Law Enforcement Assisted Diversion/ Let Everyone Advance with Dignity

Program Evaluation Report

State of Hawai‘i

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This program evaluation report presents the status of the Hawaiʻi Health & Harm Reduction Center (HHHRC) Let Everyone Advance with Dignity/Law Enforcement Assisted Diversion – formerly "Law Enforcement Assisted Diversion" – Honolulu (LEAD HNL) program on the Island of O'ahu for the State of Hawaiʻi. This report was prepared by the University of Hawaiʻi at Mānoa LEAD Program Evaluation Report Team, with essential contributions from the State of Hawaiʻi LEAD partners and staff. LEAD pilots were also being implemented on Kaua'i, Maui, and Hawaiʻi Island. But, the arrival of the COVID-19 pandemic in Hawaiʻi in March 2020 presented unforeseen funding stream issues for LEAD on the neighboring islands. This report includes background information on the program evaluation report approach and implementation as well as shows program outcomes and impacts for years one (July 1, 2018-July 31, 2019), two (August 1, 2019-July 31, 2020), three, and four (August 1, 2020-July 31, 2022) project period beginning July 1, 2018, and ending July 31, 2022. The report concludes with recommendations based on these findings.

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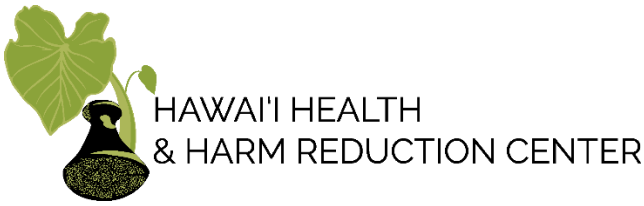

ACKNOWLEDGEMENTS

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"Reducing harm, promoting health, creating wellness, and fighting stigma in Hawai'i and the Pacific."


HAWAII STATE DEPARTMENT OF HEALTH


The Harry and Jeanette Weinberg Foundation

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LEAD Evaluation Goals

This program evaluation report focuses on the Hawai'i Health & Harm Reduction Center (HHHRC)'s Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) program implementation and outcomes in the City and County of Honolulu from July 1, 2018, through July 31, 2022. This program evaluation report also includes brief reviews of three LEAD pilot programs on Kaua'i, Maui, and Hawai'i Island, with individual status updates on each program. This evaluation aims to:

- highlight key demographics of the LEAD clients;
- understand clients' services needed and received while engaged with LEAD;
- changes in client progress between July 1, 2018, and July 31, 2022;
- assess fidelity to the LEAD model and any necessary modifications;
- detect and report outcomes and impacts (COVID-19 related where essential); and
- examine the achievements and goals of LEAD Honolulu.

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

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Executive Summary of Key Findings

LEAD in the State of Hawaiʻi

- **Non-Oʻahu-based LEAD program pilots negatively impacted by the COVID-19 pandemic:** LEAD pilots on Kauaʻi, Maui, and Hawaiʻi Island are struggling to reestablish their programs due to funding issues related to the COVID-19 pandemic, with LEAD Maui being the only on-going program at the time of the release of this report.
- **The LEAD program on Oʻahu is the longest-running LEAD program in Hawaiʻi:** LEAD in the City and County of Honolulu (LEAD HNL) launched its pilot on July 1, 2018, and is still running.

LEAD Honolulu Client Demographics

- **As of July 2022, there were 58 clients enrolled in LEAD HNL, with more than half actively engaged:** About 52% of clients were "actively engaged" in LEAD case management services.
- **LEAD HNL serves a mostly middle- to upper-middle-aged population:** The average age of clients was 55 years (age range 21-75), with the majority being 40-59 years (56%).
- **LEAD HNL serves an equal amount of male and female clients:** An equal amount of clients identified as male (43.6%) and female (43.6%).
- **LEAD HNL serves a comparatively high proportion of transgender clients:** 12.7% of clients identified as transgender – a notable overrepresentation compared to the estimated 0.6% of the state population who identify as transgender.[7]
- **LEAD HNL serves about half of clients born in Hawaiʻi:** About half of clients were born in Hawaiʻi (49.1%) compared to slightly above half (50.9%) who were not.
- **LEAD HNL serves mostly clients with a high school education or below:** Over a third of clients completed 9th-11th grade (34.5%) or were high school/GED graduates (32.7%).
- **LEAD HNL serves mostly clients who identify as Caucasian and/or Native Hawaiian:** When asked to self-identify, 45.5% of clients identified as Caucasian, and 43.6% identified as Native Hawaiian.

LEAD Honolulu Client Descriptives (at intake/enrollment)

- **Most clients experienced homelessness before enrollment in LEAD HNL:** At intake, 80% of clients were currently experiencing homelessness, and 20% had experienced homelessness within the past three years.
- **Most clients experienced homelessness before enrollment in LEAD HNL as a result of substance use and/or lack of finances:** The majority of clients reported the reason for experiencing homelessness was alcohol or drug use (61.8%), followed by being unable to pay rent or mortgage (32.7%) and loss of money or lack of funds (29.1%).
- **Most clients wanted to live in permanent housing and near public transportation:** When asked where they would most like to live, 92.7% said they would like to live in an independent apartment, and 85.5% said they would like to live near public transportation.

- **Most clients had mental and/or physical health diagnoses:** The three most reported medical diagnoses were depression (92.6%), anxiety (79.6%), and chronic pain (53.7%).
- **Most clients reported having ever used alcohol, methamphetamine, and cocaine:** The majority of clients reported ever using alcohol (87%), methamphetamine (75.9%), and cocaine (53.7%).
- **Clients reported needing an array of supportive services:** During intake, most clients reported needing case management (90%), permanent housing (90%), transportation assistance (74%), ID assistance (69%), mental health services (69%), medical services (64%), clothes closet (62%), disability services (62%), and soup kitchen/food pantry (57%).

LEAD Honolulu Outcomes (since intake/enrollment)

- **Clients spent fewer nights unsheltered:** Clients experienced a 57% decrease in nights spent sleeping on the street, in a park, or on the beach.
- **Clients spent fewer nights in an emergency shelter:** Clients experienced a 74% decrease in nights spent sleeping in an emergency shelter.
- **Clients spent more nights in an independent apartment:** Clients experienced an increase in nights spent sleeping in an independent apartment from an average of less than one night at intake to an average of nearly 15 days since enrollment.
- **Clients increased their use of alcohol and cocaine but decreased their use of methamphetamine and opioids:** Clients increased their use of alcohol by 37% and cocaine by 24% but decreased their use of methamphetamine by 25% and opioids by 15%.
- **Clients decreased their stress levels:** Clients experienced an increase of days they felt hopeful about their futures by 50%, feeling that things were going their way by 24%, and feeling confident that they could handle their personal problems by 16%.
- **Clients decreased the amount of time spent in the emergency room:** Clients experienced a 15% decrease in emergency room visits.
- **Clients experienced almost no change in overall physical health but significant improvement in overall mental health:** Clients experienced a 1% increase in physically unhealthy days but a 36% reduction in mentally unhealthy days. However, clients also reported a 37% decrease in days they felt poor physical and mental health were preventing them from engaging in their regular activities.
- **Clients experienced a decrease in traumatic experiences:** Clients experienced a 21% decrease in days they experienced violence, trauma, or sexual assault/maltreatment.
- **Clients experienced a decrease in engagement with law enforcement:** A citation analysis showed that clients experienced fewer citations before LEAD HNL began (2015-2018) than after LEAD HNL began (2019-2021).
- **Clients experienced improved quality of life but still experience greater difficulties than the average adult living in Hawaiʻi:** Physically, the average adult living in Hawaiʻi experienced 2.56 unhealthy days a month compared to LEAD HNL clients who experienced 13.59. Mentally, the average adult living in Hawaiʻi experienced 3.5 unhealthy days a month compared to LEAD HNL clients who experienced 14.93.

II. LEAD Program Background

LEAD Program Background

In 2011, as a response to gross racial disparities in police enforcement born from the War on Drugs paradigm, the first Law Enforcement Assisted Diversion (LEAD) program began in Seattle, Washington.[1] After three years of operation, a 2015 study found that LEAD participants were 58% less likely to be arrested after enrollment in LEAD than a control group who went through "system as usual" criminal justice processing.[1] Additionally, preliminary program data collected by case managers indicated that LEAD improved the health and wellbeing of participants struggling with poverty, substance use, and mental health problems.[1] Furthermore, the collaboration between stakeholders, who were often otherwise at odds with one another, proved an invaluable process-oriented outcome.[1] At the time of the release of this report, 52 LEAD programs were operating in the United States, seven (7) were launching, and ten (10) were developing.[1]

When the LEAD Honolulu 2-Year Program Evaluation Report was released on October 1, 2020, LEAD was introduced as a diversion program to improve public safety and reduce criminal behavior[2] (Link to LEAD Report: https://www.uhecolab.com/reports). Under this earlier version of the LEAD program model, law enforcement officers would connect low-level, non-violent offenders or individuals at elevated risk of arrest with social service providers in place of arrest.[2] LEAD was unique from other diversion programs in that:

- Diversion occurred pre-booking instead of after arrest;
- Clients were provided with immediate case management; and
- The program was a collaborative effort involving law enforcement, community organizations, and public officials.[2]

LEAD Paradigm Shift

Since the publication of the LEAD Honolulu 2-Year Program Evaluation Report, the LEAD model has undergone a substantial paradigm shift. The Movement for Black Lives has created an opening to radically rethink how American communities pursue public health, order, safety, and equity.[3] To meet this transformative moment, the LEAD National Support Bureau (NSB) confirmed that its flagship program in Seattle had changed its name from Law Enforcement Assisted Diversion to Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD).[3] In addition, NSB has developed a new option for LEAD operations that decenters law enforcement as gatekeepers to LEAD services.[3] LEAD Honolulu has followed suit and changed its name from Law Enforcement Assisted Diversion to Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity.

Image source: https://www.leadbureau.org

LEAD Core Principles

According to the NSB, the latest model of LEAD offers a new option to decenter law enforcement as gatekeepers. Still, LEAD aims to divert individuals from the criminal justice system and into the social services sector.[3] The following NSB core principles are essential to achieving the transformative outcomes made possible through LEAD:

1. **Reorient** the 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 criminal justice system savings; and
6. **Strengthen** the relationship between law enforcement and the community.[4]

LEAD Honolulu

In collaboration with the Hawai‘i Department of Health (HDOH), Alcohol & Drug Abuse Division (ADAD), the Hawai'i state legislature funded LEAD through ADAD in 2017. Hawai'i Health & Harm Reduction Center (HHHRC) launched the LEAD Honolulu (LEAD HNL) pilot on July 1, 2018, aiming to follow the original LEAD model by focusing on people whose criminal activity is due to behavioral health issues. LEAD HNL'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, such as homelessness, substance use, and mental illness. For more information: https://www.hhhrc.org/lead.

The vast majority of Hawai'i's prisoners (72%) are incarcerated for class C felonies and below (e.g., misdemeanors petty misdemeanors, technical offenses, or violations) compared to only 28% for more serious class A and B felonies (e.g., violent crimes, drug offenses).[5] Class C felonies and below are the kinds of crimes targeted by LEAD, making the program well-positioned to help address these systemic issues in Hawai'i.

> *“Hawai‘i is at a crossroads. If we continue on the path we have been on for the past four decades, we can expect the same poor outcomes and high recidivism rates we have experienced in the past, and our communities will not be safer despite the hundreds of millions of dollars we will spend on corrections… Hawai‘i must adopt a new and more sustainable correctional model…This can be done by making greater use of community-based alternatives to incarceration and focusing on the development of successful, evidence-based restorative and rehabilitative strategies for those who go to prison.”* (Final Report of the HCR 85 Task Force, p. 8)

LEAD Honolulu Core Principles

In addition to improving 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.** In addition to the NSB core LEAD principles, LEAD HNL has its internal core principles:

1. **A harm reduction philosophy** through which clients are engaged regardless of where they are in their lives, including their substance use and recovery journey; clients will not be penalized or denied service if they do not achieve abstinence;
2. **A non-displacement principle** through which LEAD staff and stakeholders recognize that the existing community services and resources might not meet demand; where current programs have unused capacity and where there are appropriate fits for client needs, LEAD staff will help navigate available community resources;
3. **Community transparency and accountability** where community stakeholders and public safety leaders can participate in regular staff meetings, have access to program performance reports, and have access to program staff; and
4. **Participant confidentiality,** wherein client confidentiality and respect for client privacy are crucial to their success and ethical service delivery.

In 2022, HHHRC went through the rigorous Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation process, and LEAD HNL was subsequently accredited. Through this process, LEAD HNL developed a Let Everyone Advance with Dignity Policies & Procedures Manual (LEAD HNL P&P). The LEAD HNL P&P outlines policies, procedures, scope of services, operational elements, program eligibility, program referral, service delivery, program framework, comprehensive training, initial screening, intake, assessment, transition, discharge, documentation, client records, quality assurance, and evaluation.[6]

LEAD Honolulu Objectives

LEAD HNL objectives are outlined in the LEAD HNL P&P as follows:

- Establish consistent engagement with community stakeholders through Community Leadership Team (CLT) meetings, which were previously called LEAD Hui meetings (i.e., a group of over 30 organizations who meet to coordinate the implementation of LEAD);
- Establish LEAD-trained officials in LEAD operational agencies (OAs) covered under a Memorandum of Understanding to facilitate appropriate diversions to staff members;
- Establish consistent case conferencing with OAs through an Operational Work Group;
- Provide evidence-based intensive case management (ICM) to eligible individuals;
- Provide linkage for referred individuals ineligible for ICM services by triaging immediate needs and connecting them to appropriate resources;
- Reduction of ICM clients experiencing homelessness compared to baseline assessment;
- Improve client physical and mental health when compared to baseline assessment; and
- Reduce recidivism for ICM clients with histories of citations or arrests.[6]

III. LEAD on the Neighboring Islands

This report section will outline LEAD on the neighboring islands before providing an exhaustive evaluation report of LEAD HNL.

LEAD on the Neighboring Islands

After Year 1 of LEAD HNL on Oʻahu, LEAD expanded to the neighboring islands of Kaua'i, Maui, and Hawaiʻi Island through funding provided by Act 209, Session Laws of Hawaiʻi 2018. Each LEAD pilot program is implemented differently than LEAD HNL to allow neighbor islands to make changes within each jurisdiction as deemed necessary to maximize implementation in combination with adhering to the overall LEAD model and its fundamental principles as much as possible. Based on lessons learned from LEAD HNL, the Kaua'i, Maui, and Hawaiʻi Island pilots included a shelter and housing component to provide short-term stabilization beds for LEAD clients.

Local adaptation of the general LEAD model is integral to the program's success. It helps to gain buy-in from local partners and stakeholders and gives each program the flexibility to adjust to the needs of each community. On the neighboring islands, the following organizations administered LEAD in partnership with County Prosecuting Attorney's offices and Police Departments:

- **Kaua'i:** Women in Need
- **Maui:** Mental Health Kokua
- **Hawaiʻi Island:** Big Island Substance Abuse Council

However, when the COVID-19 pandemic arrived in Hawaiʻi in March 2020, state-funded programs suffered budgetary losses due to last-minute funding reallocation for COVID-19 pandemic alleviation efforts. Unfortunately, LEAD factions on the neighboring islands were subject to these funding cuts. At the time of the publication of this report, the neighboring islands are no longer operating fully functional LEAD programs.

LEAD Kaua'i

The LEAD pilot program on Kaua'i (LEAD Kaua'i) launched in December 2019. The nonprofit organization Women in Need (WIN), whose mission is "empowering Hawai'i's families to lead healthy & full lives," was tasked with implementing LEAD Kaua'i with the initial goal of recruiting 15 clients. Program staff utilized social referrals and outreach through the Kaua'i Police Department (KPD), the public defender's and prosecutor's offices, the Department of Land and National Resources, Mental Health Kokua, park rangers, and the Housing Agency. For example, the public defender's and prosecutor's offices and a local judge provided client referrals for three charges, including theft and possessing three grams or less of marijuana.

Initially, LEAD Kaua'i reported having a good working relationship with the public defender's and prosecutor's offices, receiving client referrals from them. Those referrals received a citation, and then LEAD Kaua'i staff received a notice to follow up with the potential client to complete an initial screening. To increase its referral reach, LEAD Kaua'i was also actively fostering community relationships, such as its relationship with KPD and the child welfare office. Local prosecutors were initially enthusiastic about LEAD Kaua'i. Still, as the program progressed, it became challenging to communicate and establish protocols for dismissed charges and associated requirements for charges to be deferred or dropped for clients.

According to WIN, recruiting LEAD Kaua'i clients was a complex process. First, potential clients had to be screened to determine their eligibility for the program. While a few potential clients were screened, WIN staff could not follow up because they could not locate them post-screening. When the 2020 LEAD HNL 2-Year Program Evaluation Report was published, LEAD Kaua'i screened 11 potential clients, but only two were engaged in the program.

In June 2020, a portion of LEAD Kaua'i's funding was reallocated to address other pressing needs in the community related to the arrival of the COVID-19 pandemic. Before that time, WIN had placed one client into supportive housing. WIN believed that the community had received LEAD Kaua'i well. Unfortunately, the enthusiasm initially expressed by community partners had waned with the increased focus on COVID-19 pandemic-related issues.

During a follow-up interview with the Program Evaluation Report Team in September 2021, WIN indicated that it had not had regular contact with its funder HDOH, ADAD, since the Summer of 2020 regarding the status of LEAD Kaua'i. However, in May 2021, WIN received scant new funds to employ LEAD Kaua'i services. According to WIN, the new funding is associated with the demonstration of completing program goals, mainly related to housing.

Conversations between the new Chief of KPD and WIN have yielded renewed enthusiasm for the program. However, WIN believes it needs to redirect resources to a new case manager to meet the program goals. According to WIN, they would need to dedicate one case manager position to handle approximately 10 cases. Although the housing crisis on Kaua'i will continue to be a barrier to the program, dedicated case management with a social worker well-versed in the program requirements could help renew progress dampened by COVID.

LEAD Maui

The LEAD pilot program on Maui (LEAD Maui) launched in May 2019. The nonprofit organization Mental Health Kokua (MHK), whose mission is to "assist people with mental health and related challenges, to achieve optimum recovery and functioning in the community," was tasked with implementing LEAD Maui. The main goal of LEAD Maui was to make contact with potential clients through law enforcement to divert them into social services instead of arrest. Initially, LEAD Maui staff enrolled clients by coordinating outreach with Maui Police Department (MPD), which involved ride-along with MPD to engage in warm handoff referrals. After the warm handoff, program staff would determine if the individual was eligible for LEAD Maui. If the individual met LEAD Maui criteria, the program staff would begin case manager and service provider processes for the new LEAD Maui client. In their first year of operation, LEAD Maui estimated that they had made successful contact with more than 800 potential LEAD Maui clients through program efforts.

Due to the COVID-19 pandemic, LEAD Maui had to adjust its traditional client interactions and recruitment efforts; however, staff met face-to-face with clients when appropriate and necessary. LEAD Maui staff were mandated to wear masks when interacting with clients, and LEAD Maui could no longer transport clients to legal engagements. But LEAD Maui consistently conducted weekly meetings with MPD to check in on client progress continuously. On June 6, 2020, LEAD Maui temporarily paused recruitment efforts.

In June 2020, LEAD Maui funding was reallocated to address other pressing needs in the community related to the arrival of the COVID-19 pandemic. Despite this financial setback, as of September 2021, MHK CEO reported that LEAD Maui had been running continuously. Initially, LEAD Maui continued to operate using grant funding from the Weinberg Foundation. Also, MHK had secured funding from other sources to support LEAD Maui activities. MHK initially had five shelter beds set aside for LEAD Maui clients, but those beds were also reallocated. Now, bed funding is provided exclusively through Weinberg Foundation funding. However, shelter bed space remains at a premium on Maui as the pandemic continues to impact the overall stability and availability of shelter and temporary housing resources.

LEAD Maui's partnership with MPD has been critical to building an effective pipeline for LEAD referrals. Currently, MPD operates a unit called Critical Outreach & Response with Education (CORE) with two full-time MPD CORE officers who provide targeted assistance to Maui's at-risk population of individuals experiencing homelessness. These two officers share department-dedicated assets to identify such individuals with a history of law enforcement and legal system engagement. MPD has also been using law enforcement research tools, patrol contacts, and referrals from local businesses and residences to establish a more therapeutic connection with Maui's at-risk population.

LEAD Maui case managers still accompany MPD CORE officers on ride-along occasionally. MPD also re-purposed school buses for MPD CORE officers and LEAD Maui staff to provide triage and assessment care for those needing immediate shelter or other services, such as mental health

care and medical evaluation. The feedback from the MPD CORE to LEAD Maui has been positive and encouraging. MPD believes the ability to immediately refer potential LEAD Maui clients through MPD CORE officers is crucial for preventing escalations during police contact and future engagements with law enforcement. MPD CORE officers and LEAD Maui staff alike believe the model is successful. However, internal concerns about funding are persistent as MPD operates CORE using department funds, and CORE staff fears those funds could be reallocated, suspending CORE work with LEAD Maui.

LEAD Maui continues to receive some support from the Maui Prosecutors' office. Through case-by-case intervention, LEAD Maui and MPD have engaged in dialogue with the Maui Prosecutors' office to consider more types of citations for deferment. In some cases, direct communication has yielded citation dismissals. As a result of these engagements, LEAD Maui has received some direct referrals from prosecutors, court offices, and public defenders. MHK case managers have met the referred clients and assessed their suitability for LEAD services. MHK staff believe that the ability to maintain leading contact with the justice system, as MHK LEAD clients move through the courts, has contributed to the successful placement of LEAD clients into more stable settings.

Community and local municipal government support have also contributed to LEAD Maui's continued operations. Local elected officials have toured MHK facilities and are pushing policy measures at the council level to expand their mission. Though COVID-19 pandemic intervention measures currently constrain municipal funding, the CEO of MHK believes there is support for LEAD Maui that will drive any possible future financial aid received via municipal budgeting.

Currently, only one case manager at MHK is assigned to LEAD Maui clients. This manager typically has a caseload of 12 to 15 clients. The case manager will screen the applicant for suitability and, in most cases, seek short-term stabilization sheltering. Through interim case management, MHK can then seek the assistance of public insurance programs, which enables the client to access and use medical services. According to the case manager, once short-term housing has been established, medical needs have been stabilized, and courts have been contacted for possible deferral and citation dismissals, LEAD Maui clients have successfully achieved longer-term stability.

LEAD Maui staff believe the most critical component to successful program implementation is getting the client into a temporary shelter and eventually stable housing to reduce homelessness-related trauma and personal stress. Once housed, staff believes that clients become better equipped to participate in LEAD Maui case management services and their medical and court requirements. However, MHK staff believe that one of the current barriers to program success is the lack of short-term or stabilization bed space and shelter. However, costs for short-term sheltering can be prohibitive for agencies. As of September 2021, MHK sought to reestablish LEAD Maui shelter bed space to help offset this barrier.

LEAD Hawai'i Island

The LEAD pilot program on Hawai'i Island (LEAD Hawai'i Island) launched in January 2020. The nonprofit organization Big Island Substance Abuse Council (BISAC), whose mission is "inspiring individuals to reclaim and enrich their lives by utilizing innovative resources and harnessing the strengths within each person," was tasked with implementing LEAD Hawai'i Island. A goal of LEAD Hawai'i Island was to utilize a collaborative approach to finding clients through a community partnership network, which included Going Home Hawai'i (GHH), Bridge House (BH), and HOPE Services Hawai'i (HOPE). Partner organizations coordinated with LEAD Hawai'i Island to schedule Hawaiʻi Police Department (HPD) monthly accompaniment, wherein LEAD Hawai'i Island, GHH, BH and HOPE worked with HPD to locate potential clients through social contact referrals.

Initially, LEAD Hawai'i Island collaborated with HPD by having its case managers accompany officers to locations where citations and law-breaking often occurred, intending to divert individuals into social services. HPD would hand off individuals they had cited to program staff to engage with the possible LEAD Hawai'i Island clients, begin the screening process, and conduct assessments. HPD assigned a case number to these individuals, which was later presented to the Prosecuting Attorney's office regarding whether or not to drop the pending citation based on client participation in the program. But, set criteria for decisions around pending LEAD Hawai'i Island client citations were never solidified. Also, HPD officers allegedly felt burdened by their engagement, leaving LEAD Hawai'i Island staff trying to get officer buy-in.

LEAD Hawai'i Island kept an open line of communication with its community partners by conducting monthly team meetings to discuss clients. These monthly meetings allowed the Prosecuting Attorney's office to stay updated with each client and their progress through their service engagements. Also, key stakeholders were allowed to check in and ask questions.

In March 2020, the COVID-19 pandemic exacerbated challenges for LEAD Hawai'i Island. According to BISAC, once the pandemic began, HPD lost interest in LEAD Hawai'i Island and shifted its focus to the Mayor's COVID mitigation strategies. HPD moved to concentrate primarily on the community's safety, and the Prosecutor's Office was working remotely due to closed courts. Ultimately, LEAD Hawai'i Island was forced to cease operations.

However, clients enrolled in LEAD Hawai'i Island at the time of the program shutdown were placed in transitional housing and given access to services. For BISAC to resume LEAD Hawai'i Island, they need funding. If given a chance, BISAC staff think they would be able to reestablish the overall interest in LEAD Hawai'i Island that existed pre-COVID-19 pandemic and reinvigorate their collaboration with community partners, HPD, and the Prosecutor's Office. The Prosecutor's office worked with BISAC on another deferment program, but those referrals are not classified as LEAD Hawai'i Island referrals.

LEAD on the Neighboring Islands Summary

- LEAD Kaua'i, LEAD Maui, and LEAD Hawai'i Island are all struggling to reestablish and resume their programs since the COVID-19 pandemic arrived in Hawai'i. LEAD Maui has only managed to continue the program of these three LEAD factions.

- Dependable financial support is vital to any LEAD program for successful service provision.

- LEAD Kaua'i, LEAD Maui, and LEAD Hawai'i Island expressed concern about the dynamics of collaboration between themselves, law enforcement, and the Prosecutor's Office. A successful partnership between these three entities is crucial for successful program operations, such as client recruitment, case management, and referral to other service providers.

- It is encouraging that each program considers the program models that fit their different contextual issues. However, there is a grave need to focus on the sustainability of the LEAD programs on the neighboring islands.

IV. LEAD Honolulu Program Implementation

The University of Hawaiʻi at Mānoa LEAD Program Evaluation Report Team monitored LEAD Honolulu (LEAD HNL) program implementation and client and community-level outcomes for the program's first four years. Data sources included archival data, field notes from case management and other LEAD-related meetings, and interviews with case managers and clients. This section focuses on program implementation – eligibility, referral, intake, enrollment, and service provision processes.

Eligibility Criteria

Intensive Case Management

Individuals referred to LEAD HNL for intensive case management (ICM) must meet specific eligibility criteria. First, the individual must be an Oʻahu resident or spend most of their time on Oʻahu.[6] Second, the individual must be an adult (18 years or older).[6] Third, at the discretion of other operational agencies (OAs) that have an active Memorandum of Understanding (MOU) with HHHRC, the individual may only be diverted from law enforcement if suspected of the following offenses:

- Camping in the park
- Criminal trespass
- Criminal littering
- Entering a closed public park
- Failure to obey signage
- Intoxicating liquor in a public area
- Jaywalking (other than crosswalk)
- Obstructing sidewalk
- Open container
- Park rules and regulations
- Prohibited acts related to drug paraphernalia
- Prohibition in public areas
- Prohibition of smoking
- Promoting a detrimental drug in the 2nd degree
- Promoting a detrimental drug in the 3rd degree
- Simple trespass
- Sitting or lying on public sidewalks or public malls
- Smoking signs violation
- Structures on public sidewalks ordinance
- Tent in a public park
- Urination and defecation bans
- Use of intoxicating liquors in certain public places.[6]

Community Triage

Individuals referred to LEAD HNL who are either not interested or eligible for ICM may be offered community triage services instead, which include, but are not limited to: Transportation to shelter, application for financial assistance, referral to healthcare or application for health insurance, connection to wound care, and reconnection to an established service provider.[6] To make a community triage referral, the law enforcement, judiciary, or community provider must email the LEAD Program Manager the following information:

- Requested triage service;
- Individual's last known location;
- Individual's photo (if available); and
- Individual's contact information (if available).[6]

Community triage services should occur within 30 days of LEAD HNL staff's contact with the individual. LEAD Program Manager may consider an exception if referral services do not occur within 30 days. The triage case will be closed if no exception is made for service escalation.

Referral Classification

If eligible, individuals referred to LEAD HNL for intensive case management (ICM) are classified by program staff as a diversion or social contact referral.

Diversion

A referral is classified as a diversion if all of the following criteria are met:

- Performed by a LEAD-trained official (LTO) on behalf of an operational agency (OAs) that has an active Memorandum of Understanding (MOU) with HHHRC;
- Occurs during diversion hours;
- Takes place in the project area defined by OA's MOU;
- Referred individual is suspected of committing an eligible criminal offense that could result in citation or arrest;
- LTO verifies that referred individual can engage with program staff without presenting a credible threat to public safety; and
- LTO has not contacted law enforcement to investigate.

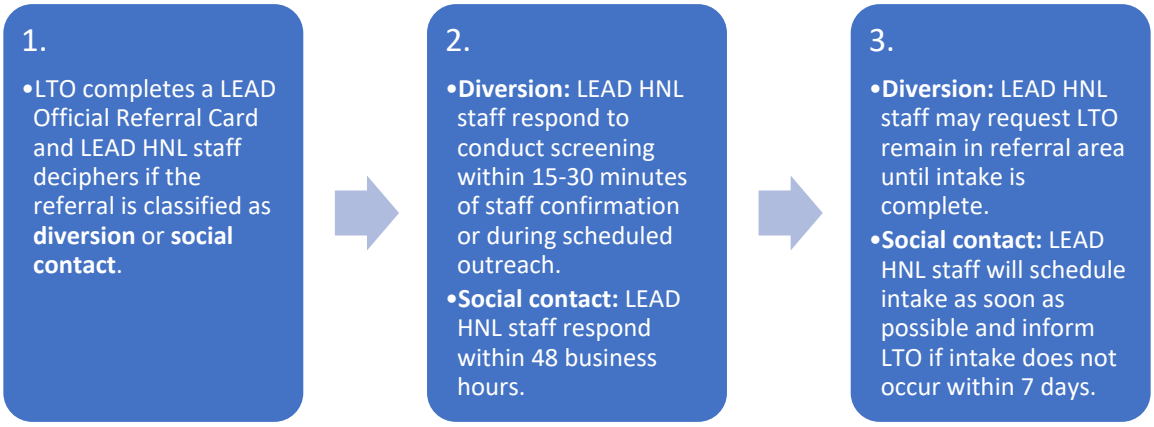
Social Contact

A referral is classified as a social contact if all of the following criteria are met:

- Performed by LTO on behalf of OA that has MOU with HHHRC outside of diversion hours;
- Referral comes from a stakeholder not covered under LEAD HNL MOU;
- Referral is verified as having "chaotic substance use":
    - **Chaotic substance use** refers to (a) any diagnosed history of Substance Use Disorder (SUD) from a licensed provider and/or (b) any use of narcotics, stimulants, alcohol, or other illicit substance in a public area.
    - **Verification** may include but is not limited to (a) police reports, arrests, jail bookings, criminal charges, or convictions indicating that the individual was engaged in chaotic substance use; (b) documented observation of the individual's chaotic substance use; and (c) reasonable suspicion that the individual is at-risk for chaotic substance use based on documented history.
- Referral has been submitted to the program staff with the following:
    - Individual's last known location;
    - Social contact eligibility verification;
    - Individual's photo (if available); and
    - Individual's contact information (if available).[6]

Intake Procedure

Once eligibility is determined, the intake procedure is as follows:



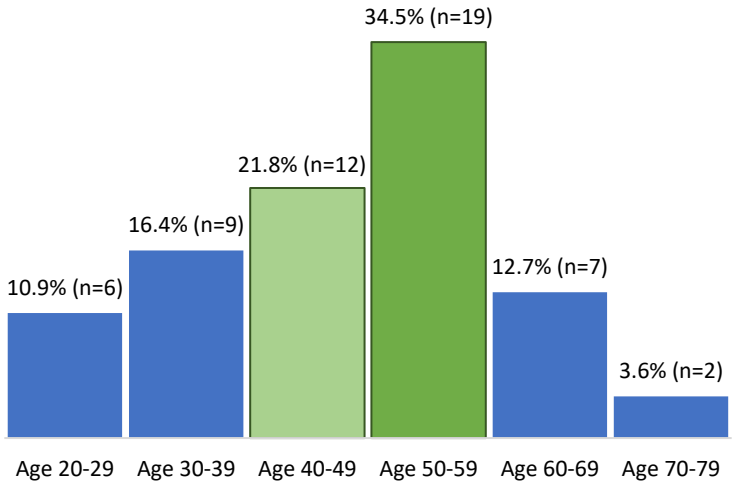
Enrollment

Once eligibility and referral criteria are met, along with screening, completing an intake – Long Intake and Needs Assessment (LINA) – with a LEAD HNL case manager is the final requirement for enrolling in the LEAD HNL. Case managers support clients in various ways, including regular intensive follow-ups, ad-hoc phone calls, assisting with client scheduling and care coordination meetings, and other intensive avenues to help their clients. **As of July 2022, there were 58 clients enrolled in LEAD HNL.** At the time of analysis, data was missing or incomplete for three (3) clients, two (2) of whom have died since their enrollment in the program. Therefore, data is available for 55 out of 58 enrolled clients. To paint a picture of LEAD HNL clientele, demographic and descriptive data from LINAs will be described next.

Demographic Data

Age. Age data was available for 100% of LEAD HNL clients (N=55). **The average age of LEAD HNL clients at enrollment was 55 years, ranging from 21 to 75. The majority were 40-59 years (n=31).** When separated into age groups, 10.9% (n=6) were 20-29 years, 16.4% (n=9) were 30-39 years, 21.8% (n=12) were 40-49 years, 34.5% (n=19) were 50-59 years, 12.7% (n=7) were 60-69 years, and 3.6% (n=2) were 70-79 years. See Figure 1.

Figure 1. No. of LEAD HNL Clients within Age Range (Years) (N=55)



Gender. Data was available for 100% (N=55) of LEAD HNL clients. **An equal amount of LEAD HNL clients identified as male (43.6%; n=24) and female (43.6%; n=24) compared to 12.7% (n=7) as transgender.** Of note, the 12.7% of transgender LEAD HNL clients is a notable overrepresentation compared to the estimated 0.6% of the Hawai'i population that identifies as transgender.[7]

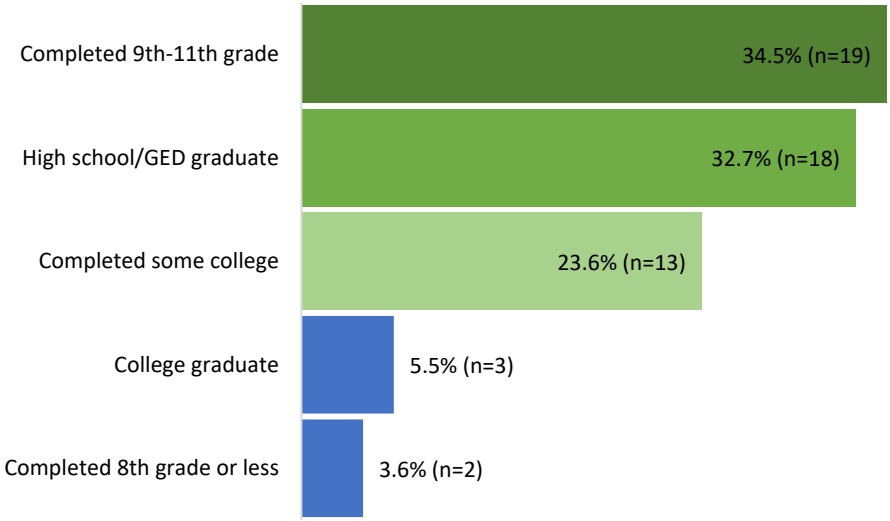
Birthplace. Data was available for 100% (N=55) of enrolled LEAD HNL clients. **About half of LEAD HNL clients were born in Hawai'i (49.1%; n=21) compared to slightly above half who were not (50.9%; n=28).**

Country of origin. Data was available for 100% (N=55) of enrolled LEAD HNL clients. **Most LEAD HNL clients originated in the United States of America (85.5%; n=47).** The remainder originated in United States territories (7.3%; n=4), Asia (3.6%; n=2), Australia (1.8%; n=1), and Europe (1.8%; n=1).

Marital status. Data was available for 100% (N=55) of enrolled LEAD HNL clients. **Over half of LEAD HNL clients reported being single/never married (52.7%; n=29) compared to 20% (n=11) who reported being divorced and 18.2% (n=10) who reported being separated.** The least amount of LEAD HNL clients reported being widowed (5.5%; n=3) and married (3.6%; n=2).

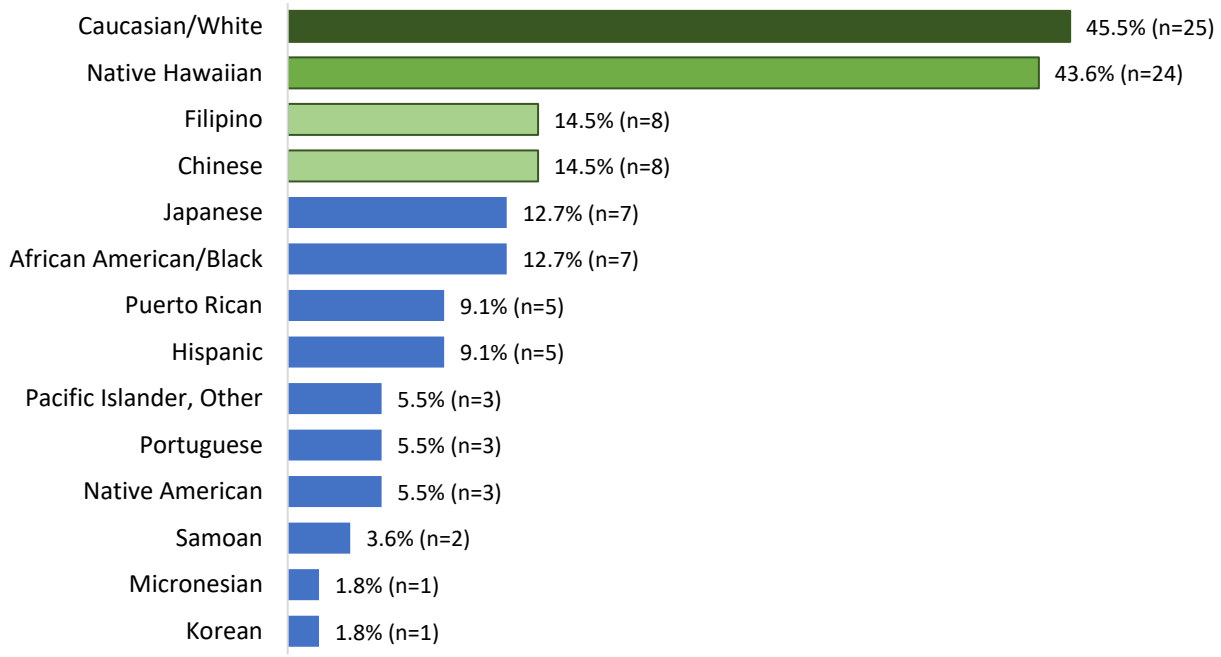
Education level. Data was available for 100% (N=55) of enrolled LEAD HNL clients. **Over a third of LEAD HNL clients completed 9th-11th grade (34.5%; n=19) or were high school/GED graduates (32.7%; n=18) compared to just under a quarter that completed some college (23.6%; n=13).** For a more detailed breakdown, see Figure 2.

Figure 2. No. of LEAD HNL Client Education Level (N=55)



Ethnicity. This report uses the Hawai'i Department of Health (HDOH) methodology for reporting Native Hawaiians, wherein any person who reports possessing Native Hawaiian ancestry is registered as Native Hawaiian. Data was available for 100% (N=55) of LEAD HNL clients. Also, clients were instructed to select all ethnicities that applied to them. **The three most reported ethnicities by LEAD HNL clients were: Caucasian/White (45.5%; n=25) and Native Hawaiian (43.6%; n=24), with Chinese (14.5%; n=8) and Filipino (14.5%; n=8) tied for third.** For a more detailed breakdown, see Figure 3.

Figure 3. Frequency & No. of LEAD HNL Client Ethnicity (N=55)



Descriptive Data – Housing Status

Experienced homelessness in the past three years. Data was available for 100% (N=55) of LEAD HNL clients. **The vast majority of LEAD HNL clients reported that they were currently experiencing homelessness (80%; n=44) during intake compared to 20% (n=11) who had experienced homelessness in the past three years but were not currently homeless.**

Times experienced homelessness in the past three years. Data was available for 82% (N=45) of LEAD HNL clients. **Cumulatively, those 45 participants reported experiencing homelessness 115 times in the past three years, ranging from as little as one (1) time to as much as 20 times in the past three years, averaging three (3) times per participant.** In terms of frequency, most participants experienced homelessness one (1) time in the past three years (57.8%; n=26) compared to the least who experienced homelessness three (3) (2.2%; n=1), eight (8) (2.2%; n=1), and 20 times (2.2%; n=1) in the past three years. For more information, see Table 1 (p. 20).

Table 1. No. of Times, No. of Participants & Frequency of Participants Experiencing Homelessness in the Past Three Years (N=45)

No. of Times Experiencing Homelessness in the Past 3 Years	No. of Participants	% of Participants
1	26	57.8%
2	9	20.0%
3	1	2.2%
4	5	11.1%
8	1	2.2%
10	2	4.4%
20	1	2.2%

Reason that best explains experiencing homelessness. Data was available for 100% (N=55) of LEAD HNL clients. Clients were instructed to select all reasons that applied to them. **The three most reported reasons for experiencing homelessness were alcohol or drug use (61.8%; n=34), unable to pay rent or mortgage (32.7%; n=18), and loss of money or lack of funds (29.1%; n=16).** Some other notable reasons were family or domestic violence (25.5%; n=14), being released from jail/prison with nowhere to go (23.6%; n=13), an argument with family or friends (23.6%; n=13), mental illness (21.8%; n=12), and lost job (20%; n=11). For a complete breakdown, see Table 2.

Table 2. No. of Participants' and Frequency of Participants' Reason(s) for Experiencing Homelessness (N=55)

Participants' Reason(s) for Experiencing Homelessness	No. of Participants	% of Participants
***Alcohol or drug use	34	61.8%
Unable to pay rent or mortgage	18	32.7%
Loss of money or lack of funds	16	29.1%
Family or domestic violence	14	25.5%
Released from jail/prison with nowhere to go	13	23.6%
Argument with family or friends	13	23.6%
Mental illness	12	21.8%
Lost job	11	20.0%
Disabled	8	14.5%
Left a substance use treatment program & had nowhere to go	7	12.7%
Divorce	7	12.7%
Death in the family or of a loved one	6	10.9%
Illness or medical problem	4	7.3%
Released from the hospital with nowhere to go	4	7.3%
Loss of public housing or Section 8 voucher	2	3.6%
Evicted from a foreclosed rental property	2	3.6%
Relocation or transition from another state	2	3.6%
Loss due to foreclosure	1	1.8%
Loss of housing due to non-economic reasons (house fire, etc.)	1	1.8%
SSI or SSD cutoff or benefits canceled	1	1.8%

*****KEY FINDING: The majority of enrolled LEAD HNL participants (61.8%) reported that "alcohol or drug use" was a reason for experiencing homelessness. This is a much higher percentage than found in the 2022 Honolulu Point-in-Time Report, which reported 19% (pg. 21).**
(Link to Honolulu Point-in-Time Report: https://www.partnersincareoahu.org/pit-reports).

*****EXPLORATORY SOLUTION: Managed Alcohol Programs (MAPs)**[8]

"Managed Alcohol Programs (MAPs) are integrated harm reduction interventions for individuals living with alcohol dependence, chronic poverty, and homelessness that focus on reducing harms through the provision of safer spaces and supply of alcohol. MAPs utilize a Housing First (HF) framework to provide accommodation, health, and social support and include the administration of beverage alcohol to stabilize drinking patterns…This low-threshold approach will reach many of those persons experiencing chronic homelessness who have been rejected by abstinence-based service programs and likely result in improvements in life circumstances and drinking behaviors. Hawai'i's systems of care will be able to more effectively respond to the ongoing behavioral health needs of those who have experienced chronic homelessness and lack of success in abstinence-based programs. Maintaining fidelity to the HF model and harm reduction principles is a cost-effective way to see a measurable reduction in harmful substance use."

[Lusk, H. M., Shaku, D., Hemrajani, A., Leverenz, N., Moefu-Kaleopa, J., & Staley, A. F. (2022). Housing First: Harm Reduction at the Intersection of Homelessness and Substance Use. *Hawai'i Journal of Health & Social Welfare, 81*.]

Place slept in the last 30 days. Data was available for 100% (N=55) of LEAD HNL clients**. At intake, most LEAD HNL clients reported spending 20.26 (68%) out of the last 30 nights unsheltered (on the street/park/beach).** The average number of nights spent in an emergency or temporary/transitional shelter was 3.07 and 2.26, respectively. Lastly, the average nights sheltered in a shared or independent apartment were 0.98 and 0.47, respectively.

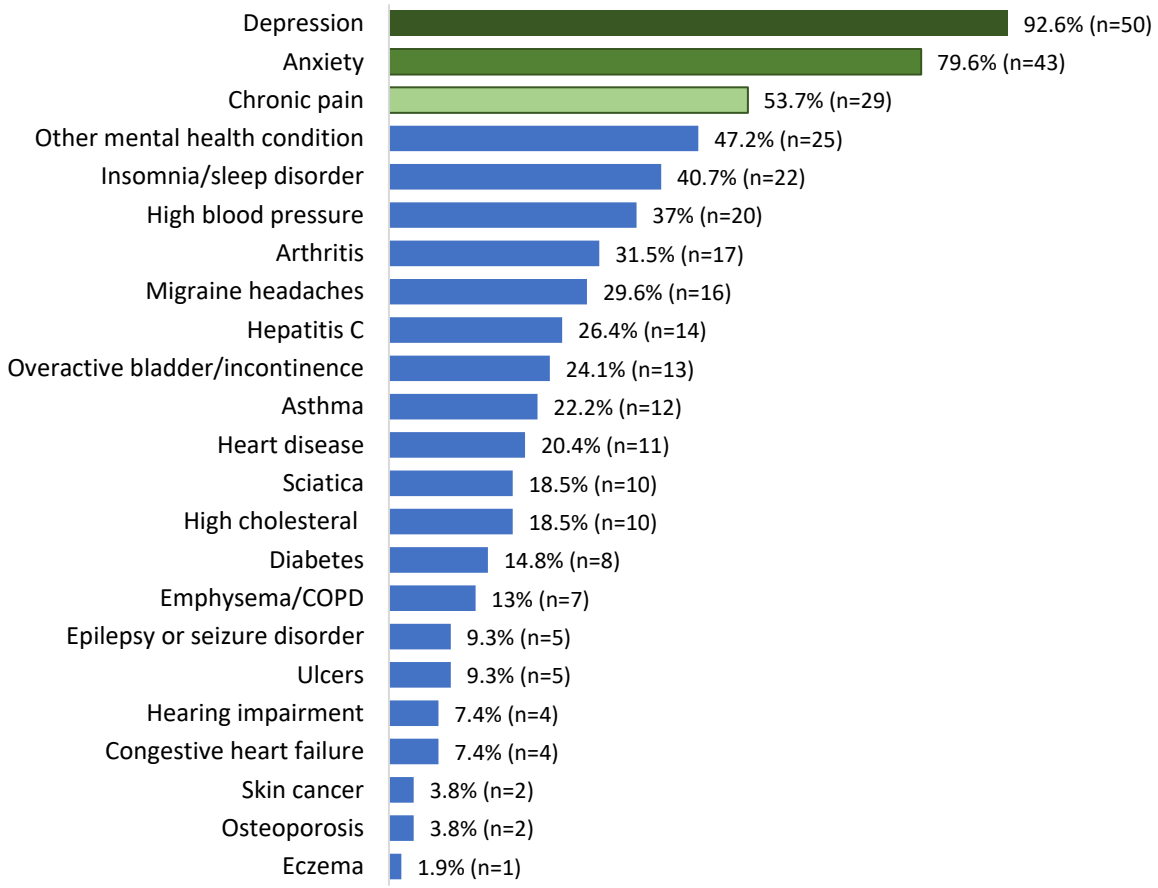
Place would most like to live. Data was available for 100% (N=55) of LEAD HNL clients. **The overwhelming majority of LEAD HNL clients reported that they would most like to live in an independent apartment (92.7%; n=51).** A small margin of clients reported that they would most like to live in a shared apartment (5.5%; n=3), and one (1) client reported that they would most like to live on the street/in a park/on the beach (1.8%; n=1).

Important to live close to. Data was available for 100% (N=55) of LEAD HNL clients. **The three most listed amenities that were important for LEAD HNL clients to live close to were public transportation (85.5%; n=47), shopping (43.6%; n=24), and friends/family (30.9%; n=17).** The three least-listed amenities that were important for LEAD HNL clients to live close to were the workplace (23.6%; n=13), religious groups (20%; n=11), and schools (9.1%; n=5).

Descriptive Data – Health

Medical diagnoses. At the time of intake, case managers ask LEAD HNL clients to report if they have ever been diagnosed with a medical condition using an exhaustive list of medical conditions for reference. LEAD HNL clients reported having 23 separate medical diagnoses from that comprehensive list of medical conditions. Also, clients were instructed to select all medical diagnoses that applied to them. Data was available for 97% (N=53.5) of LEAD HNL clients. **The three most reported medical diagnoses by LEAD HNL clients were depression (92.6%; n=50), anxiety (79.6%; n=43), and chronic pain (53.7%; n=29).** For a complete breakdown, see Figure 5 (p. 22).

Figure 5. Frequency & No. of LEAD HNL Clients with Medical Diagnoses (N=53.5)

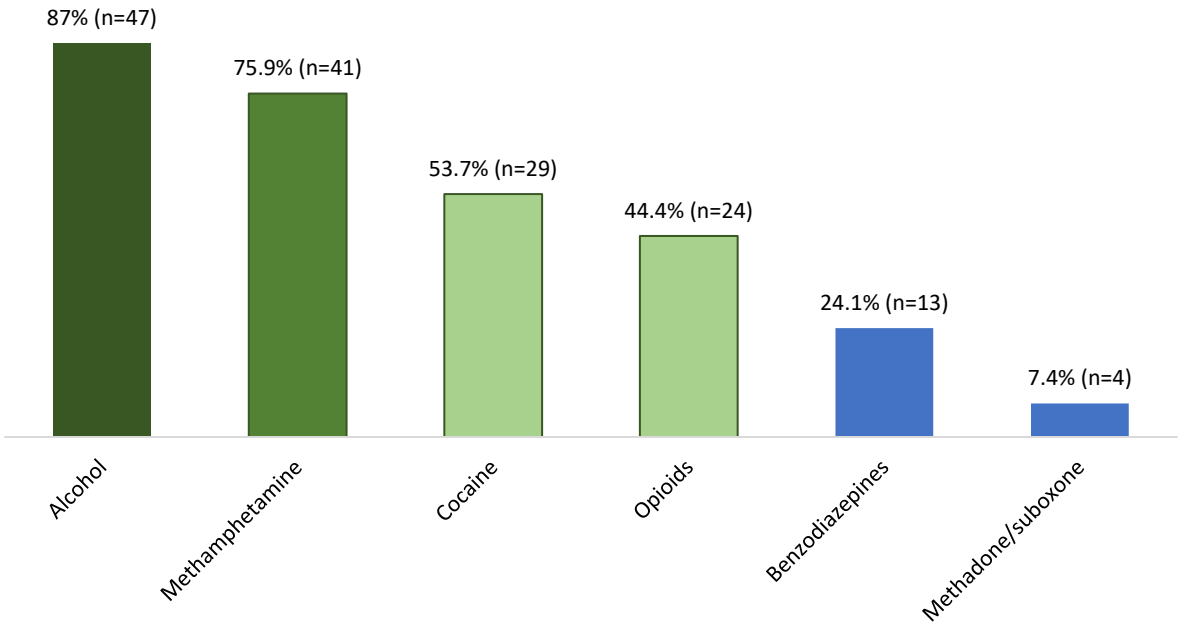


Since the arrival of the COVID-19 pandemic, health services have been critical, especially for vulnerable populations. Nationally, the frequency of depression and anxiety symptoms increased among adults after August 2020, peaking from December 2020 through January 2021.[8] The frequency of symptoms' decreased somewhat but remained elevated in June 2021 compared with estimates from the 2019 National Health Interview Survey (NHIS).[9] The increases and decreases in the symptoms of anxiety and depression at national and state levels mirrored the national weekly number of new COVID-19 cases during those periods.[9]

Descriptive Data – Substance Use

Substance used (ever). At the time of intake, case managers ask LEAD HNL clients to report if they have ever used certain substances. Data was available for 98% (N=54) of LEAD HNL clients. **The majority of LEAD HNL clients reported ever using alcohol (87%; n=47) and methamphetamine (75.9%; n=41), just over half reported ever using cocaine (53.7%; n=29), and just under half reported ever using opioids (44.4%; n=24).** The least amount of LEAD HNL clients reported ever using benzodiazepines (24.1%; n=13) and methadone/suboxone (7.4%; n=4), but significantly, some of those clients specified that those substances were administered in a treatment setting, which is why client use of those substances will not be explored beyond this point. See Figure 6.

Figure 6. Frequency & No. of LEAD HNL Clients who had Ever Used Substance(s) (N=54)



Service Engagement

After enrollment, LEAD HNL case managers provide intensive case management to help connect clients to needed services. **As of August 2022, about 52% (n=30) of enrolled clients (N=58) were actively engaged in LEAD case management services.** Of the 48% (n=28) of enrolled clients not actively engaged with the program, the reasoning might range from the client having received the services they required and no longer needing hands-on assistance to the case manager not being able to locate the client for an extended period. However, any enrolled LEAD client is still considered a LEAD client and can reengage with the program. Lastly, 7% (n=2) of the enrolled clients who were not actively engaged (n=28) were actively engaged up until they died.

Inactive Client Status: A client is "inactive" if they have not engaged with LEAD HNL case management services in 90 days.

Services Needed & Used Over Time

This section shows the services needed and used over time by LEAD HNL clients. Using a list of 15 services, LEAD HNL clients self-reported the types of services they still needed and had utilized at enrollment and during subsequent follow-ups. The data presented is extracted from (1) the Long Intake & Needs Assessment (LINA) – baseline for client service needs and utilization at the time of enrollment, and (2) the Follow-up Long Intake & Needs Assessment (F-LINA) – captures updated client service needs and utilization at various times after enrollment to track progress. Data was available for 100% (N=211) of LINAs (n=42) and F-LINAs (n=169).

Services Needed

Data was available for 100% of LINAs (n=42). **At enrollment, most LEAD HNL clients reported needing case management (90%; n=38), permanent housing (90%; n=38), transportation assistance (74%; n=31), ID assistance (69%; n=29), mental health services (69%; n=29), medical services (64%; n=27), clothes closet (62%; n=26), disability services (62%; n=26), and soup kitchen/food pantry (57%; n=24).** The least amount of LEAD HNL clients reported needing legal services (48%; n=20), day center (43%; n=18), job readiness/search (29%; n=12), temporary/transitional housing (24%; n=10), emergency shelter (24%; n=10), and substance use treatment (24%; n=10). See Figure 7 (p. 27).

Services Used

Data was available for 100% of LINAs (n=42). **At enrollment, most LEAD HNL clients reported having used soup kitchen/food pantry (62%; n=26) and medical services (50%; n=21).** The least amount of LEAD HNL clients reported having used emergency shelter (40%; n=17), transportation assistance (36%; n=15), clothes closet (36%; n=15), case management (33%; n=14), day center (29%; n=12), substance use treatment (26%; n=11), mental health services (24%; n=10), disability services (17%; n=7), ID assistance (14%; n=6), legal services (10%; n=4), temporary/transitional housing (10%; n=4), permanent housing (7%; n=3), and job readiness/search (0%; n=0). See Figure 8 (p. 27).

Figure 7. Frequency & of LEAD HNL Clients Reporting Services Needed Over Time

Services Needed (N=211)	Enrollment (n=42)	3 months (n=37)	6 months (n=27)	9 months (n=21)	12 months (n=16)	15 months (n=20)	18 months (n=16)	21 months (n=13)	24-30 months (n=8)	33-48 months (n=11)
Case management	90%	62%	41%	52%	56%	60%	50%	62%	38%	91%
Permanent Housing	90%	76%	78%	71%	69%	65%	56%	54%	63%	45%
Transportation assistance	74%	59%	52%	67%	75%	60%	44%	77%	38%	55%
ID assistance	69%	54%	37%	43%	25%	20%	31%	38%	50%	36%
Mental health services	69%	65%	44%	52%	56%	35%	63%	46%	50%	9%
Medical services	64%	65%	44%	62%	69%	60%	56%	62%	63%	36%
Clothes closet	62%	49%	52%	29%	69%	25%	25%	23%	0%	9%
Disability services	62%	46%	52%	57%	56%	35%	19%	31%	13%	0%
Soup kitchen/food pantry	57%	54%	52%	81%	88%	80%	69%	62%	25%	18%
Legal services	48%	35%	11%	38%	50%	25%	13%	8%	38%	27%
Day center	43%	27%	22%	48%	50%	30%	6%	46%	13%	0%
Job readiness/search	29%	16%	19%	10%	19%	15%	0%	8%	13%	0%
Temporary/transitional housing	24%	19%	26%	5%	6%	0%	0%	8%	13%	0%
Emergency shelter	24%	16%	7%	5%	6%	0%	0%	0%	0%	0%
Substance use treatment	24%	16%	7%	14%	25%	15%	31%	23%	25%	0%

Figure 8. Frequency & of LEAD HNL Clients Reporting Services Used Over Time

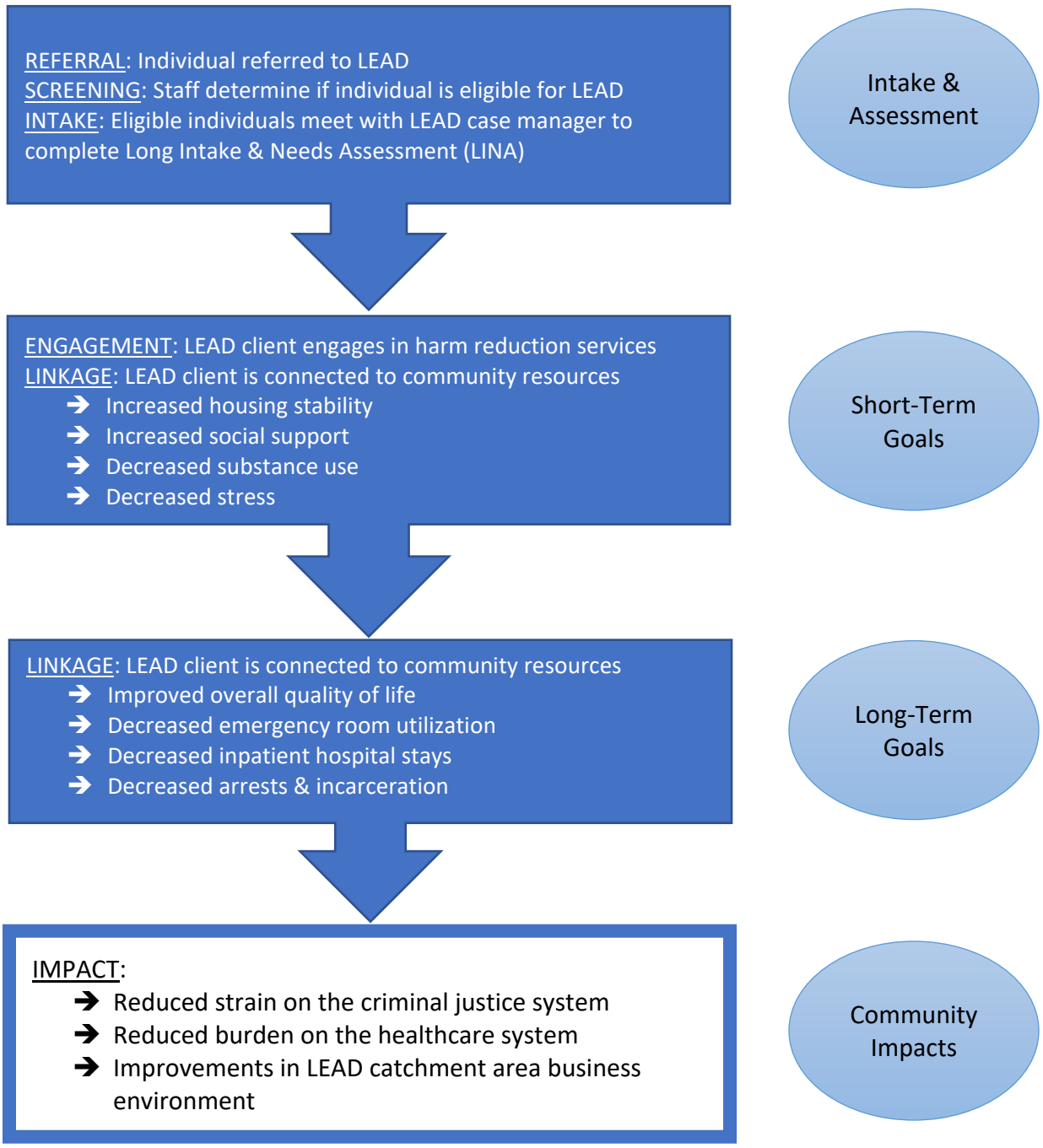
Services Used (N=211)	Enrollment (n=42)	3 months (n=37)	6 months (n=27)	9 months (n=21)	12 months (n=16)	15 months (n=20)	18 months (n=16)	21 months (n=13)	24-30 months (n=8)	33-48 months (n=11)
Case management	33%	78%	85%	90%	100%	100%	94%	92%	88%	100%
Permanent Housing	7%	22%	33%	38%	50%	30%	44%	46%	25%	64%
Transportation assistance	36%	59%	67%	71%	88%	70%	44%	62%	63%	64%
ID assistance	14%	38%	44%	33%	44%	35%	0%	8%	38%	36%
Mental health services	24%	38%	26%	48%	81%	50%	38%	15%	38%	9%
Medical services	50%	57%	67%	76%	81%	75%	69%	46%	63%	36%
Clothes closet	36%	54%	56%	29%	50%	25%	19%	38%	0%	0%
Disability services	17%	22%	41%	24%	44%	35%	19%	31%	13%	0%
Soup kitchen/food pantry	62%	57%	74%	67%	88%	90%	81%	77%	63%	27%
Legal services	10%	32%	19%	10%	31%	15%	6%	8%	50%	18%
Day center	29%	32%	41%	57%	63%	55%	19%	46%	38%	0%
Job readiness/search	0%	5%	7%	5%	0%	5%	0%	0%	0%	0%
Temporary/transitional housing	10%	24%	22%	10%	13%	20%	6%	8%	13%	0%
Emergency shelter	40%	35%	35%	33%	31%	30%	13%	8%	13%	0%
Substance use treatment	26%	22%	7%	10%	13%	15%	19%	15%	13%	0%

V. LEAD Honolulu Outcomes & Impacts

LEAD Theory of Change

In addition to examining the LEAD program process, the University of Hawai'i at Mānoa LEAD Program Evaluation Report Team assessed program outcomes and impacts based on the goals identified in the LEAD Theory of Change model (see Figure 9). This section considers the LEAD program's progress toward its short-term and long-term goals adhering to the harm reduction approach utilized by the LEAD program.

Figure 9. LEAD Theory of Change



What is a "harm reduction" approach?

The harm reduction approach seeks 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.[10]

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

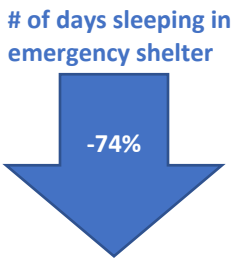
Short-Term Goals

The short-term goals of LEAD HNL are for clients to experience increased housing stability, increased social support, decreased substance use, and reduced stress through engagement with the LEAD program and linkage to community services. After the initial intake (LINA), case managers aim to conduct a follow-up assessment (F-LINA) every three months. **Between intake and their most recent follow-up assessment, the time elapsed ranged from three (3) to 48 months, with an average of 14.5 months.**

Housing Stability

The University of Hawai'i at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL client housing status. This was accomplished by comparing the number of days lived in various locations in the past 30 days at the time of intake (LINA) and most recent follow-up assessment (F-LINA). **Intake (LINA) data was available for 95% (n=55) of 58 LEAD HNL clients, and follow-up (F-LINA) data from 181 F-LINAs was also available for those 55 clients.**

Days spent sleeping outdoors. At intake, the average number of days LEAD HNL clients spent the night outdoors was 20.26 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 8.66. Therefore, **LEAD HNL clients experienced a 57% decrease in days spent sleeping outdoors from intake to most recent follow-up.**



Days spent sleeping in an emergency shelter. At intake, the average number of days LEAD HNL clients spent the night in an emergency shelter was 3.07 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 0.8. Therefore, **LEAD HNL clients experienced a 74% decrease in days spent sleeping in an emergency shelter from intake to most recent follow-up.**

Days spent sleeping in a shared apartment. At intake, the average number of days LEAD HNL clients spent the night in a shared apartment was 0.98 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 2.39. Therefore, **LEAD HNL clients experienced an increase from less than one day spent sleeping in an independent apartment at intake to 2.39 days at most recent follow-up.**

Days spent sleeping in an independent apartment. At intake, the average number of days LEAD HNL clients spent the night in an independent apartment was 0.47 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 14.59. Therefore, **LEAD HNL clients, on average, experienced a dramatic increase in days spent sleeping in an independent apartment from intake (close to zero days) to most recent follow-up (almost 15 days).**

Mini-qualitative analysis. This analysis on housing placement and retention was conducted in addition to the above measures designed to quantify housing stability. The mini-analysis of case manager encounter notes was conducted for the period beginning January 1 and ending December 31, 2021.

Housing placement and retention – enrolled clients. Data was available for 35 enrolled LEAD HNL clients. This analysis revealed that out of 35 LEAD HNL clients enrolled in intensive case management (ICM), 57% (n=20) were able to sustain housing. Of the 20 LEAD clients who sustained housing, 20% (n=7) were housed between January 1 and December 31, 2021, and 65% were housed before January 1, 2021.

Housing placement and retention – triage. Data was available for 21 individuals triaged through LEAD HNL. This analysis revealed that out of 21 individuals triaged through LEAD HNL, 19% (n=4) could sustain housing. Of the 4 LEAD clients who sustained housing, 100% (n=4) were housed between January 1 and December 31, 2021.

These findings suggest that LEAD HNL clients are experiencing increased housing stability as evidenced by spending less time sleeping outdoors (street/park/beach) and more time in emergency shelters and shared or independent apartments since enrolling in the LEAD program. Increased housing stability is also evidenced by high rates of housing placement and retention of both LEAD HNL clients (57%) and individuals triaged through LEAD (100%).

Social Support

The University of Hawai‘i at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL social support status. This was accomplished by analyzing responses to questions designed to gauge clients' social support systems at the time of intake (LINA) and their most recent follow-up assessment (F-LINA).

Number of close friends and relatives. At intake, the average number of close friends and relatives LEAD HNL clients estimated they had was 4.98. In comparison, at the time of their most recent follow-up assessment, the average was 5.07. Therefore, **LEAD HNL clients experienced a 2% increase in the number of close friends and relatives they felt they had from intake to most recent follow-up.**

Someone to help if confined to bed. At intake, the average number corresponding to LEAD HNL clients' feeling they had someone to help them if confined to bed was 2.64 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 2.82. Therefore, **LEAD HNL clients experienced a 7% increase in feeling they had someone to help them from intake to most recent follow-up.**

Someone to give a ride to the doctor. At intake, the average number corresponding to LEAD HNL clients' feeling they had someone to take them to the doctor if needed was 2.8 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.11. Therefore, **LEAD HNL clients experienced an 11% increase in feeling they had someone to take them to the doctor if they needed it from intake to most recent follow-up.**

Someone to share worries and fears with. At intake, the average number corresponding to LEAD HNL clients' feeling they had someone to share their most private worries and fears with was 2.84 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.11. Therefore, **LEAD HNL clients experienced a 10% increase in feeling they had someone to share their most private worries and fears with from intake to most recent follow-up.**

Someone to turn to for suggestions. At intake, the average number corresponding to LEAD HNL clients' feeling they had someone to turn to for advice about how to deal with a personal problem was 2.95 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.29. Therefore, **LEAD HNL clients experienced a 12% increase in feeling they had someone to turn to for suggestions on how to deal with a personal problem from intake to most recent follow-up.**

Someone to do something enjoyable with. At intake, the average number corresponding to LEAD HNL clients' feeling they had someone to do something enjoyable with was 2.8 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.14. Therefore, **LEAD HNL clients experienced a 12% increase in feeling they had someone to do something fun with from intake to most recent follow-up.**

Someone to love and make feel wanted. At intake, the average number corresponding to LEAD HNL clients' feeling they had someone to love and make them feel wanted was 2.8 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.02. Therefore, **LEAD HNL clients experienced an 8% increase in feeling they had someone to love and make them feel wanted from intake to most recent follow-up.**

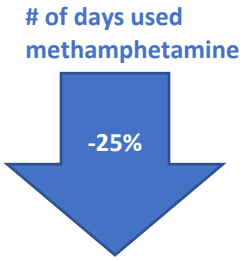
These findings suggest that LEAD HNL clients felt nominal improvements (7-12%) in their sense of social support as evidenced by increases in feeling they have someone to help them if confined to bed, take them to the doctor, share their worries/fears with, turn to for suggestions, do something enjoyable with and make them feel loved and wanted since enrolling in the LEAD program. However, there was only a 2% increase in the number of friends and relatives they felt they had.

Substance Use

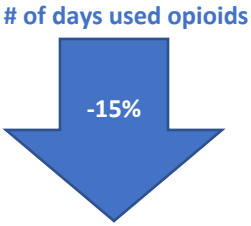
The University of Hawai‘i at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL substance use. This was accomplished by analyzing responses to questions designed to gauge clients' substance use in the past 30 days at the time of intake (LINA) and their most recent follow-up assessment (F-LINA).

Days used alcohol. At intake, the average number of days LEAD HNL clients used alcohol was 6.19 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 8.46. Therefore, **LEAD HNL clients experienced a 37% increase in the number of days using alcohol from intake to most recent follow-up.**

Days used methamphetamine. At intake, the average number of days LEAD HNL clients used methamphetamine was 17.97 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 13.45. Therefore, **LEAD HNL clients experienced a 25% decrease in the number of days using methamphetamine from intake to most recent follow-up.**



Days used cocaine. At intake, the average number of days LEAD HNL clients used cocaine (including crack cocaine) was 1.83 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average number was 2.27. Therefore, **LEAD HNL clients experienced a 24% increase in the number of days using cocaine from intake to most recent follow-up.**



Days used opioids. At intake, the average number of days LEAD HNL clients used opioids was 12.9 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 10.95. Therefore, **LEAD HNL clients experienced a 15% decrease in the number of days using opioids from intake to most recent follow-up.**

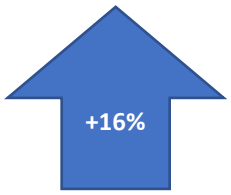
Days used benzodiazepines. At intake, the average number of days LEAD HNL clients used benzodiazepines was 3.82 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 3.33. Therefore, **LEAD HNL clients experienced a 13% decrease in the number of days using benzodiazepines from intake to their most recent follow-up.**

Findings suggest that LEAD HNL clients are decreasing some of their substance use as evidenced by spending less time using methamphetamine, opioids, and benzodiazepines since enrolling in the LEAD program. However, LEAD HNL clients are spending more time using alcohol and cocaine since enrolling in the LEAD program.

Stress

The University of Hawai‘i at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL substance use. This was accomplished by analyzing responses to questions designed to gauge clients' stress during intake (LINA) and their most recent follow-up assessment (F-LINA).

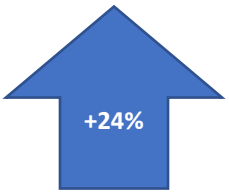
Felt unable to control important things in life. At intake, the average number corresponding to LEAD HNL clients' inability to control the important things in their lives was 3.58 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.14. Therefore, **LEAD HNL clients experienced a 12% decrease in feeling unable to control the important things in their lives from intake to most recent follow-up.**



felt confident handling personal problems

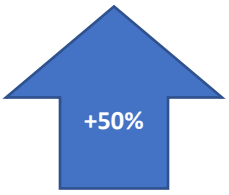
Felt confident handling personal problems. At intake, the average number corresponding to LEAD HNL clients' feeling confident about their abilities to manage their personal issues was 3.18 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.68. Therefore, **LEAD HNL clients experienced a 16% increase in confidence in their ability to handle personal problems from intake to most recent follow-up.**

Felt things were working out. At intake, the average number corresponding to LEAD HNL clients' feeling that things were going their way was 2.59 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.2. Therefore, **LEAD HNL clients experienced a 24% increase in feeling things were going their way from intake to most recent follow-up.**



felt things were going your way

Felt things were piling up too high to overcome. At intake, the average number corresponding to LEAD HNL clients' feeling that things were piling up so high that they could not overcome them was 3.34 on a scale of 1 (never) to 5 (very often). In comparison, at the time of their most recent follow-up assessment, the average was 3.23. Therefore, **LEAD HNL clients experienced a 3% decrease in feeling that things were piling up so high that they could not overcome them from intake to most recent follow-up.**



# of days hopeful about the future

Felt hopeful about the future. At intake, the average number of days LEAD HNL clients felt optimistic about the future was 10.93 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 16.36. Therefore, **LEAD HNL clients experienced a 50% increase in the days they felt hopeful about the future from intake to most recent follow-up.**

Findings suggest that LEAD HNL clients are experiencing decreased levels of stress as evidenced by spending less time feeling out of control in their lives and that things were piling up too high, and more time feeling confident about their abilities to handle problems, that things were going their way, and more days hopeful about the future since enrolling in the LEAD program.

Long-Term Goals

The long-term goals of LEAD HNL are for clients to have decreased emergency room utilization and inpatient hospital stays, decreased arrests and incarceration, and improved overall quality of life through continued engagement with the LEAD program and linkage to community services. After the initial intake (LINA), case managers aim to conduct a follow-up assessment (F-LINA) every three months. Between intake and their most recent follow-up assessment, the time elapsed ranged from three (3) to 48 months, with an average of 14.5 months.

Emergency Room Utilization & Inpatient Hospital Stays

The University of Hawaiʻi at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL emergency room visits and inpatient hospital stays. This was accomplished by analyzing how often LEAD HNL clients reported going to the emergency room and being admitted/staying overnight at the hospital in the past 30 days at the time of intake (LINA) and their most recent follow-up assessment (F-LINA).

Gone to the emergency room. At intake, the proportion of available data on LEAD HNL clients who reported whether or not they went to the emergency room in the last 30 days (N=44) was 27% (n=12). In comparison, at the time of their most recent follow-up assessment (N=43), the proportion was 12% (n=5). Therefore, **LEAD HNL clients experienced a 15% decrease in emergency room visits from intake to most recent follow-up.**

Been admitted or stayed overnight at the hospital. At intake, the proportion of available data on LEAD HNL clients who reported whether or not they went to the emergency room in the last 30 days (N=43) was 7% (n=3). In comparison, at the time of their most recent follow-up assessment (N=43), the proportion was 5% (n=2). Therefore, **LEAD HNL clients experienced a 2% decrease in being admitted to or staying overnight at the hospital from intake to most recent follow-up.**

These findings suggest that LEAD HNL clients are decreasing time spent in the emergency room and being admitted to or staying overnight at the hospital since enrolling in the LEAD program.

Overall Quality of Life – Physical & Mental Health

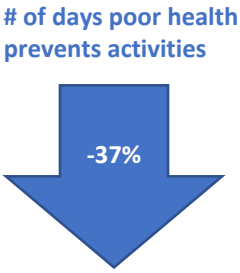
The University of Hawaiʻi at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL clients' physical and mental health status. This was accomplished by analyzing responses to questions designed to gauge perceived physical and mental health in the past 30 days at the time of intake (LINA) and their most recent follow-up assessment (F-LINA).

Overall physical health. At intake, the average number of days LEAD HNL clients felt that their physical health was not good was 13.49 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 13.59. Therefore, **LEAD HNL clients experienced a 1% increase in the days they felt their physical health was not good from intake to most recent follow-up.**

LEAD HNL clients' experienced almost no change in physical health, as evidenced by a 1% increase in days they felt their physical health was not good since enrolling in the LEAD program. Client physical health needs require more support and monitoring by LEAD HNL staff and community partners. At intake and most recent follow-up (n=13.49-13.59), LEAD HNL clients experienced significantly more physically unhealthy days out of the past 30 days than the state average of 2.56 and the national average of 3.54.[11]

Overall mental health. At intake, the average number of days LEAD HNL clients felt that their mental health was not good was 23.27 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 14.93. Therefore, **LEAD HNL clients experienced a 36% decrease in the days they felt their mental health was not good from intake to most recent follow-up.**

LEAD HNL clients' experienced improved mental health as evidenced by a 36% reduction in mentally unhealthy days since enrolling in the LEAD program. Despite this reduction, mental health needs require more support and monitoring. At intake, LEAD HNL clients experienced significantly more mentally unhealthy days in the past 30 days (n=23.7) than the state (n=3.5) and national (n=4.64) averages.[11] At follow-up, LEAD HNL clients still experienced more mentally unhealthy days in the past 30 days (n=14.93) than the national and state averages.[11]



Poor health preventing usual activities. At intake, the average number of days LEAD HNL clients felt poor physical and mental health prevented them from their regular activities was 17.89 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 11.3. Therefore, **LEAD HNL clients experienced a 37% decrease in the days they felt that poor physical and mental health prevented them from their usual activities from intake to most recent follow-up.**

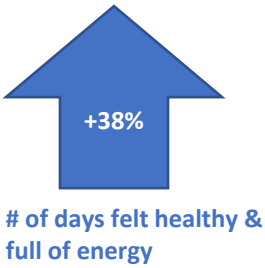
Pain preventing usual activities. At intake, the average number of days LEAD HNL clients felt pain that made it hard to do their regular activities was 13.98 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 12.37. Therefore, **LEAD HNL clients experienced a 12% decrease in the days that pain made it hard to do their usual activities from intake to most recent follow-up.**

Felt sad, blue, or depressed. At intake, the average number of days LEAD HNL clients felt sad, blue, depressed was 21.41 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 16.7. Therefore, **LEAD HNL clients experienced a 22% decrease in days feeling sad, blue, and depressed from intake to most recent follow-up.**

Felt worried, tense, or anxious. At intake, the average number of days LEAD HNL clients felt worried, tense, or anxious was 23.39 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 16.52. Therefore, **LEAD HNL clients experienced a 29% decrease in the days they felt worried, tense, or anxious from intake to their most recent follow-up.**

Felt did not get enough rest/sleep. At intake, the average number of days LEAD HNL clients felt they did not get enough rest/sleep was 19.84 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 13.98. Therefore, **LEAD HNL clients experienced a 30% decrease in the days they felt they did not get enough rest/sleep from intake to most recent follow-up.**

Felt healthy and full of energy. At intake, the average number of days LEAD HNL clients felt healthy and full of energy was 8.28 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 11.42. Therefore, **LEAD HNL clients experienced a 38% increase in the days they were healthy and full of energy from intake to most recent follow-up.**



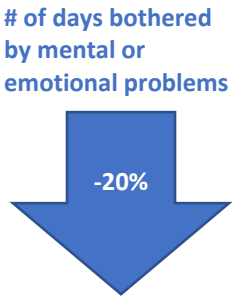
LEAD HNL clients experienced improved overall quality of life as evidenced by reporting fewer days where physical/mental health/pain prevented them from doing their usual activities, felt sad, blue, depressed, worried, tense, anxious, and were not getting enough rest since enrolling in the LEAD program. Also, LEAD HNL clients reported feeling healthier and energized more days since enrolling in LEAD.

Overall Quality of Life – Risk & Trauma

The University of Hawai‘i at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL client housing status. This was accomplished by analyzing responses to questions about the number of days clients experienced risk and trauma out of the past 30 days at the time of intake (LINA) and their most recent follow-up assessment (F-LINA).

Engaged in unprotected or high-risk sexual activity. At intake, the average number of days LEAD HNL clients engaged in unprotected or high-risk sexual activity was 1.86 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was

1.63. Therefore, **LEAD HNL clients experienced a 12% decrease in the days they engaged in unprotected or high-risk sexual activity from intake to most recent follow-up.**



Bothered by mental or emotional problems. At intake, the average number of days LEAD HNL clients were bothered by mental health or emotional issues causing them to reduce or give up essential activities was 3.73 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 3. Therefore, **LEAD HNL clients experienced a 20% decrease in the days they felt bothered by mental health or emotional problems, causing them to reduce or give up essential activities from intake to most recent follow-up.**

Difficulty sleeping. At intake, the average number of days LEAD HNL clients had difficulty sleeping most nights due to anxiety, bad dreams, or feeling something terrible might happen was 3.73 out of the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 2.8. Therefore, **LEAD HNL clients experienced a 25% decrease in days they had difficulty sleeping most nights due to anxiety, bad dreams, or feeling like something terrible might happen from intake to most recent follow-up.**

Experienced violence, trauma, sexual maltreatment/assault. At intake, the average number of days LEAD HNL experienced violence, trauma, and sexual maltreatment/assault was 2.64 in the past 30 days. In comparison, at the time of their most recent follow-up assessment, the average was 2.09. Therefore, **LEAD HNL clients experienced a 21% decrease in the days they experienced violence, trauma, or sexual maltreatment/assault from intake to most recent follow-up.**

LEAD HNL clients are experiencing an improved overall quality of life as evidenced by reporting fewer days engaging in unprotected or high-risk sexual activity, being bothered by mental health or emotional problems, having difficulty sleeping most nights, and experiencing violence, trauma, and sexual maltreatment/assault since enrolling in the LEAD program.

Arrests & Incarceration

The University of Hawai‘i at Mānoa LEAD Program Evaluation Report Team evaluated changes in LEAD HNL client arrests and incarceration by looking at client encounters with law enforcement. This was accomplished by analyzing citation data from publicly available eCourt* Kokua records. Between the beginning of 2015 and the end of 2021, 1,332 citations were available for analysis. Citation data was available for 41 out of 58 LEAD HNL clients. Some reasons for not having citation data available for all 58 clients include clients not having citations and evaluators not being able to definitively match LEAD HNL client names to eCourt* Kokua records.

Figure 10. Client Citation Categories & Sub-categories

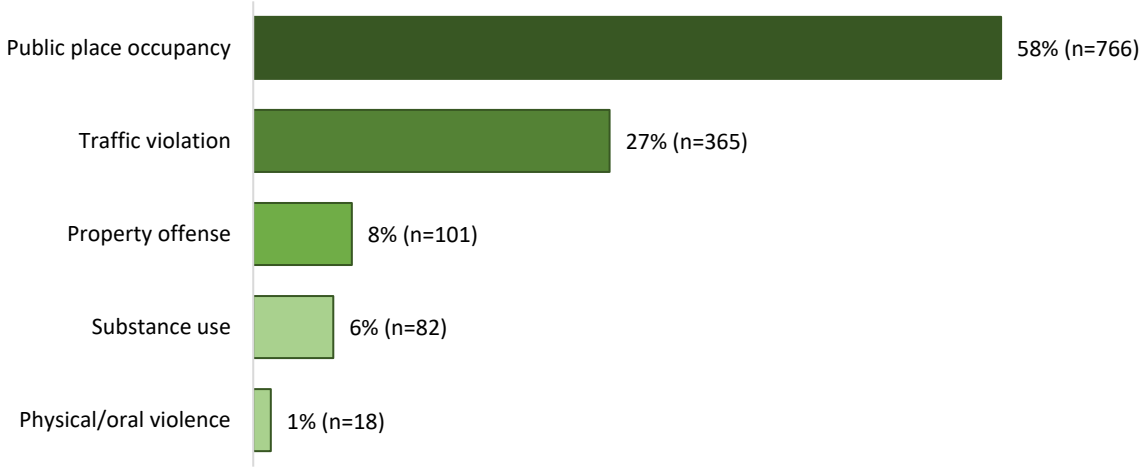
Category	Sub-category
Public Place Occupancy	Improper residence
	Sit/lie
Traffic Violation	Pedestrian
	Safety
	License/plates
	Delinquent tax
	Vehicle maintenance
	Parking
	Traffic fraud
Property Offense	Trespassing
	Theft
	Littering
Substance Use	-
Physical/Oral Violence	-

General citations analysis. This analysis provides an overview of LEAD HNL client citations by analyzing eCourt* Kokua records citation codes, which are based on Hawai'i Revised Statutes and Revised Ordinances of Honolulu. For analysis, client citations were grouped into five categories:

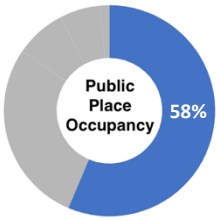
1. Public place occupancy;
2. Traffic violation;
3. Property offense;
4. Substance use; and
5. Physical/oral violence.

The most frequently cited categories were public place occupancy, traffic violation, and offenses against property. These three groups have been assigned sub-categories. Refer to Figure 10. From the beginning of 2015 to the end of 2021, LEAD HNL client citation data was available for 1,332 citations. **Public place occupancy and traffic violations account for 85% of client citation data in that most LEAD HNL clients had citations that fell into the category of public place occupancy (58%; n=766), and just over a quarter fell into the category of traffic violation (27%; n=365).** In comparison, the least number of clients had citations that fell into the categories of property offense (8%; n=101), substance use (6%; n=82), and physical/oral violence (1%; n=18). See Figure 11.

Figure 11. Frequency & No. of LEAD HNL Clients who had Citations by Category (N=1,332)

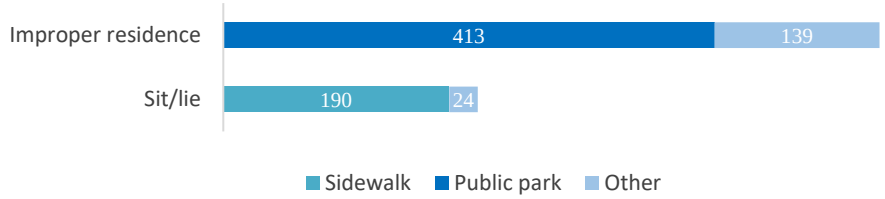


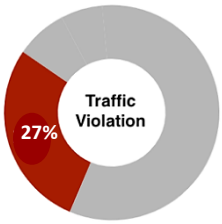
Most citations falling into public place occupancy and traffic violation categories indicate that clients were primarily involved in misdemeanors rather than serious criminal offenses. This applies to physical/oral violence citations, as well, in that there are no reported first- or second-degree assaults (only third-degree assaults).



***Public place occupancy*.** Public place occupancy citations (N=766) fell into two sub-categories: (1) improper residence and (2) sit/lie. Improper residence citations were given to clients occupying public places such as sidewalks, parks, schools, and shopping malls, while a sit/lie citation may occur in any public place where the client sits or lies. **Improper residence citations accounted for most public place occupancy citations (72%; n=552), and sit/lie citations accounted for 28% (n=214).** See Figure 12.

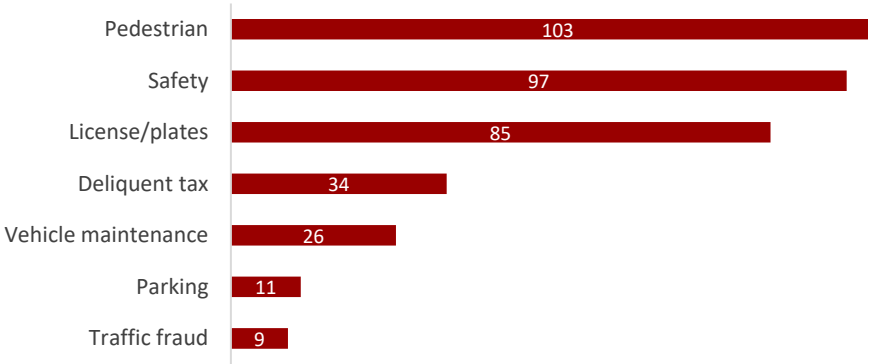
Figure 12. Frequency & No. of LEAD HNL Clients who had Public Place Occupancy Citations by Sub-category (N=766)

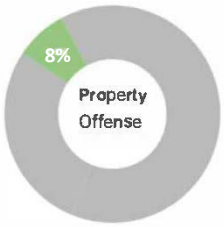




***Traffic violation*.** Traffic violation citations (N=365) fell into seven sub-categories: (1) pedestrian, (2) safety, (3) license/plates, (4) delinquent tax, (5) vehicle maintenance, (6) parking, and (7) traffic fraud. All seven categories are minor traffic violations, but citations were often given to pedestrians instead of drivers for violations like jaywalking, ignoring the crosswalk sign, and soliciting. **The most frequently cited traffic violations were pedestrian (28%; n=103), safety (27%; n=97), and license/plate (23%; n=85).** See Figure 13.

Figure 13. Frequency & No. of LEAD HNL Clients who had Traffic Violation Citations by Sub-category (N=365)

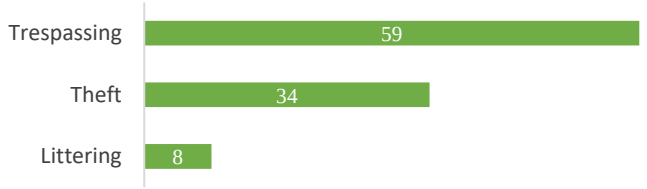




***Property offense*.** Property offense citations (N=101) fell into three sub-categories: (1) trespassing, (2) theft, and (3) littering. **The most frequently cited property offenses were trespassing (58%; n=59) and theft (34%; n=34), and the least frequently cited was littering (8%; n=8).** Regarding trespassing, only 20% (n=12) of citations were for first-degree trespass compared to 80% (n=47) for second-degree or simple trespass. Regarding

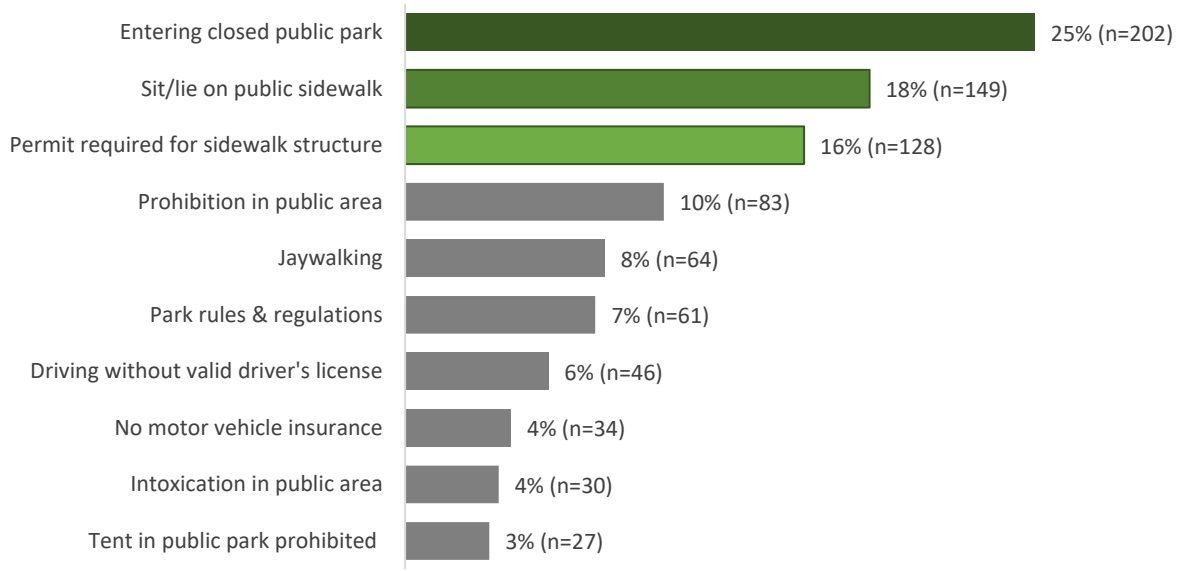
theft, there were no first-degree thefts, and only 18% (n=6) were second-degree theft. See Figure 14.

Figure 14. Frequency & No. of LEAD HNL Clients who had Property Offense Citations by Sub-category (N=101)



Frequency citation analysis. This analysis was conducted to determine the frequency of specific reoccurring citations received by LEAD HNL clients. Data related to citations used in this analysis was available for 62% (N=824) of the 1,332 that occurred from the beginning of 2015 to the end of 2021. **The citation analysis revealed that the three most frequently received citations by LEAD HNL clients belonged in the category entitled "public place occupancy": (1) entering a closed public park (25%; n=202), (2) sitting or lying on a public sidewalk (18%; n=149) and (3) not having the required permit for a sidewalk structure (16%; n=128).** See Figure 15.

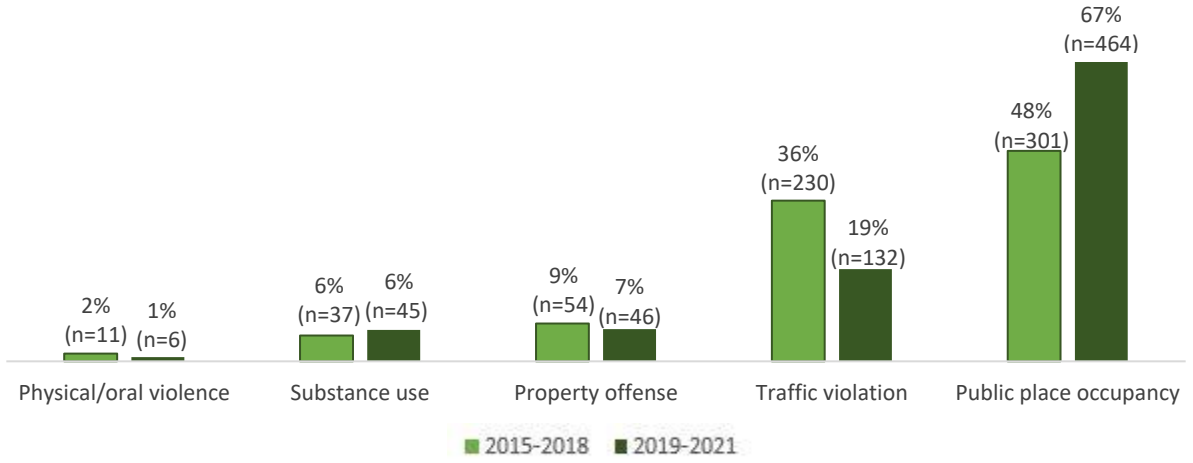
Figure 15. Frequency & No. of LEAD HNL Clients Most Frequently Issued Citations during 2015-2021) (N=824)



Comparative citation analysis. This analysis provides an overview of LEAD HNL client citations by analyzing two distinct periods using the eCourt* Kokua records citation data presented earlier in this section. The two specific periods are the beginning of 2015 to the end of 2018 (2015-2018) and the beginning of 2019 to the end of 2021 (2019-2021). The purpose of these periods is to attempt to look at citations pre-dating the start of LEAD HNL (2015-2018) and post-dating the start of LEAD HNL (2019-2021).

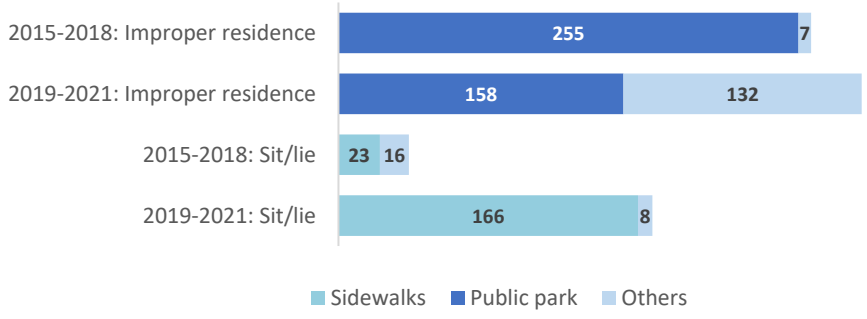
Data related to citations used in this analysis was available for 99.5% (N=1,326) of the 1,332 that occurred from the beginning of 2015 to the end of 2021. **Between 2015-2018 and 2019-2021, four of the five main citation categories decreased or were similar: physical/oral violence (-1%), substance use (no change), property offense (-2%), and traffic violation (-17%). The only category which did not decrease or stay the same was public place occupancy (+19%).** The increase in public place occupancy citations between 2019 and 2021 are likely related to the increased police enforcement of houseless-related citations during COVID-19 pandemic lockdown periods. See Figure 16 for a complete breakdown of citations.

*Figure 16. Comparison of Frequency & No. of LEAD HNL Clients who had Citations by Category during **2015-2018 (n=633)** and **2019-2021 (n=693)** (N=1,326)*



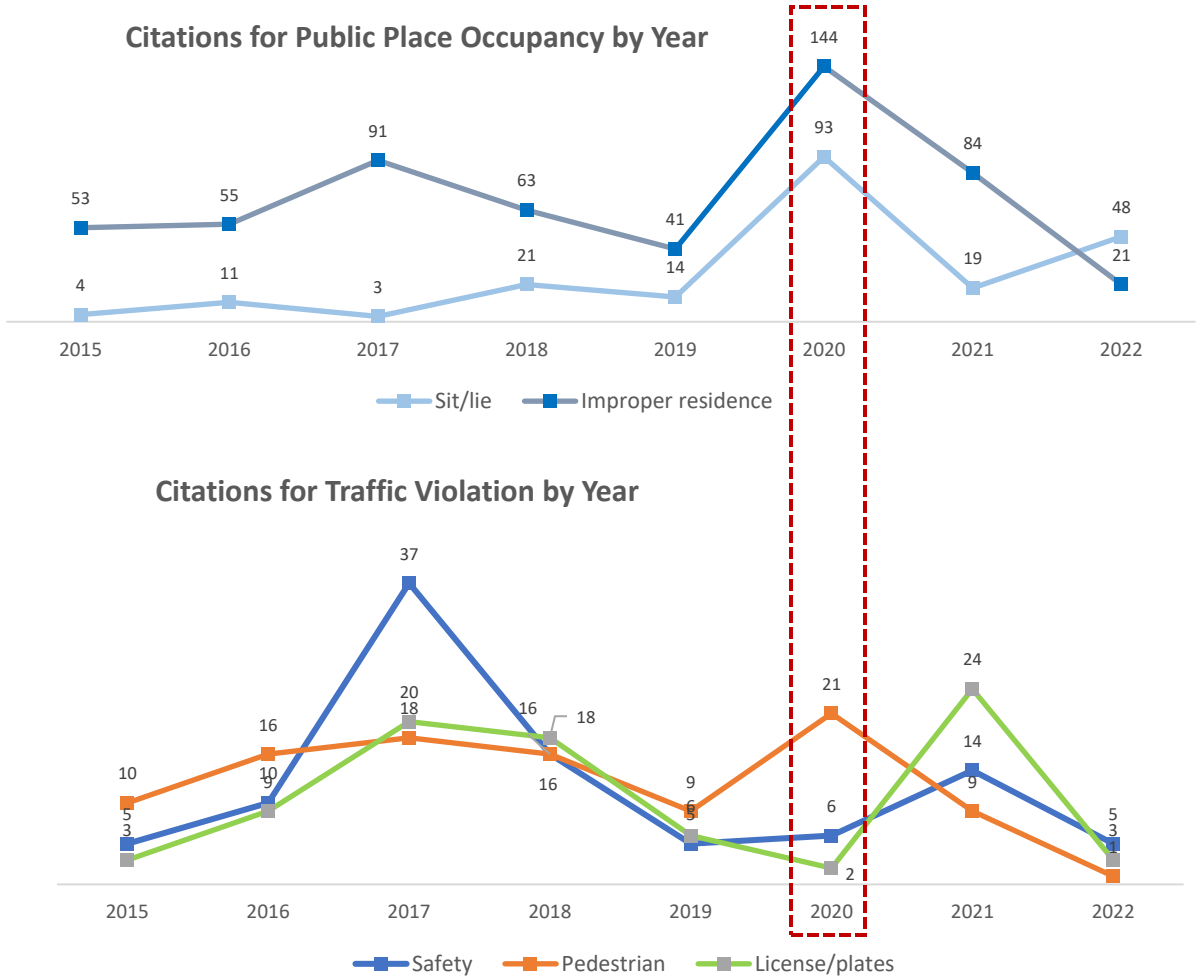
Increase in public place occupancy. The increase in public place occupancy citations is likely linked to increased police enforcement of houseless-related citations during COVID-19 pandemic lockdown periods. The specific sub-categories during two time periods (2015-2018 and 2019-2021) were analyzed to explore this increase. **Between 2015-2018 and 2019-2021, the increase in public place occupancy citations is related to sidewalk-specific citations. In the sub-category improper residence, public park-related citations decreased by 38% from 255 to 158, and other-related citations increased by 1,786% from 7 to 132. In the sub-category sit/lie, sidewalk-related citations increased by 622% from 23 to 166, and other-related citations decreased by 50% from 16 to 8**. During 2019-2021, regarding improper residence other-related category, 97% (n=128) of citations were for unpermitted structures on sidewalks, and regarding sit/lie sidewalk-related citations, the number rose by 722%. See Figure 17.

Figure 17. Comparison of No. of LEAD HNL Clients who had Citations by Public Place Occupancy Sub-categories during 2015-2018 and 2019-2021



Citations by year. When analyzing the citations by year, public place occupancy citations in both the improper residence and sit/life sub-categories follow a decreasing trend from 2018 (n=84) to 2019 (n=55), then rise significantly in 2020 (n=237). Traffic violation citations in the pedestrian sub-category also follow a decreasing trend from 2018 (n=16) and 2019 (n=9), then rises in 2020 (n=21). Following the rising trend of these citations in 2020, the public place occupancy and traffic violation citations gradually decreased until the end of 2021, except for the public place occupancy sit/lie sub-category, which rose from the beginning of 2021 (n=19) to the end of 2021 (n=48). **The categories and sub-categories where the number of citations rose after LEAD began are likely related to the increase in punitive measures taken toward the houseless during the COVID-19 pandemic shutdown periods in 2020.** See Figure 18.

Figure 18. Comparison of No. of LEAD HNL Clients who had Citations by Year (2015-2021)



LEAD HNL clients are experiencing reduced engagement with law enforcement since enrolling in the LEAD program, as evidenced by reporting fewer citations in four out of five citation categories when comparing the number of citations before LEAD began (2015-2018) and after LEAD began (2019-2021).

Interview Analysis

In July 2022, the University of Hawaiʻi at Mānoa LEAD Program Evaluation Report Team interviewed LEAD case managers (n=2) and LEAD HNL clients (n=3). All interviews were in-person adhering to HHHRC's internal COVID-19 pandemic social distancing requirements. Interview questions were designed to evaluate the LEAD HNL program from the perspective of LEAD case managers and clients.

Case Managers

Challenges. At the time of the interviews, there was an expressed disparity between case managers' caseloads. Case managers also expressed frustration at the need for more collaboration from law enforcement for diversion referrals and the seemingly inefficient referral process for potential new LEAD clients in the Waikiki area. Finally, case managers expressed difficulties related to transportation and communication with their clients. Some notable excerpts related to these barriers will be shared next.

Referral disparities. The original downtown Honolulu (Chinatown) catchment area was meant to be in collaboration with HPD. But, with HPD's lack of participation in the LEAD program, LEAD HNL sought referral opportunities in the Waikiki area – a new catchment area. However, there were issues getting referrals from Waikiki:

> *What happened was because the plan was, "We're moving to Waikiki. We will get all these referrals from Waikiki Business Improvement District." [Other current LEAD case manager] was going to be more based out of Waikiki, and I stick with the folks in Chinatown, but we'll both start getting referrals from Waikiki. But the referrals from Waikiki haven't been coming or are strange. Because the way it works is [LEAD navigators] go out with Waikiki Business Improvement District outreach workers. They take [LEAD navigators] to people they identify as, "Oh, maybe this person wants case management." For some reason or another, people don't want case management, So something with a referral thing kind of broke down, and that's why there's this big disparity. So I'm hoping that [other current LEAD case manager] can take some other folks in [their] caseload, and then we're both at the same level.*

Since these interviews, the issue of referral disparities has been improved upon by HHHRC LEAD program management.

Transportation & communication difficulties. Both case managers expressed experiencing challenges that hindered their ability to serve their clients. Two of the most inconvenient problems were being unable to get in touch with or get transportation for their clients: "*I would say transportation and communication are tied.*" Regarding communication difficulties, one case manager commented:

> *[Clients] either not having a cell phone or not knowing how to use it. That's huge. So people not having phones, not having access to phones, or not paying their phone bills. So there's no way to reach them. So [if they have an important appointment], you have*

> *to show up at their house and [risk] them being unable to get ready to go even if they want to go.*

Regarding transportation difficulties, one case manager explained:

> *Every time I have to go out to someone, it's like a half-day thing. And then transportation…some people that we work with, especially physically disabled people and those living with severe mental illness…I can't just give someone a bus pass and expect them to make it to their appointment in a reasonable time frame where the provider can be expected to see them.*

The case manager went on to explain that they often have to drive clients to and from appointments themselves:

> *Driving them to their appointments can happen, and it does. But it's this whole effort, so if the [LEAD navigators] had access to a car, that would make life much easier. There's a couple of [clients] where it's just hard. It's nothing against them. It's hard for them to leave the house. Or some are living in their wheelchair. It's really hard for them.*

While the solutions to the above communication and transportation issues seem simple, they require funding to support additional staff and specialized transportation.

Successes. At the time of the interviews, case managers shared some of their successes with their clients. Two primary sources of pride were getting LEAD HNL clients patched into medical treatment and stable housing. Some notable excerpts related to these successes will be shared next.

Hepatitis C treatment. During the interviews, one case manager expressed that their most significant success was facilitating the treatment of LEAD HNL clients for Hepatitis C: "*Hepatitis C treatments are huge. We've successfully treated three people for Hepatitis C. That's awesome.*" The case manager went on to explain how they coordinate this care with other HHHRC staff members:

> *It's cool that it works; [HHHRC LEAD HNL and clinic staff] teamed up, and we've cured people who have Hepatitis C while they're living on the street. It's like pretty freaking amazing for them.*

HHHRC has in-house Hepatitis C testing and treatment, one of many services LEAD HNL case managers can utilize when serving their clients.

Housing placement. At the time of the interviews, one case manager expressed that their most tremendous success was finding stable housing for clients. The case manager shared the stores of LEAD HNL Clients A and B:

> *I've housed or been involved in housing six people, but especially [Client A] and [Client B]. So [Client A] is really sweet and wonderful but also very difficult to work with just because of the nature of [their] mental illnesses. So, there were a lot of barriers. There*

> *are still many barriers, but [they are] in a house. Someone is paying the rent. And that was not looking like it was going to happen for a long time, so when that happened, and it worked out, that was awesome.*
>
> *And then the same thing with [Client B], who had a bench warrant. So [Client B] was "unhouse-able" because every housing background check came up red. But, we got [them] connected with a pro bono lawyer, which connected [them] with all this stuff and basically got all those charges completely dismissed, which is crazy. So [they're] going to literally have a clean record for the first time. Wow, this is really cool.*

HHHRC provides wraparound services, which greatly benefit LEAD HNL clients. For example, HHHRC has in-house staff that assists with the housing placement of HHHRC program clients into the Housing First program, mainly comprised of LEAD HNL clients. Also, HHHRC has built relationships with Community Outreach Court (COC), which helps put HHHRC programs like LEAD in touch with legal representation willing to work with LEAD HNL clients.

Clients

Challenges. Clients expressed that the challenges they experienced most often were related to services outside HHHRC. Getting the documents they needed for services and navigating getting and keeping housing was the most challenging.

Documentation. One client said it took a long time to acquire necessary documents after being released from jail: "When I got out of jail, I did have to wait six months for the documents I needed, which is kind of long." Another client reported having extensive difficulties getting their state identification card:

> *When I go to get me a state ID, the lady told me I needed some kind of paper showing I'm an American citizen. I told the lady, "I am an American citizen. I even got my birth certificate, and you still don't want to give me my state ID?" What a pain in the ass. I got to do the rest of my life without ID, I guess. I was in the military, and I got military papers and everything. The state and governor don't know what to do.*

Navigating housing. Clients described challenges navigating getting and keeping housing. One client said that they found the "regulations" in their housing unit challenging and reported being cited by building management for "violations," such as not sleeping in their unit often enough or having unregistered guests, resulting in eviction. Another client described their negative experience with building management after reporting a problem in their unit:

> *I was talking to the manager of the building. I was mentioning I have a leak in my roof, and she was like, "Ok. Perfect. I'll move it." Three days later, I have a notice on my door saying I need to vacate in 45 days. So it was scary for me. I was literally evicted. I was like, "Oh my gosh. What am I going to do?"*

At the time of the interview, the client had been successfully placed in Section 8 housing through in-house HHHRC staff and did not have a gap between eviction and re-housing.

Successes. Clients expressed gratitude for HHHRC and the LEAD HNL program. Specifically, clients talked about feeling they had reconnected with the world and overwhelming gratitude to the program staff since enrolling in LEAD HNL.

Reconnecting. At the time of the interviews, clients reported that they felt reconnected – with society, loved ones, and themselves. One client stated, "When I was on the streets, [people] were afraid of me. Now, they approach me; they talk to me. It feels good to have another human that you can talk to. I'm part of society." That same client reported that LEAD HNL helped them to reconnect with their family:

> *[LEAD HNL] gave me my family back: My brothers and sisters, my daughters. Before my oldest daughter passed away, she said, "Daddy, I got my father back." I got eight granddaughters – that's great – and I talk to them every day. Put it this way: I was on the other side of the fence, sleeping in the doorway, eating out of a garbage can. Now, I'm on the side where the grass is greener. [LEAD HNL] gave me that chance.*

When asked about their most significant success since joining LEAD HNL, one client responded: "Being myself. Well, my real self that I used to be. [LEAD HNL] gave me my life. I can look you in your eyes and not be ashamed." Another client reported feeling they had regained their sense of worthiness since enrolling in LEAD HNL through housing placement:

> *[LEAD HNL] helps you get on to where you can start without having to worry. Then, all of a sudden, you have someplace to go and be, and you can just sit there for like 30 hours straight, and you're fine. [LEAD HNL staff] are helping us to build a foundation of life. I feel like I can ground myself to where I can pick up the types of habits that a person who lives somewhere has. That way, you can go about your life like everyone else does.*

Gratitude for LEAD HNL staff. Clients were grateful for LEAD HNL's low-barrier services and harm reduction approach utilized by LEAD HNL program staff and HHHRC staff. One client attributed their massively improved physical health to LEAD HNL staff, who "never gave up on me." That client reported that they had been diagnosed with "heart failure," but since enrolling in LEAD HNL, their heart function has risen from 15% to 85%. That client affectionately said, "Now I'm living on top of cloud nine. I get me a second chance." A client who entered recovery for substance use disorder and had been housed since enrolling in LEAD HNL recounted asking a staff member how they would react if the Client backslid on their progress:

> *I asked, "What if I slipped?"*
>
> *[HHHRC staff] responded, "What do you mean?"*
>
> *I asked, "What if I go back to smoking [meth] and sleeping in the street, and I'm out there [houseless] again, and you see me?"*
>
> *[HHHRC staff] responded, "I'll come to you and pick you up. You can do it again."*
>
> *That meant so much to me. It's a beautiful thing.*

Lastly, client expressed gratitude for their "second chance": "Put it this way: I was on the other side of the fence, sleeping in the doorway, eating out of a garbage can. Now, I'm on this side; the grass is greener. [LEAD HNL] gave me that chance. [LEAD HNL] gave me a second chance."

Final Thoughts

LEAD HNL clients experienced improved quality of life since enrolling in LEAD, particularly in their mental health. However, they still experience greater difficulties than the average adult living in Hawai'i and the general United States. To express this point, LEAD HNL client quality of life data is compared to state- and national-level data according to the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) in 2021.[10]

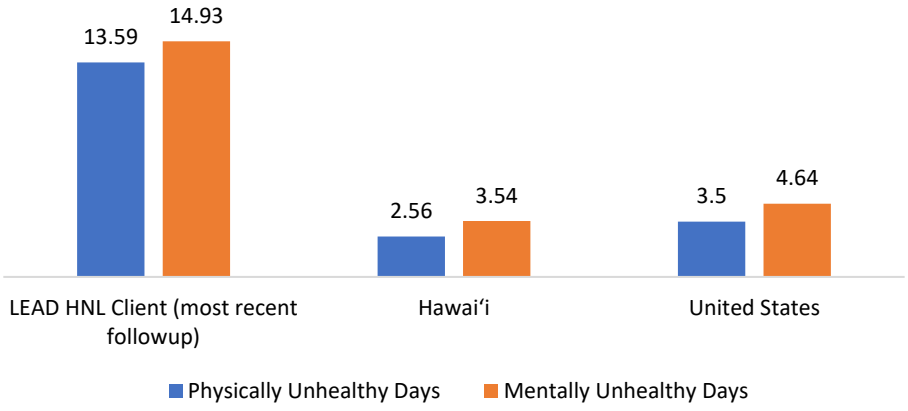
Physically & Mentally Unhealthy Days - Statewide

Regarding physical health, the average adult living in Hawai'i experienced 2.56 physically unhealthy days in the past 30 days compared to LEAD HNL clients who experienced 13.49 at intake and 13.59 at their most recent follow-up.[11] Regarding mental health, the average adult living in Hawai'i experienced 3.5 mentally unhealthy days compared to LEAD HNL clients who experienced 23.27 at intake and 14.93 at most recent follow-up.[11] See Figure 19.

Physically & Mentally Unhealthy Days - Nationally

Regarding physical health, the average adult living in the United States experienced 3.54 physically unhealthy days in the past 30 days compared to LEAD HNL clients who experienced 13.49 at intake and 13.59 at their most recent follow-up.[11] Regarding mental health, the average adult experienced 4.64 mentally unhealthy days compared to LEAD HNL clients who experienced 23.27 at intake and 14.93 at most recent follow-up.[11] See Figure 19.

Figure 19. Comparison of Averages of Physically & Mentally Unhealthy Days (in the Past 30 Days)



Ultimately, the findings of this report suggest that LEAD HNL has accomplished many of its short- and long-term goals for its clients. However, despite the accomplishments of LEAD HNL in improving the quality of life of its clients, clients are still experiencing significantly lower quality of life than the average adult in both the State of Hawai'i and the general United States. Therefore, recommendations will be made in the next section.

VI. Recommendations

Recommendations

Based on program implementation and outcomes findings, the University of Hawaiʻi at Mānoa LEAD Program Evaluation Report Team makes the following recommendations.

Recommendations for the LEAD Program

- Cultivate more effective data collection practices for specific domains, such as housing status, engagement with substance use treatment, emergency department utilization, and engagement with law enforcement.
- Consistently conduct follow-up assessments every three months for all actively engaged clients during the first and second years in the program and every six months after that.
- Continue to seek stable housing options for clients experiencing houselessness, including, but not limited to, funding more permanent supportive housing options.
- Continue to support Housing First (HF) implementation.
- Continue to provide harm reduction services to clients actively using substances and engaging in other high-risk behaviors.
- Explore Housing First's adaptation of Managed Alcohol Programming (MAP) for clients with substance use disorder (SUD) specifically related to alcohol.
- Explore if more transgender-specific services are appropriate for transgender clients.
- Explore if more culturally-based services are appropriate for Native Hawaiian clients.
- Explore enhanced access to mental and physical health services for mentally and physically challenged clients, focusing on depression, anxiety, and chronic pain.
- Work toward fostering relationships with local law enforcement, the Prosecutor's office, and other criminal justice-related entities to establish effective community partnerships.
- Seek continuous technical assistance from the LEAD National Support Bureau (NSB).
- Scale up LEAD in the City and County of Honolulu to enroll more clients into LEAD.

Recommendations for Funders & Community Stakeholders

- It is strongly encouraged that local law enforcement and the Prosecutor's office reconsider securing a Memorandum of Agreement (MOA) with LEAD to enable diversion to begin. The LEAD program has experienced success without the active engagement of these entities but would likely experience greater success if the program could refer clients using diversion instead of referral only.
- Consider recommencing funding LEAD factions on the neighboring islands that had put in time and effort to build infrastructure into their pilot programs, which ended abruptly due to the re-appropriation of their promised funds during the COVID-19 pandemic.
- Provide funds to support LEAD HNL to send its core staff for LEAD NSB technical assistance and training at LEAD NSB headquarters since the LEAD staff has had nearly a total turnover since LEAD HNL staff attended training in 2019.

VII. References

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VII. Appendices

A. Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) Program Logic Model

Situation

Individuals often enter the criminal justice system for low-level offenses, such as drug possession and prostitution-related crimes. Unfortunately, these individuals rarely receive treatment, utilize limited enforcement resources, and are likely to reoffend in the future.

Of the 16,000 arrests in 2015:

- 61% of arrested involved people who were severely mentally ill or abusing drugs
- 43% of arrests involved individuals who were experiencing homelessness
- 2,229 drug possession arrests

Resources

Human Capital

- Staff
  - Outreach workers
  - Case managers
  - Substance use specialists
- Volunteers

Social Capital

- Collaborating agencies
- HPD support
- Public support

Physical/Monetary Capital

- State of Hawaii Funding
- Transportation vehicles
- Office space
- Shared outreach services Space

Activities

Policing

- Peer to peer training by sergeants and offices
- Training on social service challenges
- Operational protocol
- Diversion decision

Outreach

- Opportunistic engagement
- Education and support

Case Management

- Specialized Case Management
- Housing Placement
- Legal support and services
- Delivery of health care services
- Transportation services

Outputs

- Documentation of direct and timely connections made to legal services, employment, housing and transportation as needed
- Documentation case contact and service utilization
- Establishment of individual case plans developed for 100% of participants
- Establishment of peer counseling program.
- Completion of long intake form and ongoing assessments every 3 months

Goals

Short-term Goals

- Engagement in case management services
- Connection to community recourses and services
- Reductions in criminal citations
- Improved housing stability
- Increased in social support
- Decreased in substance use
- Decreased stress

Long-tem Goals

- Reduction in emergency room use
- Reeducation in inpatient hospital stays
- Reeducation in arrests and incarceration
- Increased educational attainment
- Improved quality of life

Impacts

- Decreased recidivism rates
- Decreased demand for social services in catchment area
- Improved relationship between the police and those policed
- Increased satisfaction of residential and business leaders with public safety
- Public safety resources freed up for other uses
- Decreased financial burden on:
  - Health care system
  - Legal system
  - Housing services

Current Status

Many individuals are not engaged in the social service system. For example, in Seattle, about one third of LEAD participants reported that they had never previously participated in a social service program. (LEAD Case Management Report)

Research Questions

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 well-being

Data

Archival: Services use - HMIS, Correctional Databases

Quantitative Survey: Housing history/needs, Health history/needs, social support, gaps in service, quality of life

Qualitative Interview: Service limitations, barriers to care, housing preferences

Analysis

1. Regression analyses to determine whether participation in LEAD services are associated with reduced recidivism compared to prior history and neighboring areas.
2. Regression analyses to determine whether increased sense of community and social support is associated with decreased stress and better quality of life
3. Qualitative review of best practices and potential gaps in service

Successful Implementation

- Participation in LEAD services results in a stable foundation and a reduced chance of homelessness
- Participation in LEAD services results in better physical and mental health.
- Participation in LEAD services results in an elimination of substance abuse a reduced risk of relapse.

B. Program Evaluation Methodology

This program evaluation report will focus on the implementation of LEAD in urban Honolulu between July 1, 2018, and July 31, 2022. In particular, the evaluation strives to:

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

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

Process and Implementation

To document the intended program process, the program evaluation report 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 delineate the process that leads to attaining 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 fit better the communities in which they are implemented. However, measuring fidelity by tracking what components are changed and what elements are implemented as intended to assess which elements can be altered and still achieve program effects is essential. **The core principles that are essential to achieve the transformative outcomes that are possible through LEAD are[4]:**

1. **Reorient** the 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 criminal justice system savings; and
6. **Strengthen** the relationship between law enforcement and the community.

Many components of LEAD can be adapted to fit local needs and circumstances. However, certain core principles are essential to achieve the transformative outcomes 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] Programs should contain most of the above components to be considered a LEAD model.

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 illegal activity, and improvements in health and wellbeing.

Specific Goals and Objectives

Several goals LEAD services attempt to achieve. Short-term goals are focused on the physical aspects of clients' daily lives. These include improved housing stability, increased social support, reduced substance use, decreased stress, and increased engagement in services and connection to community resources. Long-term goals focus on strength and include a 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 the program's potential impact are outlined using the LEAD Theory of Change model (See Figure 9, p. 29). In addition, the overall program logic model is summarized using the Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) Program Logic Model (Appendix A, p. 53).

The following research questions – as stated in the Logic Model (Appendix A, p. 53) – address four primary 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 than 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?

LEAD Honolulu Measures

Informed by best practices, the program evaluation report team works closely with frontline staff at HHHRC to capture data that helps understand how the LEAD Honolulu (LEAD HNL) 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 serving 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, including:

- social services clients currently receiving
- 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 houselessness
- 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

Follow-up LEAD Intake and Needs Assessments (F-LINA): Caseworkers 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.

eCourt Kokua: Used to calculate client recidivism.

Data collection frequency:

	Administration of Measure by Month				
Measure	Enrollment	3 months	6 months	9 months	12 months
LEAD Screening Form	X				
LEAD Intake and Needs Assessment (LINA)	X				
Follow-up LEAD Intake and Needs Assessment (F-LINA)		Ongoing (every three months)			
Qualitative Interviews with LEAD Service Providers	Annually				
Direct Service Summaries & Feedback	Ongoing				
Interaction with law enforcement histories (eCourt Kokua)	Ongoing				

C. Program Evaluation Timeline

July-August 2018	Develop assessment tools and protocols. Begin recruiting program clients through social contact referrals. 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 the LEAD Maui team. Released Honolulu's Law Enforcement Assisted Diversion (LEAD) Program Evaluation Report 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 the WITS database

	Gathered data on encounters with law enforcement experienced by program participants before and after being enrolled using the eCourt Kokua database. Begin to analyze 1-Year evaluation findings.
September-October 2019	Continue to analyze 1-Year evaluation findings. Write up and report 1-Year evaluation findings.
November-December 2019	Re-commenced recruiting program clients. Continued surveying of program clients. Finalized Case Management Acuity Tool Form for use by LEAD HNL staff. Initiate surveying of program clients using the Case Management Acuity Tool.
January-February 2020	Continued surveying of program clients. Released four briefs highlighting findings of the 1-Year evaluation findings: (1) Honolulu LEAD 1-Year Citations Report; (2) Honolulu LEAD 1-Year Reasons for Experiencing Homelessness Report; (3) Honolulu LEAD 1-Year Services Needed & Used Report; and (4) Honolulu Law Enforcement Assisted Diversion Qualitative Report: Staff Interviews.
March-April 2020	Continued surveying of program clients. Conducted client interviews. Conducted Zoom program evaluation report check-in with the LEAD Hawai'i Island team. Conducted Zoom program evaluation report check-in with the LEAD Kaua'i team.
May-June 2020	Continued surveying of program clients. Conducted client interviews. Conducted Zoom program evaluation report check-in with the LEAD Maui team.
July-August 2020	Continued surveying of program clients. Conducted client interviews.

	Gathered data on encounters with law enforcement experienced by triage and program participants before and after being enrolled in the program using the eCourt Kokua database. Begin to analyze 2-Year evaluation findings.
September-October 2020	Continue to analyze 2-Year evaluation findings. Write up and report 2-Year evaluation findings.
November 2020-August 2021	Contract gap due to funding stream issues related to the COVID-19 pandemic.
September-October 2021	Biweekly LEAD Program Evaluation Team meetings (x2). Zoom interview with LEAD Maui staff member(s). Zoom interview with former LEAD Hawai'i Island staff member(s). Zoom interview with former LEAD Kaua'i staff member(s). LEAD Hui meeting.
November-December 2021	Biweekly LEAD Program Evaluation Team meetings (x2). Draft neighboring island LEAD summaries. Draft pieces of 1-4-Year evaluation findings.
January-February 2022	Biweekly LEAD Program Evaluation Team meetings (x2). Gathered data on encounters with law enforcement experienced by program participants before and after being enrolled using the eCourt Kokua database. Draft pieces of 1-4-Year evaluation findings.
March-April 2022	Biweekly LEAD Program Evaluation Team meetings (x2). Analyzed data on encounters with law enforcement experienced by program participants before and after being enrolled using the eCourt Kokua database. Gather client data from LEAD HNL internal caseload tracker. Draft pieces of 1-4-Year evaluation findings.

May-June 2022	Biweekly LEAD Program Evaluation Team meetings (x2). LEAD Community Leadership Team (CLT) meeting. HHHRC meeting. Draft pieces of 1-4-Year evaluation findings.
July-August 2022	Biweekly LEAD Program Evaluation Team meetings (x2). LEAD National Support Bureau meeting. LEAD Community Leadership Team (CLT) meeting. LEAD HNL Case Manager Interviews (x2) LEAD HNL Client Interviews (x4) Transcribe LEAD HNL Case Manager Interviews (x2) Transcribe LEAD HNL Client Interviews (x4) Draft pieces of 1-4-Year evaluation findings.
September-October 2022	Create graphics from data on encounters with law enforcement experienced by program participants before and after being enrolled using the eCourt Kokua database. Analyze LEAD HNL Case Manager Interviews (x2) Analyze LEAD HNL Client Interviews (x4) LEAD client data analysis using LINAs and F-LINAs.
November-December 2022	LEAD client data analysis using LINAs and F-LINAs. Continue to analyze 1-4-Year evaluation findings. Write up and report 1-4-Year evaluation findings.