increasing access points.

Depending on an individual's needs, as well as their threshold for engagement, the Clinician may direct the individual to (1) High Engagement STARR II 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, referrals and low engagement care.

High Engagement Services. DPH will contract with the Salvation Army (SA) Harbor Light facility to provide 10 SUD social detox and 18 residential treatment beds for eligible participant. 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.

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 100 client slots. 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.

Program and Partner Goals & Objectives

Program Grant Goals and Objectives

As outlined in the Project Work Plan for this grant, the following goals and objectives will be used to determine program success. The evaluation will be used to monitor progress toward these stated goals and objectives, and reporting will focus on successes and challenges as they are related to the work plan.

Table 1. STARR II Project Work Plan Goals

(1) Goal:	Successfully triage individuals into appropriate Referral services.
Objectives:	**1.1** At least 150 individuals will be referred to STARR annually. **1.2** At least 100 individuals will be triaged and referred for case management or residential treatment annually.
(2) Goal:	Successfully triage individuals into appropriate treatment services (SUD Treatment, Outpatient/Case Management services).
Objectives:	**2.1** At least 60% of individuals connected to grant-funded outpatient case management services will engage with a case manager at least one time. **2.2** At least 50% of participants who meet three times with a grant-funded case manager will receive an Individualized Intervention Plan (IIP). **2.3** Maintain at least 90% occupancy rate for withdrawal management/residential treatment beds. **2.4** 50% of individuals enrolled in withdrawal management will successful 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** Fewer than 30% of individuals who enroll in STARR programming will recidivate within three years **3.2** There will be 50% fewer arrests for STARR enrollees one year after enrollment compared to one year prior

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: 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 or residential treatment 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.

Partner 2: 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. 50% of participants who engage with a grant-funded case manager at least 3 times 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 II) program. HTA will utilize a utilization-focused approach combining mixed methods of program data, surveys, and focus groups to address the impact of the Proposition 47 grant funds on STARR II 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. Details about each element of the evaluation follow.

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 annual surveys 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 Final Local Evaluation Report, 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 2 (starting on page 8) for detailed overview of evaluation questions, program/partner objectives, indicators/outcomes, data sources, and frequency of collection.

Outcome Evaluation

Because STARR I was granted an extension through mid-January 2023, SFDPH anticipates beginning program enrollment in STARR II in February 2023. Individuals will be eligible for the program if they are residents of San Francisco and 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 90 days, 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

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 periods: once before participants receive treatment at their time of enrollment (baseline) and once to measure outcomes immediately after treatment has concluded.

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 2 (starting on page 8) for a 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, only the BSSC definition 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. 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.

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. 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 2 below 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.

Table 2. 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 STARR II • 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 STARR • History of involvement with criminal justice system • Mental health/substance use history	• STARR SFDPH Case Log/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/Intake form	Quarterly
P-1. **O-1.**	**2.1**	Meet moderate engagement enrollment targets	• # of individuals referred to outpatient case management	• STARR SFDPH Case Log/Intake form • STARR SFDPH Referral Form	Quarterly

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
			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)	• Felton Case Log	
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 • 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,	• STARR SFDPH Case Log/Intake form • STARR SFDPH Referral Form • Salvation Army Case Log • Avatar	Quarterly

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
			successful completion)		
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 •	• Felton Case Log	Quarterly / Annually (SSM scores)
No specified evaluation question	**2.3**	Individual Intervention Plans (IIPs)	• # of participants with an IIP • # of participants who receive an IIP within 3 meetings with their Case Manager	• Felton Case Log • IIPs	Quarterly
No specified evaluation question	**2.4** **SA1.1**	High occupancy	• Occupancy rate (sum of daily beds used/sum of daily beds available)	• Avatar (daily census maintained by Salvation Army) • Salvation Army Case Log	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,	• STARR SFDPH Case Log/Intake form • STARR SFDPH Referral Form • Salvation Army Case Log	Quarterly

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
			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		
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
P-4.	*No specified program/partner objective*	Effective transition between levels of program engagement	• Dates of enrollment/exit in residential treatment	• Felton Case Log • Salvation Army Case Log • Implementation team meeting notes	Quarterly Annually

Evaluation Question(s)	Objective(s)	Outcomes	Indicators	Data Source(s)	Frequency of Collection
			• Date of enrollment in outpatient case management • Description of participant handoff between partners • Description of collaboration between partners	• Partner survey • Participant focus groups notes/transcripts	
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 survey	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 survey	Quarterly Annually

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 and 2019 STARR 1 Program infrastructure

Challenges:
Limited affordable housing in SF

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 and 2019 STARR 1 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 & 18 residential treatment beds)

Full-time Health Worker (0.48 FTE grant-funded)

DPH Behavioral Health Clinician (In-kind, 6.0 FTE)

Health Workers (In-kind, In-kind, 1 FTE)

Activities

Referrals to STARR from jail staff and law enforcement

Intake, needs assessments & triage by referral partners

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

residential treatment bed days occupied

participants completing residential treatment

The Intended Results

Short-term Outcomes

Individuals triaged into appropriate referral services
- 150 individuals referred to STARR annually
- 100 individuals will be triaged and referred for case management or residential treatment annually

Individuals triaged into appropriate treatment services
- 60% of individuals connected to grant-funded outpatient case management services engage with a case manager at least once
- 50% of participants who meet with a grant-funded case manager will receive an Individualized Intervention Plan (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
- Fewer than 30% of individuals who enroll in STARR programming will recidivate within three years

- 50% fewer arrests for STARR enrollees one year after enrollment compared to one year prior

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

	Nurse Practitioner (In-kind, 1 FTE) Felton Case Managers (4.0 FTE) Felton Division Director (0.75 FTE) Felton Program Manager (0.3 FTE) Felton Clinical Supervisor (0.2 FTE) Flexible Funds and Fiscal Intermediary (SF Public Health Foundation)			

Timeline

Activity	Year 1					Year 2				Year 3					
	Q1/2 *8/22-3/23*	Q3 *4/23-6/23*	Q4 *7/23-9/23*	Q5 *10/23-12/23*	Q6 *1/24-3/24*	Q7 *4/24-6/24*	Q8 *7/24-9/24*	Q9 *10/24-12/24*	Q10 *1/25-3/25*	Q11 *4/25-6/25*	Q12 *7/25-9/25*	Q13 *10/25-12/25*	Q14 *1/26-3/26*	Q15 *4/26-6/26*
Planning and Development														
Project launch/grantee orientation														
Project planning														
Evaluation and data collection plan developed														
Instrument / data collection tool development														
Implementation														
Quarterly data collection: partner case logs, IIPs, program completion forms, and other program instruments *(Referral Services, Outpatient Case Management, Social Detox)*														
Quarterly data collection: partner case logs, IIPs, program completion forms, and other program instruments *(Residential Treatment)*														
Data collection: Felton SSM Data														
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 3 summative report draft														
Year 3 summative report final (*Final Local Evaluation Report Due to BSCC June 1, 2026)*														

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