



Law Enforcement Assisted Diversion Honolulu 1-Year Program Evaluation Report

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This report presents the status of the Hawai‘i Health and Harm Reduction Center (HHRC) Law Enforcement Assisted Diversion Honolulu (LEAD HNL) pilot program for State of Hawai‘i. This report includes background information on the program, the evaluation approach, and program implementation and presents outcomes and impacts for project period July 1, 2018 and July 31, 2019. It concludes with recommendations based on these findings.

This report was prepared by the University of Hawai‘i at Mānoa LEAD Program Evaluation Team with important contributions from the LEAD Honolulu Hui.

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I. LEAD Honolulu 1-Year Program Evaluation Report

Executive Summary



LEAD Honolulu 1-Year Program Evaluation Report Executive Summary

Program Background

- The goal of LEAD HNL is to reduce recidivism for minor offenses by referred clients in an effort to reduce the burden on the criminal justice system and improve clients' health and wellness. The program aimed to achieve this by engaging clients in social services aimed at addressing housing, substance use, behavioral health, and health issues.
- As of the date of this report, LEAD HNL diversion referrals have not begun. Therefore, all referrals described in this report came through social contact. Social contact referrals have been conducted in collaboration with HPD's Health Efficiency Long-term Partnership (H.E.L.P.) initiative and the Sheriff Division of the Hawai'i Department of Public Safety (Sheriff's Division) in collaboration with the Governor's Office on Homelessness.
- Between July 1, 2018 and July 31, 2019, 47 individuals were referred to LEAD HNL through social contact referral. Of those 47 referred clients, 37 were enrolled in and received services through LEAD HNL.

Client Background

- The majority of enrolled clients were female (60%) compared to 51% of referred clients, suggesting females were slightly more likely to engage in LEAD services after referral.
- Nearly half of enrolled clients were Hawaiian/Pacific Islander (49%), with over half of enrolled clients being multiracial (54%).
- The majority of enrolled clients were single (41%) and had completed high school or received a GED (41%).
- At referral, 92% reported currently experiencing homelessness, with the vast majority living unsheltered (84% of those experiencing homelessness).
- 78% reported using Methamphetamine, 68% reported using alcohol, and 33% reported using opioids and/or heroin in the last six months.



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Findings

- Over the period under study, service use increased over time, particularly the use of case management, medical service, transportation assistance, and permanent housing services.
- On average, clients had 55% fewer cited encounters with law enforcement after referral to the LEAD HNL program.
- LEAD HNL clients decreased the time they spent unsheltered by 38%, on average, a drop from 21 days a month unsheltered to 13 days unsheltered at last assessment. There was also an increase in the time clients spent in emergency (138%) and transitional shelters (90%). Finally, despite large percentage increases in clients who obtained permanent housing, clients were still unlikely to be living in a shared apartment (an average of 3.61 days a month) or an independent apartment (1.61 days a month) at last assessment.
- LEAD HNL clients across all assessments cited permanent housing services as one of their highest needs.
- Clients indicated using methamphetamines the most days a month (17 days on average, with 15% reporting no use) compared to other substances across all assessments. Marijuana was the second most frequently used substance at 6 days a month at first assessment, followed closely by opioids/heroin (5 days) and alcohol (5 days). No other drugs surpassed an average of one day a month at first assessment.
- The average number of days a month clients (who self-reported use) used methamphetamines decreased by 18% (from 17 days a month to 14 days a month, with 23% reporting no use), while alcohol use increased by 51% (an increase from just under 5 days a month to just over 7 days a month).
- Hospital admissions increased from 10% of clients reporting being admitted to the hospital in the previous month at first assessment to 13% at last assessment. A small increase in hospital admissions is not unexpected given that many of the clients suffered from untreated medical conditions prior to obtaining services.
- Emergency room visits decreased from 32% of clients reporting visiting them in the previous month to 19% at last assessment.
- Notable gains were observed in clients' quality of life while in the program. They include improvements in hope for the future, social support, and mental health. Although, it should be noted that while clients' general health and quality of life have improved, they continue to fare much worse than the average adult living in Hawai'i.



Conclusions

- The LEAD HNL program achieved its primary goal of reducing recidivism rates of program clients. At the time of this report, this achievement was accomplished solely through social referral, which lacks the potential threat of legal action if clients do not engage with the program following referral.
- Our evaluation found notable improvements in the stability of housing experienced by clients since enrollment in the program as well as their overall quality of life. Specifically, participants increased the amount of social support they received, reported decreased stress, and improved mental health. They still reported considerable substance use but operating under a harm reduction model, these are considerations that might be best addressed after a period of stabilization in other aspects of clients' lives.
- We recommend the expansion of the program across the entirety of the County, City & State. We also strongly recommend the introduction of the diversion arm of the program. With the potential costs savings associated with reduced emergency room use and the decreased burden on the criminal justice system, this program will likely result in net savings as well as improving the lives of those who participate.



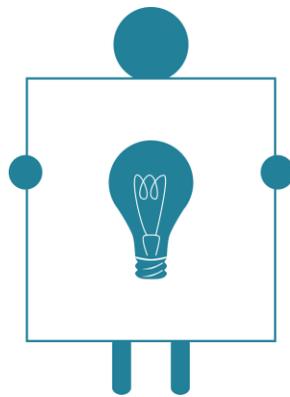
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II. LEAD Program Background



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The LEAD Model

Law Enforcement Assisted Diversion (LEAD) is a diversion program that aims to improve public safety and to reduce criminal behavior.¹ Under the LEAD program model, law enforcement officers connect low-level, non-violent offenders or individuals at high risk of arrest with social service providers in lieu of arrest. The LEAD program is unique from other diversion programs in that:

- diversion occurs pre-booking instead of after arrest;
- LEAD provides participants with immediate case management; and
- LEAD is a collaborative effort, involving law enforcement, community organizations, and public officials.²
- LEAD was funded and supported by the Hawai‘i State Department of Health, Alcohol and Drug Abuse Division (ADAD). ADAD is also an active LEAD Hui Participant.

The original LEAD program in Seattle, Washington showed successful outcomes. After three years of operation, a 2015 study found that LEAD participants were 58% less likely to be arrested after enrollment in the program compared to a control group that went through “system as usual” criminal justice processing.³ Additionally, preliminary program data collected by case managers indicated that LEAD improved the health and well-being of people struggling with poverty, drug use, and mental health problems. Furthermore, the collaboration between stakeholders, who were often otherwise at odds with one another, proved an invaluable process-oriented outcome.⁴

LEAD Honolulu

In collaboration with Hawai‘i Department of Health and the Office of the Governor's Coordinator on Homelessness, the Hawai‘i state legislature funded the current program through the Alcohol and Drug Abuse Division (ADAD) in 2017. The “LEAD HNL” pilot launched July 1, 2018 and has aimed to follow the original LEAD model by focusing specifically on people whose criminal activity is due to behavioral health issues. LEAD’s intensive case management further aims to help individuals, many of whom have cycled in and out of jails and prisons, receive the assistance they need to face complex issues (e.g., homelessness, substance use, and mental illness).⁵

In addition to aiming to improve individual wellbeing, **LEAD HNL aims to help Hawai‘i decrease recidivism rates, address overcrowded correctional facilities, and transform Hawai‘i’s criminal justice system from punitive to rehabilitative.** Given that nearly three fourths of Hawai‘i’s jail and prison population are incarcerated for misdemeanors, petty misdemeanors, technical offenses, or violations⁶—the kinds of offenses targeted by LEAD—the program is well-positioned to help address these systemic issues.

LEAD Hui: A major component of LEAD HNL is the engagement and coordination of services with key stakeholders. The “LEAD Hui” is a group of over 30 organizations who meet 1-2 times per month to coordinate the implementation of LEAD. Members include homeless service providers, substance use treatment facilities, and representatives from the Department of Health, Honolulu Police Department (HPD), the Governor’s Office on Homelessness, and the Alcohol and Drug Abuse Division (ADAD).



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III. Program Implementation



The evaluation team monitored program implementation as well as client and community-level outcomes. This section focuses on program implementation, examining the referral and enrollment processes and service provision. Data sources included archival data, field notes from case management meetings, staff interviews, and client surveys.

LEAD Referrals

LEAD clients are identified through referrals from community partners. These referrals can include both social contact referrals and diversion referrals. Individuals who are perceived to be high risk for arrest are eligible for LEAD through **social contact referral**. Individuals who have committed low-level, non-violent offenses are eligible through **diversion referrals**.

Mode of Referral

Diversion referrals. Eligible offenses include, but are not limited to trespassing, littering, park closure violations, sit/lie offenses, and open container violations. Individuals who have committed violent offenses in the last 10 years (e.g., drug traffickers, promoters of prostitution, sex offenders, and those exploiting minors) are ineligible for LEAD HNL.⁴ In place of an arrest or citation, LEAD-trained officers refer individuals directly and immediately to LEAD HNL staff. As of the date of this report, diversion referrals have not begun due to LEAD HNL still being in the process of facilitating a partnership with HPD and the Prosecutor’s Office. Therefore, all referrals described in this report came through social contact, as described below.

Social contact referrals. The primary avenue for social contact referrals in the LEAD HNL program has been in collaboration with HPD’s Health Efficiency Long-term Partnership (H.E.L.P.) initiative and the Sheriff Division of the Hawai’i Department of Public Safety (Sheriff’s Division) in collaboration with the Governor’s Office on Homelessness. H.E.L.P. is a collaboration of police officers, social service workers, and advocates who jointly conduct outreach aimed at providing connecting individuals to shelter and/or detox services.

Other social contact referral methods include direct recommendations from officers or Sheriff deputies. In addition to accompanying HPD on H.E.L.P. Honolulu operations, LEAD staff regularly accompany the Sheriff’s Capitol Patrol unit on patrols in the Iwilei area and to Community Outreach Court.

Since July 1, 2018, 47 individuals have been referred to LEAD through “social contact.”

- Of these 47 referrals, the majority (56%) were through the H.E.L.P. program (See Fig. 1).
- Over a third (38%) were referred from the Sheriff’s Division (See Fig. 1).

Fig. 1 Mode of Referrals (N = 47)

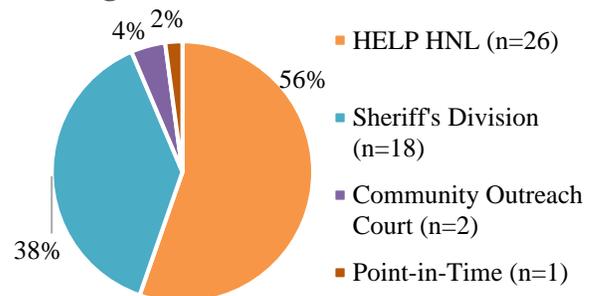


Fig. 2 Referral Locations



The majority of referrals were from the 96817 zip code area (68%, $n = 32$), which includes Iwilei ($n = 14$), A‘ala Park ($n = 9$), River Street ($n = 5$), Chinatown ($n = 3$) and Pauahi ($n = 1$) (See Fig, 2).

Of the seven people who were referred from zip code 96813, two were referred from Community Outreach Court, two were referred from the grounds of ‘Iolani Palace, and three were referred from Kaka‘ako.

Of the four people referred from 96814, one was referred from Ala Moana, and three were referred from Thomas Square Park. Another three people were referred from Kapi‘olani Park (96815).

Intake Procedures

Once the referred individual has accepted the referral, LEAD HNL staff arrive on-site to conduct an initial intake and to schedule a follow-up appointment to complete a full needs assessment and begin to link the client with services.

The following sections present client demographics for LEAD referred clients:

- At referral, **92% reported currently experiencing homelessness**, with the vast majority living unsheltered (84% of those experiencing homelessness).
- **78% reported using methamphetamines**, 68% reported using alcohol, and 33% reported using opioids and/or heroin.

Fig. 3 Referred Client Age (N = 47)

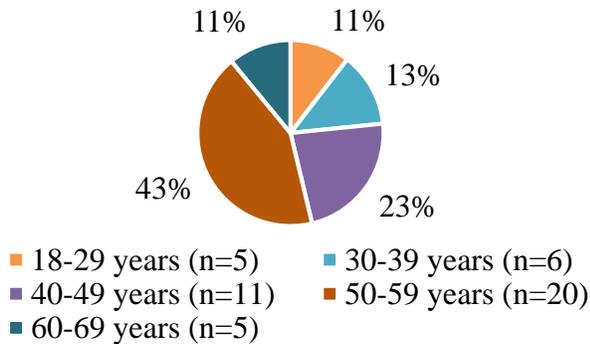
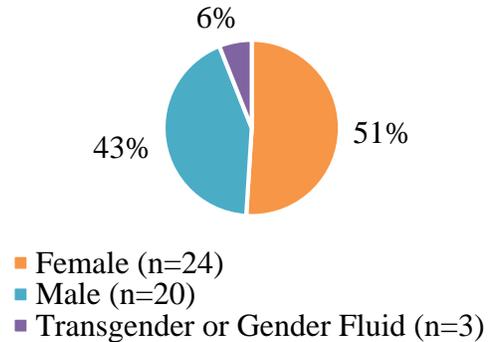


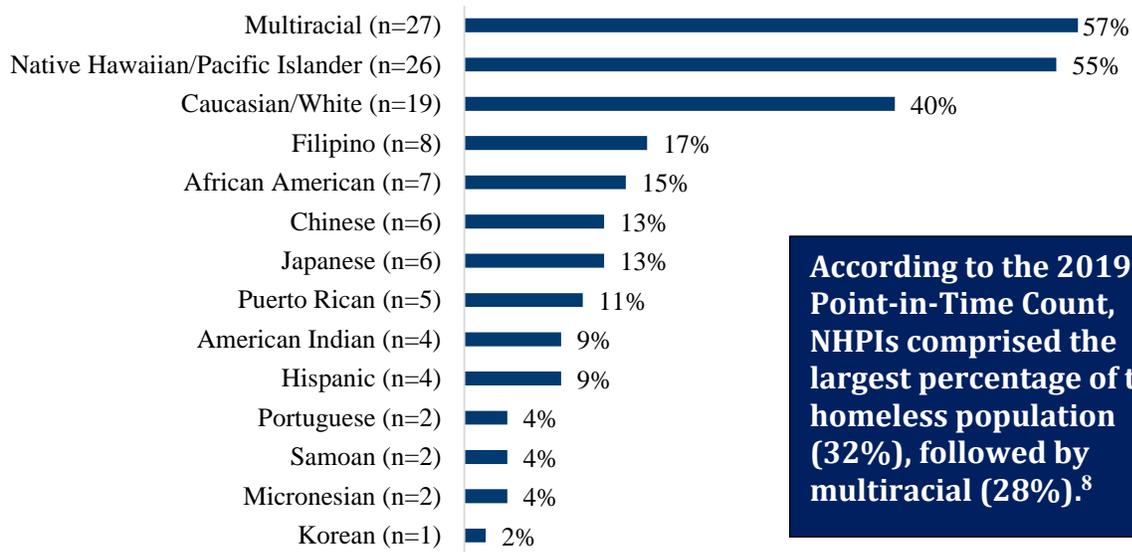
Fig. 4 Referred Client Gender (N = 47)



Referred Clients’ Demographics

- Client age at referral ranged from 18 to 69 years, with a median age of 51, and the majority of clients (43%) being between 50 and 59 years of age (See Fig. 3).
- A slight majority (51%) of the 47 referred clients were female (See Fig. 4).
- Clients could identify with more than one race by selecting multiple races/ethnicities (i.e., select all that apply) on the intake form. Of the 47 clients, 57% identified as multiracial (See Fig. 5).
- A majority of referred clients also identified as Native Hawaiian/Pacific Islander (NHPI) (55%) (See Fig. 5).

Fig. 5 Referred Client Ethnicity

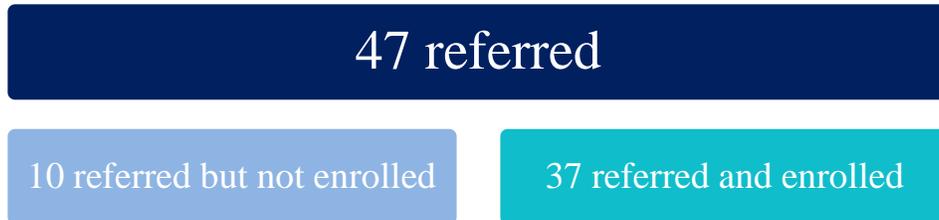


According to the 2019 Point-in-Time Count, NHPIs comprised the largest percentage of the homeless population (32%), followed by multiracial (28%).⁸

Compared to the overall population on O‘ahu, NHPIs and multiracial individuals are overrepresented in referred LEAD clients. NHPI and multiracial individuals made up 24% & 23% of O‘ahu’s population in 2017,⁷ compared to 55% & 57% of LEAD referrals, respectively. However, the program’s referred client racial breakdown reflects recent data showing that NHPIs and multiracial individuals are disproportionately represented in the homelessness population on O‘ahu, comprising 50% and 33% of the unsheltered homeless population.⁸ Additionally, data shows that Native Hawaiians are over-represented in the prison population.⁹ Thus, the referred clients’ racial composition roughly reflects those most likely to experience homelessness and/or have been incarcerated on O‘ahu.

LEAD Enrollments

Out of 47 individuals referred to LEAD, 37 are enrolled in LEAD. Clients who have completed a long intake and needs assessment (LINA) with a LEAD case manager are considered enrolled in the program. LEAD case managers provided intensive follow-ups, calls, client scheduling and meetings, and other intensive avenues to aid in turning referrals into enrolled clients. Currently, this assessment is the only requirement for participation.



Enrolled Client Demographics

The majority of the 37 enrolled clients (46%; *n*=17) are between 50 and 59 years of age. The majority of clients (60%; *n* = 22) are women and have graduated high school or obtained their GED (70%; *n* = 26). About a quarter have not completed high school (27%; *n* = 10). Thirty percent (*n* = 11) have attended some college.

Fig. 6 Enrolled Client Age (N = 37)

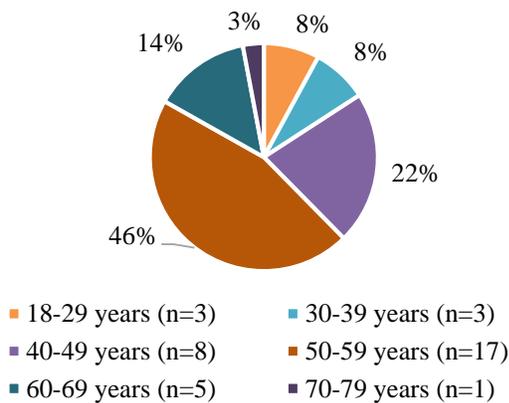
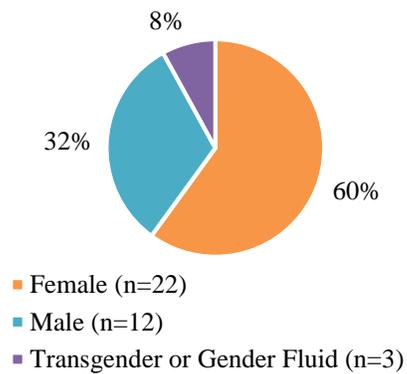
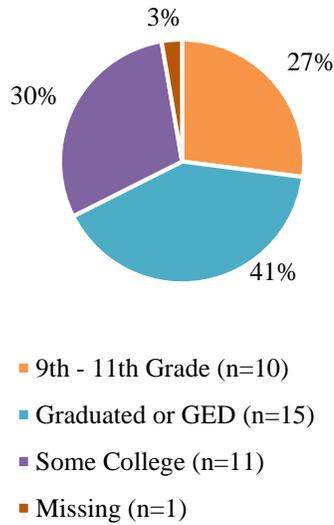


Fig. 7 Enrolled Client Gender (N = 37)



Client age at enrollment ranged from 24-70, with a median age of 53. The majority of enrolled clients are in their fifties, with 46% (*n*=17) being 50-59 years of age; 22% (*n*=8) being 40-49 years of age; 14% (*n*=5) being 60-69 years of age; 8% (*n*=3) being 30-39 years of age; 8% (*n*=3) being 18-29 years of age; and 3% (*n*=1) being 70-79 years of age (See Fig. 6).

Fig. 8 Enrolled Client Highest Level of Education (N = 37)

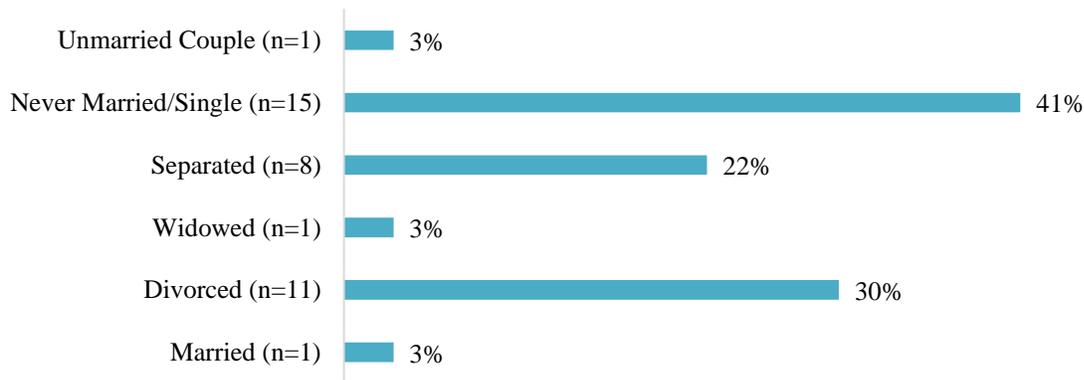


The majority of enrolled clients identify as female, with 60% ($n=22$) identifying as female, 32% ($n=12$) identifying as male, and 8% ($n=3$) identifying as transgender or gender fluid (See Fig. 7).

The majority of enrolled clients have graduated or received their GED, with 41% ($n=15$) reporting graduating high school or receiving their GED; 30% ($n=11$) reported attending some college; and 27% ($n=10$) reported attending 9th-11th grade (See Fig. 8).

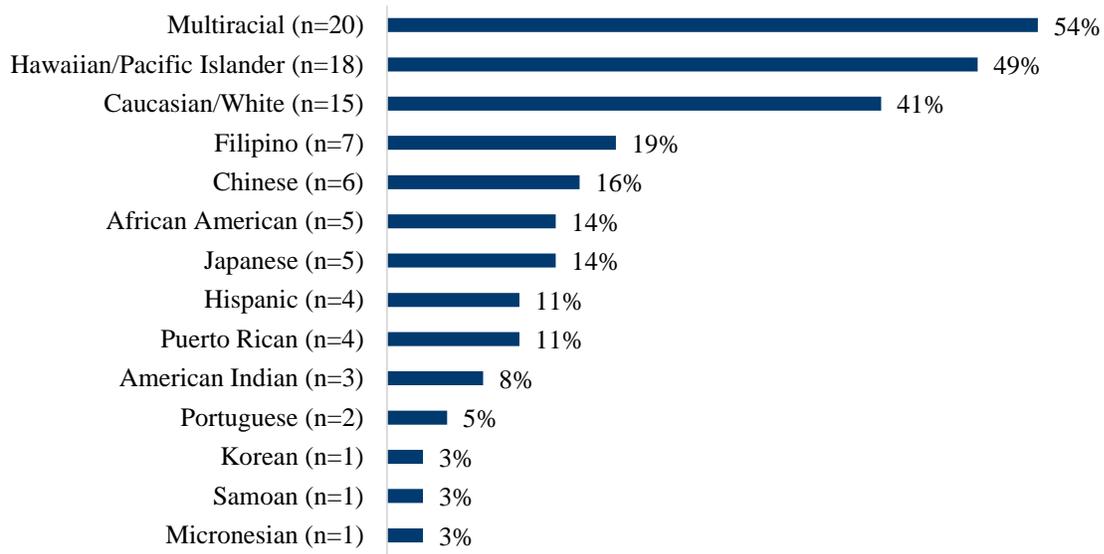
The majority of enrolled clients are single, with 41% ($n = 15$) of clients reporting never being married; 30% ($n = 11$) reporting being divorced; 22% reporting being separated ($n = 8$), and 3% ($n = 1$) reporting being widowed. Only two clients reported being married ($n = 1$) or part of an unmarried couple ($n = 1$) (See Fig. 9).

Fig. 9 Enrolled Client Family Status



- Enrolled clients were able to select more than one ethnicity on the LINA form, and the majority of enrolled clients identified as multiracial (54%; $n = 20$), and 49% ($n = 18$) of enrolled clients identified as NHPI (See Fig. 10).

Fig. 10 Enrolled Client Ethnicity

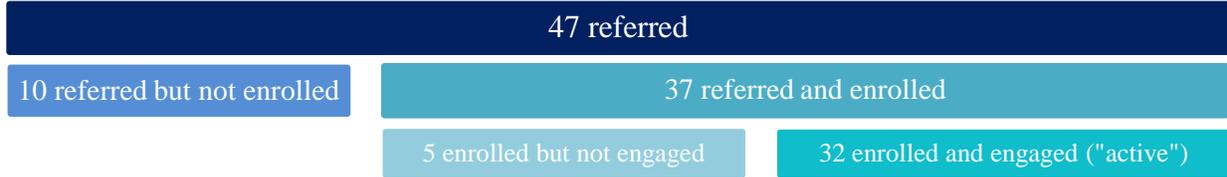


Thus, the plurality of enrolled clients are single, multiracial cisgender women with at least a high school degree between the age of 50 and 59.



Service Engagement

After enrollment, LEAD case managers provide intensive case management services to help connect clients to other services. About 86% ($n = 32$) of the 37 enrolled clients are actively engaging in LEAD case management services. Five individuals are not actively working with their case managers by choice but are still considered LEAD clients.



The following section demonstrates the amount of time case managers devoted to LEAD clients, calculated by data collected from service utilization records.

Fig. 11 Average Number of Hours Case Managers Spent Per LEAD Client Per Month*



*Missing data on an enrolled but not engaged client

- Case managers spent an average of 5.51 hours per LEAD client per month for active clients compared to 0.15 hours a month for clients who were referred but not enrolled. However, these hours do not reflect all of the hours that case managers spend looking for clients and some other client assistance (See Fig. 11).
- Within these groups, considerable variations existed by client. For example, for active clients, time spent ranged from less than 30 minutes to more than 13.5 hours per month.
 - This range in time spent is expected because LEAD does not force clients to engage in services, and clients who need more services likely require more hours than clients with more stability.
- The amount of time spent also varies within the same person by month. For example, a client who exceeded 35 hours in their second month in the program averaged very few hours in subsequent months.



For active clients, time spent with case managers ranged from less than 30 minutes to more than 13.5 hours per month.



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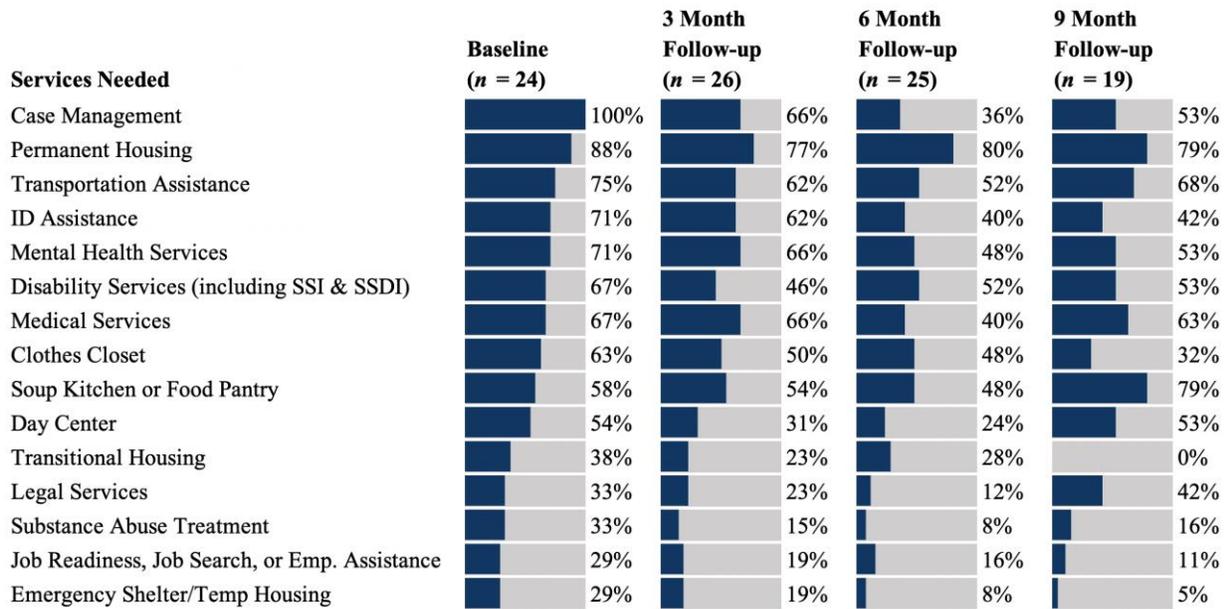
Services Needed and Services Used

The following section presents clients’ self-reported services needed and services used. Clients provided the type of services they would like to utilize (Fig. 12) as well as services used within the past 30 days (Fig. 13) at baseline and at subsequent follow-up time periods.

Operational Work Group:
LEAD HNL utilizes weekly meetings to discuss and coordinate care with community partners, such as representatives from HPD, the Governor’s Office on Homelessness, and the funding agency ADAD.

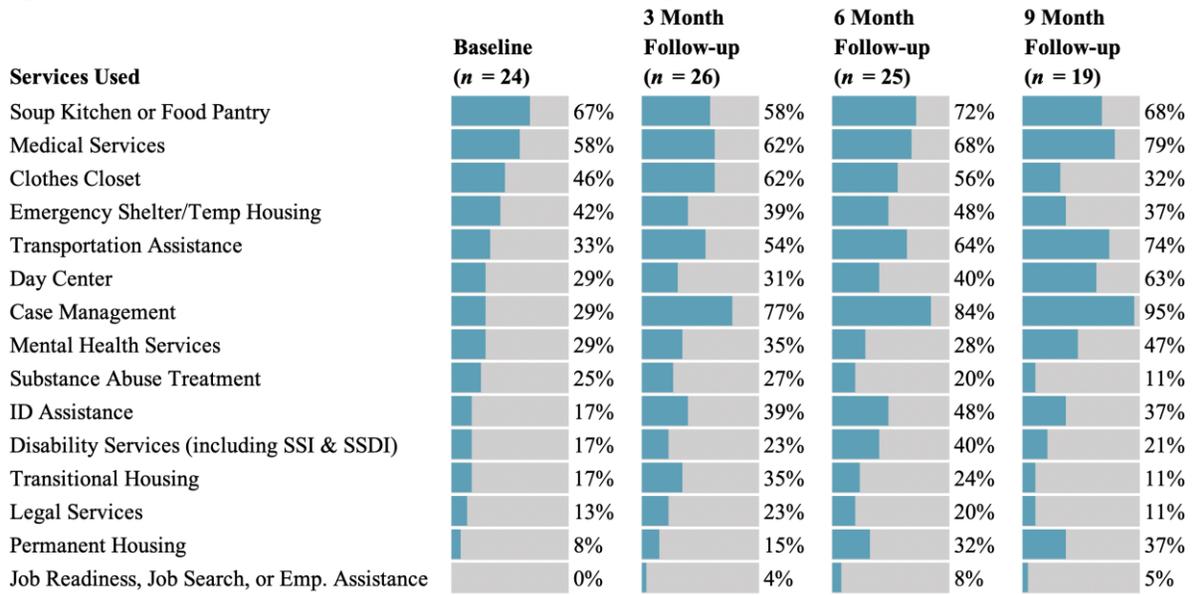
“My goal is still to get permanent housing.”
– LEAD Client

Fig. 12 Client Services Needed over Time in the Program



- At baseline, the majority of clients who answered this question indicated needing 10 of the 15 listed services, with 100% indicating needing case management services. At 9-month follow-up, 53% still wanted case management services (See Fig. 12).
- Over three quarters of clients who responded indicated also needing permanent housing (88%) and transportation assistance (75%) at baseline.
- ID assistance dropped dramatically from 71% at baseline to 42% at 9-month follow-up. At 9-month follow-up, transportation assistance and permanent housing services continued to be reported as needed by the majority of clients (68% & 79%, respectively).
- The number of clients needing soup kitchens or food pantries increased from 58% to 79% from baseline to 9-month follow-up and was tied with permanent housing as the most-needed service at 9-month follow-up.

Fig. 13 Client Services Used over Time in the Program



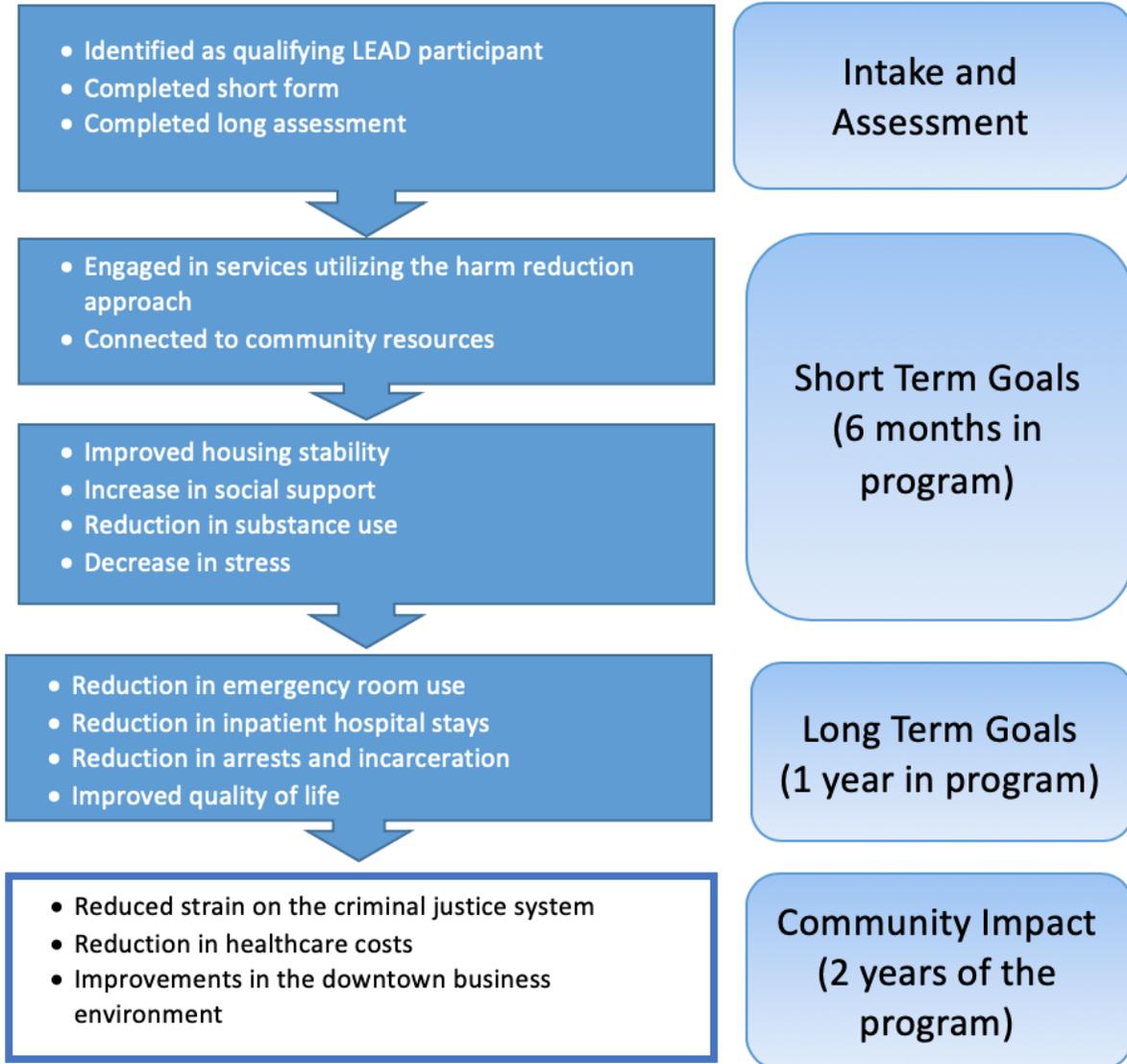
- The majority of clients indicated using only two services—soup kitchens (67%) and medical services (58%)—at baseline. This is in stark contrast to findings that the majority of clients indicating **needing ten** services at baseline. At follow-up, the majority of clients were using soup kitchens, medical services, transportation assistance, day centers, and case management (See Fig. 13).
- The percentage of clients using each service increased for every service except clothes closets, emergency shelters, substance abuse treatment, transitional housing, and legal services.
 - The percentage of clients using substance abuse treatment, transitional housing, and legal services increased at 3-month follow-up, suggesting that clients did access needed services.
 - Similarly, the percentage of clients using emergency shelters increased at 6-month follow-up. Given the increase in usage of permanent housing, it is likely that emergency and transitional housing were no longer needed at 9-month follow-up.
- Use of case management increased substantially from 29% to 95%. Given that at baseline, case management was needed by 100% of clients who answered this question, the substantial increase suggests that clients are receiving needed services (See Fig. 13).
- Use of medical services, transportation assistance, and permanent housing increased substantially, suggesting that clients were receiving more comprehensive, wrap-around services.

IV. Outcomes & Impacts



In addition to examining program process, the evaluation team assessed program outcomes and impacts based on goals identified in the LEAD Theory of Change (Fig. 14 below). This section of the report assesses program progress toward participants’ short-term goals and long-term goals, as well as a brief description of harm reduction as it pertains to the goals of the LEAD program.

Fig. 14 LEAD Theory of Change



What is a “harm reduction approach?” *Harm reduction attempts to reduce the adverse consequences of drug use among persons who continue to use drugs. It developed in response to the excesses of a “zero tolerance approach”. Harm reduction emphasizes practical rather than idealized goals. It has been expanded from illicit drugs to legal drugs and is grounded in the evolving public health and advocacy movements.*

[Single, E. (1995). Defining harm reduction. Drug and Alcohol Review, 14(3), 287-290.]



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Short-Term Goals

Short-term goals include increased housing stability and social support and decreased substance use and stress.

Housing Stability

The evaluation team assessed changes in housing by examining the number of days lived in different locations for the last 30 days at baseline and follow-up. Of the 37 enrolled clients, 31 clients completed at least the baseline and a follow-up assessment. The time between baseline and last assessment for these clients ranged 2-10 months, with an average of 6.8 months.

At baseline, the average number of days spent living on the street was 20.83. The average was 12.90 days at the last assessment, showing a 38% decrease.

Days sleeping on street/park/beach



The percentage of clients who did not sleep unsheltered the entire previous month increased from 13% at first assessment to 48% at the last assessment.

On the other hand, the average number of days spent in an emergency shelter and transitional shelter increased from 2.10 and 2.03 days to 5.00 and 3.07 days, respectively.

Days staying in emergency shelter



Days living in transitional housing



The average number of days living in a shared or independent apartment also increased from less than one day for both shared and independent apartments to 3.61 and 1.61, respectively.

The percentage of clients who lived in an independent apartment for the entire previous month increased from 0% at first assessment to 10% at the last assessment.

Days living in shared apartment



Days living in independent apartment



While the average number of days spent sleeping on the streets was higher than other sleeping locations at both first and last assessment, the average decreased by 38% from 20.83 days at first assessment to 12 days at last assessment.

The average number of days spent in independent apartment increased 442%, from 0.67 days at first assessment to 3.61 days at last assessment.

These findings suggest that LEAD clients are spending less time on the streets and more time in shelter or housing since enrolling in the program.

What has changed in your life since starting LEAD?



*“I’m off the streets and in a shelter”
– LEAD Client*



*“From living homeless to transitional home to being close to
permanent housing”
– LEAD Client*

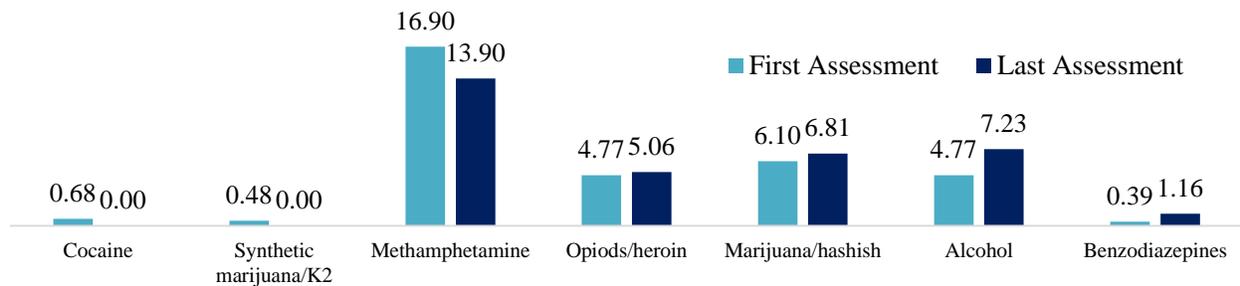


Substance Use

Using self-reported substance use data, evaluators assessed changes in LEAD clients’ substance use and engagement in treatment services.

Clients indicated using methamphetamines the most days a month compared to other substances. However, the number of days using methamphetamines decreased by 18% from 16.90 days at first assessment to 13.90 days at last assessment (See Fig. 15).

Fig. 15 Average Number of Days Used Each Substance in Past Month at First & Last Assessment

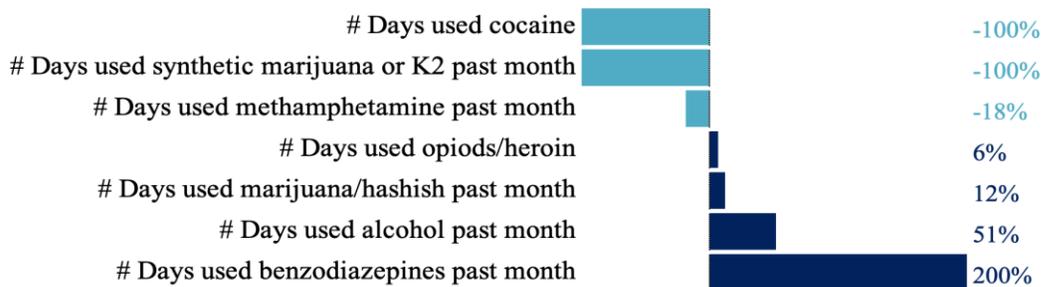


The average number of days per month using opioids, marijuana, and benzodiazepines increased slightly from 4.77, 6.10, and 0.39 days to 5.06, 6.81, and 1.16, respectively. Alcohol use also increased from 4.77 days a month to 7.23 days per month (51%; see Fig. 16). Please note that benzodiazepines are sometimes used to help reduce the impact of Alcohol Withdrawal Syndrome (AWS).

12 out of 37 enrolled LEAD clients engaged in some type of substance use service, such as substance use counseling in the last 3 months of the assessment period.

- The percentage of clients who reported no methamphetamine use in the previous month increased from 15% at first assessment to 23% at the last assessment.

Fig. 16 Percent Change in Substance Use from First to Last Assessment



“I was living on the streets. I was addicted to drugs and was always in jail. Life was hopeless. This program helped me get into treatment, helped me with clean and sober living. I am no longer addicted to drugs or homeless. I now have hope I didn’t have before.” – LEAD Client

Stress

Clients showed overall improvement in perceived stress from their first assessment to their last. Clients saw the most gains in the number of days they felt hopeful about the future, increasing from an average of 9.06 days to 14.68 days a month, a 62% increase (Fig. 17).

Fig. 17 Change in Client Perceived Stress from First to Last Assessment

	First Assessment	Last Assessment	Percent Change
Days felt unable to control the important things in life	3.53	3.35	-5.05%
Days felt difficulties could not be overcome	3.52	3.42	-2.75%
Days felt that things were going their way	2.52	2.90	15.38%
Days felt confident about ability to handle personal problems	3.03	3.48	14.89%
Days felt hopeful about future	9.06	14.68	61.92%

“[I like] the emotional support and to have someone I can trust and talk to honestly. I love the program” – LEAD Client



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Long-Term Goals

Long-term goals for clients include decreased reliance on emergency and hospital usages, decreased recidivism, and increased client quality of life. While it is likely that program-related impact on these goals has likely not been reached, the following section examines current progress.

Emergency and Hospital Use

While hospital admissions increased from 10% of clients at first assessment to 13% at last assessment, emergency room visits in the past month decreased from 32% of clients to 19% at last assessment (Fig. 18).

While hospital admittance rates did increase slightly, increased use is expected among people who have otherwise ignored persistent medical issues prior to receiving services. Over time, it is believed that hospital admission rates will likely decline.

These findings suggest progress toward reducing strain on healthcare services.

Fig. 18 Changes in Client Usages of Emergency Rooms and Hospitals in Past Month from First Assessment to Last Assessment

	First Assessment	Last Assessment	Percent Change
% gone to the emergency room in the past month	32%	19%	-40%
% admitted to hospital in the past month	10%	13%	33%

Crime and Recidivism

The evaluation team examined recidivism for LEAD clients using criminal citations recorded in eCourt Kokua, which provides “access to public information from traffic cases, District Court criminal, Circuit Court criminal, Family (Adult) Court criminal and appellate cases.”¹⁰ Evaluators examined records for three years prior to LEAD referral and the period after referral through July 1, 2019.

“LEAD has made me want to stay out of trouble.” - LEAD Client



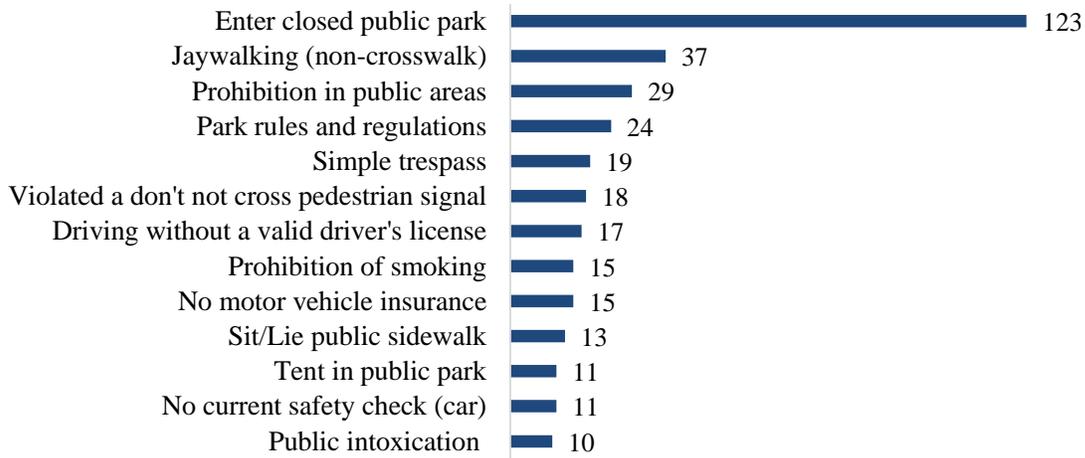
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In the three years prior to the start of the LEAD program, the most commonly cited offenses among enrolled LEAD clients was entering a closed public park, followed by jaywalking, drinking in public areas, and disobeying park rules and regulations, including a variety of separate citations that were essentially different versions of sit/lie on a public sidewalk.

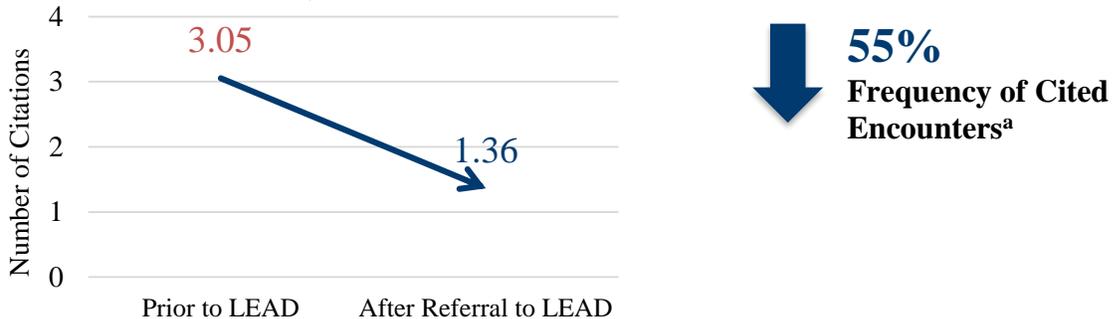
Fig. 19 Number of Citations by Regulation Issued to LEAD Clients in the 3 Years Prior to Referral - Most Frequently Issued



After being adjusted for the number of months clients participated in the LEAD program, on average, clients received 62% fewer total citations per month after referral into LEAD and had 55% fewer cited encounters with an enforcement officer (See Fig. 20).

The average number of cited encounters per year, per client before LEAD ranged from 0-31 and 0-10 after starting LEAD.

Fig. 20 Cited Encounter Frequency Per Client, Per Year



^a Citations were calculated by averaging the number of encounters that resulted in receiving at least one citation prior to (starting three years before being referred to LEAD) and after starting the LEAD program. Data were adjusted for the number of months each client was in the program.



Client Quality of Life

Clients’ quality of life was assessed through self-reported physical and mental health, social support, and frequency of trauma within the past 30 days.

Clients saw improvements on several indicators of quality of life. Clients increased in the number of times they attended community groups and participated in recreational activities (Fig. 21). They also experienced noticeable increases in the amount of support available to them if they were to need assistance or support (Fig. 22).

Fig. 21 Change in Community Support from First to Last Assessment

	First Assessment	Last Assessment	Percent Change
Times visited a spiritual group in the last 30 days	2.32	2.29	-1.39%
Times attended a community group in the last 30 days	0.29	0.52	77.78%
Times engaged in recreational activities in the last 30 days	6.03	8.90	47.59%
Times participated in a support group in the last 30 days	1.77	0.39	-78.18%

Fig. 22 Change in Social Support from First to Last Assessment

	First Assessment	Last Assessment	Percent Change
Someone to help you if you were confined to bed.	2.42	3.26	34.67%
Someone to take you to the doctor if you need it.	2.65	3.29	24.39%
Someone to share your most private worries and fears with.	2.77	3.30	18.95%
Someone to turn to for suggestions about how to deal with a personal problem.	2.90	3.39	16.67%
Someone to do something enjoyable with.	2.84	3.19	12.50%
Someone to love and make you feel wanted.	2.84	3.03	6.82%

Range: 1 = *Not at all* , 5 = *All of the time*

Clients saw gains in mental health, sleep, and energy. The number of mentally unhealthy days decreased by 17%; the number of days anxious decreased by 18%; the number of days depressed decreased by 13%; the number of days not getting enough sleep decreased 19%; and the number of days full of energy increased by 38% (Fig. 23).

However, physical health did not see the same gains. While number of days in pain and days of activity limitation decreased slightly, the number of physically unhealthy days increased by 17%.

These findings suggest the physically vulnerable state of LEAD clients and reflect previous findings that perceptions of physical health decline after gaining stability.^{xi}



Fig. 23 Change in Client Health and Wellbeing from First to Last Assessment

	First Assessment	Last Assessment	Percent Change
General health (excellent (1) - poor (5))	3.58	3.74	4.50%
# Physically unhealthy days past month	14.10	16.55	17.36%
# Mentally unhealthy days past month	21.42	17.71	-17.32%
# Activity limitation days past month	17.87	16.65	-6.86%
# Days in pain past month	14.70	14.58	-0.81%
# Days depressed past month	20.81	18.19	-12.56%
# Days anxious past month	22.23	18.19	-18.14%
# Days not enough sleep past month	21.29	17.32	-18.64%
# Days full of energy past month	8.27	11.39	37.75%

Clients saw reductions in frequencies of traumatic experiences from first to last assessment. Experiences with trauma decreased by 30%, and witnessing trauma decreased by 6%. Overall, experiences with trauma was infrequent (Fig. 24).

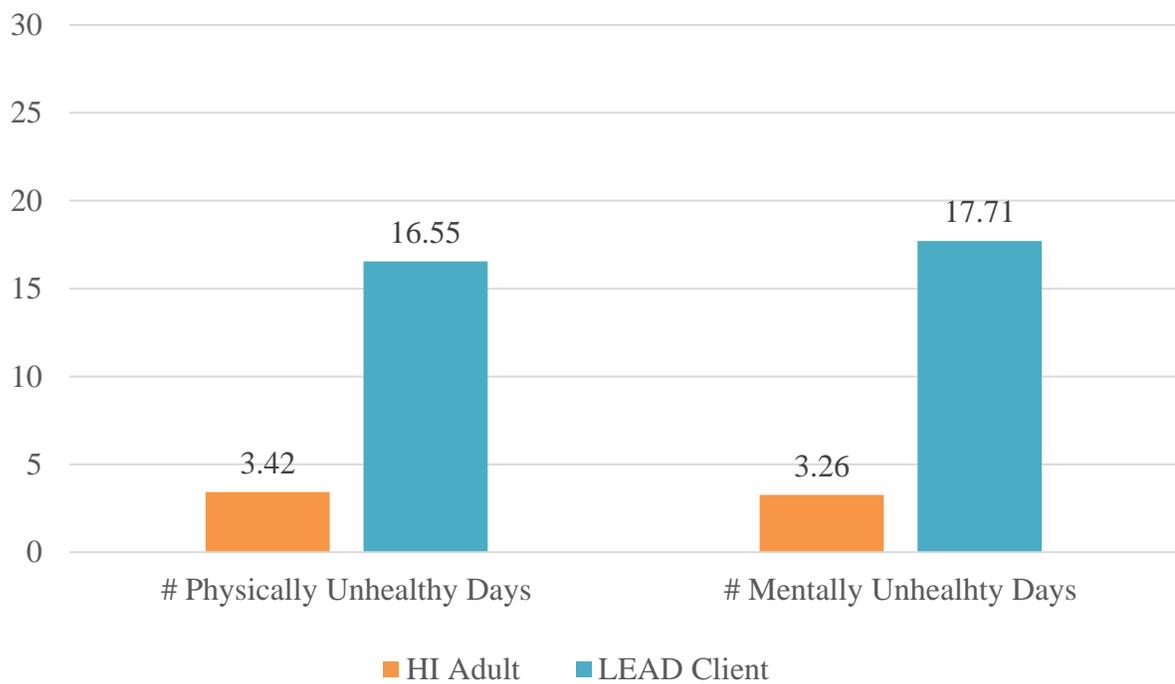
Fig. 24 Frequency of Experiences with Trauma—Never (1) to Very Often (5)—from First to Last Assessment

	First Assessment	Last Assessment	Percent Change
Experienced violence, trauma, or sexual maltreatment/assault within or outside of the family in past month.	2.71	1.90	-29.88%
Witnessed someone close to you being hit, kicked, slapped, or otherwise physically or emotionally hurt in past month.	2.10	1.97	-6.21%

While LEAD clients improved on many indicators of health and wellbeing, it is important to note that they still scored well above state and national averages on these indicators (Fig. 25).

- According to data from the CDC BRFSS,^{xiii} in 2018, the average adult living in Hawai‘i experienced 3.42 physically unhealthy days per month, compared to 16.55 per month experienced by the LEAD HNL sample at their last assessment.
- The average adult living in Hawai‘i experienced 3.26 mentally unhealthy days per month, while LEAD HNL clients experienced 17.71 at their last assessment.
- While the LEAD HNL clients have made some progress in their overall quality of life, particularly in their mental health, they still experience difficulties much greater than the average adult living in Hawai‘i.

Fig. 25 LEAD Clients Compared to General HI Population in Number of Unhealthy Days



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Conclusions

- While LEAD HNL has not begun diversion yet, the program is currently operating at capacity, relying on social referrals from HPD's H.E.L.P. initiative, the Sheriff's Division, and other community partners.
- Sixty-eight percent of the 47 referred clients are actively engaged with LEAD case management services, while 5 are enrolled but not engaged and 10 were referred but not enrolled.
- Client service use has increased. Use of medical services, transportation assistance, and permanent housing has increased substantially, suggesting that clients are receiving more comprehensive, wrap-around services.
- Permanent housing continues to be one of the most pressing needs for LEAD clients. While the percentage of clients who lived in an independent apartment for the entire previous month increased from 0% at first assessment to 10% at the last assessment, 90% of the participants still need to be permanently housed.
- The number of cited encounters for enrolled LEAD clients dropped by 55%, suggesting that LEAD is reducing recidivism for clients at a high risk for arrest.
- While substance use increased slightly for some substances, the most often used substance for LEAD clients was methamphetamines, which decreased by 18% over time in the program.
- Clients have improved significantly on indicators of quality of life from first to last assessment. They have seen increased hope for the future, decreased stress, decreased trauma, and increased mental wellbeing.
 - Despite these notable improvements, clients still score well below national averages on indicators of physical and mental health.
 - Additionally, the number of physically unhealthy days increased 17%. This uptick in physically unhealthy days mirrors other findings that after 3-6 months of housing or stability, clients often experience a dip in wellbeing.^{xiii}
- Overall, results suggest that socially referred LEAD clients are improving on indicators established in the LEAD Theory of Change and that the program is on track to achieve projected community impacts.



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V. Recommendations



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Based on findings related to program implementation and outcomes, we make the following recommendations for the program, funders, and community stakeholders.

Recommendations for the Program

- For LEAD HNL to continue to work with local law enforcement, the prosecutor's office and other criminal justice agencies to seek reconciliation over a working relationship in order for diversion to begin.
- Continue to seek permanent housing services for clients.
- Develop culturally appropriate and community-based approaches to harm reduction initiatives because of the high percentage of Native Hawaiian and Pacific Islander clients.
- Consider addressing increases in alcohol use, perhaps encouraging engagement in treatment services or creating new community support groups for LEAD clients.
- Consider expending additional resources and time per month to outreach to enrolled but not engaged clients.
- Develop a triage protocol for individuals referred to or encountered by LEAD HNL through social contact referral who are not suitable for the program/unable to join the program due to saturation, but need assistance nonetheless in order to triage (link and sync) those individuals out to other local service providers.

Recommendations for Funders & Other Stakeholders

- We strongly encourage the state prosecutor's office to seek reconciliation over a Memorandum of Agreement (MOA) in order for diversion to begin. While the program has been successful, we anticipate greater success when the program can operate with full fidelity to the program model, which stressed diversion.
- We strongly encourage operational work group training of law enforcement to create a better link-and-sync between partners.
- Development and implementation of training for law enforcement on how they can participate in the implementation of LEAD is highly encouraged.
- While we did not assess the cost-effectiveness of this program, in the first year, only taking into account the large drop in cited encounters (55%) and emergency room use (40%), it is very likely that the financial benefits outweigh the financial costs of the program. This, paired with clear improvements in the well-being of clients, inclines us to recommend the expansion of the program across the entire County of Honolulu.



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VI. Next Steps



For Evaluators

- Continue collecting survey and archival data.
- Conduct interviews with clients to identify barriers to achieving personal goals.
- Examine key differences in service utilization and history of clients with different program status (i.e., enrolled but not engaged, referred but not enrolled, and active).
- Pursue data recourses to estimate the financial costs vs. benefits of administering the program.
- Pursue the inclusion of an acuity scale to clients upon client enrollment and then every three months thereafter.
- Ensure LEAD HNL meets regularly with outer island LEAD stakeholders to provide technical assistance.



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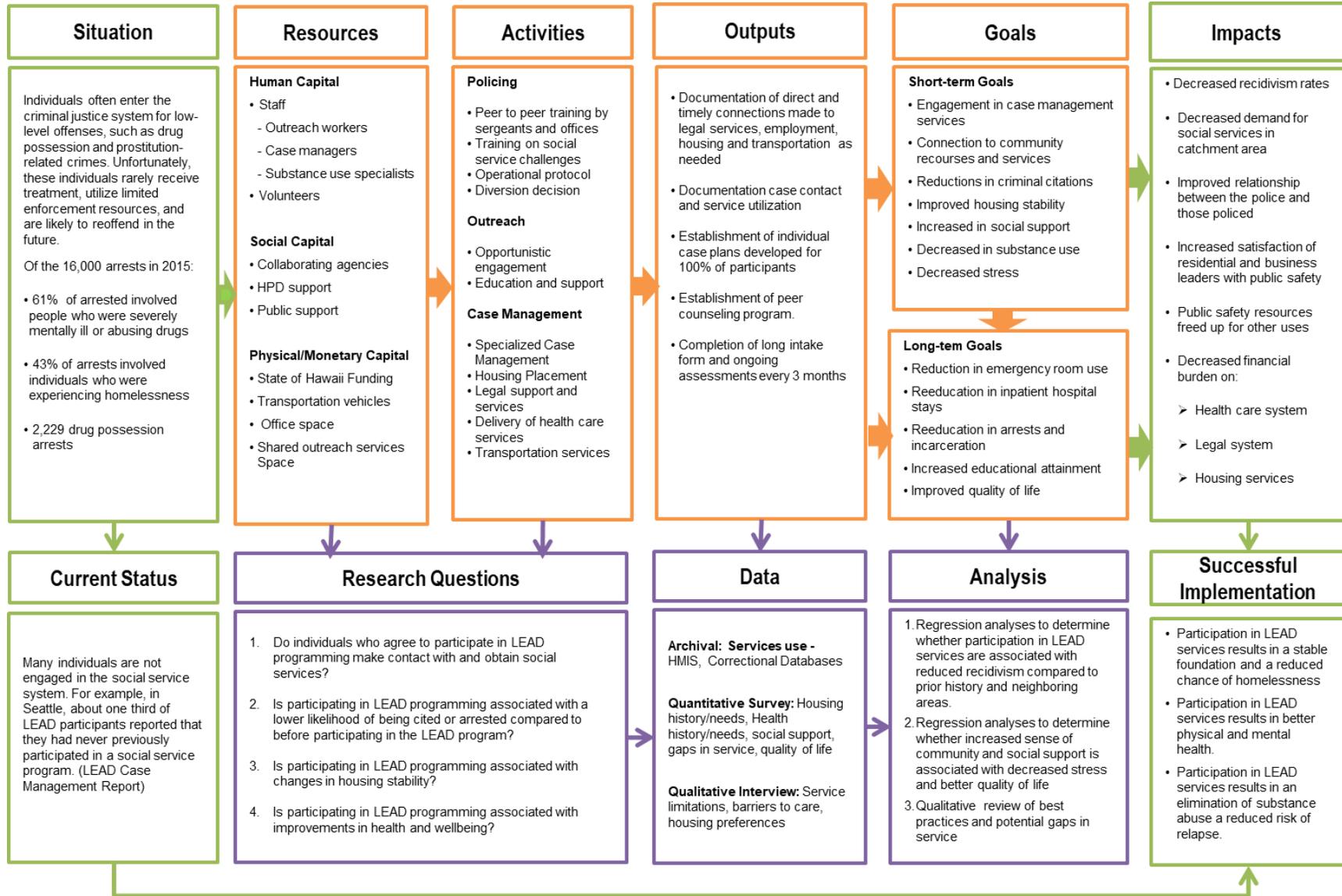
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I. Appendices



A. The Law Enforcement Assisted Diversion (LEAD) Program Logic Model



B. Evaluation Methodology

This program evaluation report will focus on the implementation of LEAD in urban Honolulu between July 1, 2018 and July 31, 2019. In particular, the evaluation strives to:

- Understand aspects of LEAD HNL process and implementation;
- Assess adherence to LEAD fidelity and extent of necessary program modifications;
- Detect outcomes and impacts; and
- Examine achievement of goals and objectives.

This program evaluation report outlines progress achieved thus far and explains the program evaluation plan in more detail.

Process and Implementation

In an effort to document the intended program process, the program evaluation team, in collaboration with HHHRC, developed a logic model that details program activities (e.g., identification of vulnerable people, case management services, etc.) and expected outputs (e.g., number of people identified, number of services needed, number of services received). Additionally, the logic model lists anticipated short-term goals, long-term goals, and overall program impacts and delineates the process that leads to the attainment of these goals and objectives.

Program Fidelity

Fidelity refers to the degree to which a program is implemented as intended.⁵ Sometimes programs must be adapted to better fit the communities in which they are implemented. However, it is important to measure fidelity by tracking what components are changed and what components are implemented as intended in order to assess which components can be changed and still achieve program effects. LEAD advances 6 primary goals:

1. **Reorient** government's response to safety, disorder, and health-related problems.
2. **Improve** public safety and public health through research based, health-oriented and harm reduction interventions.
3. **Reduce** the number of people entering the criminal justice system for low level offenses related to drug use, mental health, sex work, and extreme poverty.
4. **Undo** racial disparities at the front end of the criminal justice system.
5. **Sustain** funding for alternative interventions by capturing and reinvesting justice systems savings.
6. **Strengthen** the relationship between law enforcement and the community.¹

Many components of LEAD can be adapted to fit local needs and circumstances. However, there are certain core principles that are essential in order to achieve the transformative outcomes



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seen in Seattle. Those include: (i) LEAD’s harm reduction/Housing First framework, which requires a focus on individual and community wellness rather than an exclusive focus on sobriety, and (ii) the need for rank-and-file police officers and sergeants to be meaningful partners in program design and operations.¹ In order to be considered a LEAD model, programs should contain most of the components outlined above.

Outcomes and Impacts

The overall outcomes and impacts of the LEAD model include decreasing Hawai‘i recidivism rates, addressing overcrowded correctional facilities, and transforming Hawai‘i’s criminal justice system from punitive to rehabilitative. With the successful implementation of the LEAD model, outcomes will include engagement in services, a reduction in criminal activity, and improvements in health and well-being.

Specific Goals and Objectives

There are several goals that LEAD services attempt to achieve. Short-term goals are focused on physical aspects of clients’ daily lives. These include improved housing stability, increase in social support, reduction in substance use, decrease in stress, as well as increasing engagement in services and connection to community resources. Long-term goals focus on stability and include reduction in emergency room use, reduction in inpatient hospital stays, reduction in arrests and incarceration, and improved quality of life.

The anticipated progression of these outcomes and potential impact of the program were outlined in the LEAD Theory of Change (Figure 14). In addition, the overall program logic model is outlined in Appendix A.

The following research questions – as stated in the Logic Model (Appendix B) – address four main areas of concern:

1. Do individuals who agree to participate in LEAD programming make contact with and obtain social services?
2. Is participating in LEAD programming associated with a lower likelihood of being cited or arrested compared to before participating in the LEAD program?
3. Is participating in LEAD programming associated with changes in housing stability?
4. Is participating in LEAD programming associated with improvements in health and wellbeing?



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LEAD HNL Measures

Informed by best practices, the program evaluation team works closely with frontline staff at HHHRC to capture data that helps understand how the LEAD program works in urban Honolulu.

LEAD HNL case managers work with clients to address their specific needs and challenges by offering services directly at HHHRC and also serve as a liaison between other community service providers. Data is collected throughout this process in the following way:

Honolulu LEAD Client Screening Form: Collects demographic and contact information for data follow-up, as well as provides an initial introduction of the client to the case manager, which may include:

- social services clients currently receive
- social services clients are interested in receiving
- recent substance use history
- housing situation

Honolulu LEAD Intake and Needs Assessment (LINA) – LEAD HNL staff follow up with clients to collect more in-depth information about them:

- housing
- history of homelessness
- substance use
- social support
- community engagement
- stress levels
- risky behavior
- general health
- history of chronic conditions and treatment
- social services clients currently receive
- social services clients are interested in receiving
- recent arrest information
- recent hospitalization information



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Honolulu Follow-up LEAD Intake and Needs Assessments (F-LINA): Case workers use a shortened version of the LINA called the F-LINA to follow-up with clients regarding the in-depth information collected during the LINA. Our measurement timeline is listed below.

HMIS: Used to examine housing and social service history for clients.

eCourt Kokua: Used to calculate client recidivism.

WITS Database: Used to calculate service provision and case management hours.

Data collection frequency

Measure	Administration of Measure by Month					
	Intake	1 month	3 months	6 months	9 months	12 months
Honolulu LEAD Client Screening Form	X					
Honolulu LEAD Intake and Needs Assessment (LINA)		X				
Honolulu Follow-up LEAD Intake and Needs Assessment (F-LINA)			X	X	X	X
Qualitative Interviews with LEAD HNL Service Providers						X
Direct Service Summaries & Feedback	Ongoing					
Interaction with law enforcement histories (eCourt Kokua)	Ongoing					
Hours billed for LEAD staff interactions with clients (WITS database)	Ongoing					

C. Evaluation Timeline

- July-August 2018:** Develop assessment tools and protocols.
- Begin recruiting program clients through social contact referral.
- Initiate surveying of program clients using the Honolulu LEAD Client Screening Form and the Honolulu Long Intake and Needs Assessment (LINA) form.
- September-October 2018:** Continue recruiting program clients.
- Established and continued widespread surveying of each program participant.
- November-December 2018:** Continue recruiting program clients.
- Continued surveying of program clients.
- Initiate surveying of program clients using the Honolulu Follow-up LEAD Intake and Needs Assessment (F-LINA).
- Released Honolulu’s Law Enforcement Assisted Diversion (LEAD) Progress Status Report.
- January-February 2019:** Stopped recruiting new clients.
- Continued surveying of program clients.
- March-April 2019:** Continued surveying of program clients.
- Conducted Zoom training on intake and assessment tools (i.e., LEAD Client Screening Form, LINA, and F-LINA) with Maui LEAD team.
- Released Honolulu’s Law Enforcement Assisted Diversion (LEAD) Program Evaluation Plan.
- May-June 2019:** Continued surveying of program clients.
- July-August 2019:** Continued surveying of program clients.
- Conducted staff interviews.



Gathered data on billable hours spent by case managers with program participants using WITS database

Gathered data on encounters with law enforcement experienced by program participants before and after being enrolled in the program using eCourt Kokua database.

Begin to analyze 1-Year evaluation findings.

August-September 2019: Continue to analyze 1-Year evaluation findings.

Write-up and report 1-Year evaluation findings.



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