Law Enforcement Assisted Diversion San Francisco

LEAD SF

Completed Proposal Checklist

A complete LEAD Grant Proposal packet must contain the following (to be submitted in the order listed):

Required Sections:	Check once Complete (✓)
Proposal Checklist (signed by the applicant)	✓
Section I: Applicant Information Form (with original signature in blue ink)	✓
Section I (a): Abstract	✓
Sections II – VII (a): Proposal Narrative (not exceeding 25 pages)	✓
Section VII (b): Budget Table and Detail	✓
Section VIII: Project Work Plan	✓
Section IX: Key Stakeholder Committee Roster	✓
Section X: List of Partner Agencies and Services	✓
Required Attachments to Proposal:	
MOUs to Include Statements of Intent	✓
Other Required Documents:	
Governing Board Resolution Note: The Governing Board Resolution is not due at time of proposal submission but must be received prior to the Grant Award Agreement	In progress
Optional:	
Geographical Map of Service Area	✓
One Endnote Page	✓

I have reviewed this checklist and verified that all required items are included in this proposal packet. Additionally, by signing this checklist I am affirming that our proposal does not contain a catchment area that duplicates that of any other applicants applying from the same jurisdiction.

X

Public Agency Applicant Authorized Signature (see Applicant Information Form, next page)

NO OTHER ATTACHMENTS WILL BE CONSIDERED

SECTION I: Applicant Information Form

A. APPLICANT AGENCY				B. TAX IDENTIFICATION NUMBER
NAME OF APPLICANT AGENCY City and County of San Francisco				**TAX IDENTIFICATION #:** 946000417
STREET ADDRESS 1 Dr. Carlton B. Goodlett Place	**CITY** San Francisco		**STATE** CA	**ZIP CODE** 94102
MAILING ADDRESS (if different)	**CITY**		**STATE**	**ZIP CODE**

C. PROJECT TITLE	D. GRANT FUNDS REQUESTED
LEAD SF	$5,900,000

E. PROJECT SUMMARY

The City and County of San Francisco seeks to implement LEAD as a pre-booking diversion program for substance-dependent individuals who come into contact with the criminal justice system. LEAD SF is a multi-agency collaborative partnership that will incorporate San Francisco's standards for harm reduction practice into program planning and implementation. With the goals of reducing criminal behavior and improving public safety by connecting low-level drug offenders with the City's robust network of services, the program aims to reach at least 250 individuals and divert at least 100 participants in the Tenderloin and Mission neighborhoods over the 26-month project period.

F. PROJECT DIRECTOR			
NAME Colleen Chawla	**TITLE** Deputy Director of Health		**TELEPHONE NUMBER** (415) 554-2769
STREET ADDRESS 101 Grove Street, Room 310			**FAX NUMBER** (415) 255-3798
CITY San Francisco	**STATE** CA	**ZIP CODE** 94102	**EMAIL ADDRESS** colleen.chawla@sfdph.org

G. FINANCIAL OFFICER				
NAME Greg Wagner	**TITLE** Chief Financial Officer			**TELEPHONE NUMBER** (415) 554-2610
STREET ADDRESS 101 Grove Street, Room 308				**FAX NUMBER** (415) 554-2710
CITY San Francisco	**STATE** CA	**ZIP CODE** 94102		**EMAIL ADDRESS** greg.wagner@sfdph.org
PAYMENT MAILING ADDRESS (if different)	**CITY**		**STATE**	**ZIP CODE**

H. DAY-TO-DAY CONTACT PERSON			
NAME Angelica Almeida, PhD	**TITLE** Director of Assisted Outpatient Treatment		**TELEPHONE NUMBER** (415) 225-3798
STREET ADDRESS 1380 Howard Street, Room 423			**FAX NUMBER** (415) 554-2710
CITY San Francisco	**STATE** CA	**ZIP CODE** 94103	**EMAIL ADDRESS** angelica.almeida@sfdph.org

I. AUTHORIZED SIGNATURE

By signing this application, I hereby certify that I am vested by the Public Agency Applicant with the authority to enter into contract with the BSCC, and that the grantee and any subcontractors will abide by the laws, policies and procedures governing this funding.

NAME OF AUTHORIZED OFFICER	TITLE	TELEPHONE NUMBER	EMAIL ADDRESS
Edwin M. Lee	Mayor	(415) 554-6141	aneeka.chaudhry@sfgov.org
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**
1 Dr. Carlton B. Goodlett Place	San Francisco	CA	94102
APPLICANT'S SIGNATURE (Blue Ink Only)			**DATE**
x			2/9/2017

SECTION I (a): Project Abstract

Law Enforcement Assisted Diversion San Francisco (LEAD SF) is an innovative pre-booking diversion program that will refer repeat, low-level drug offenders, at the earliest contact with law enforcement, to community-based health and social services as an alternative to jail and prosecution. LEAD SF participants will have access to the city's extensive system of care that includes comprehensive behavioral health services (substance use disorder and mental health treatment), physical health services, transitional housing, employment, and other relevant services. LEAD SF is a multi-agency collaborative partnership between the San Francisco Mayor's Office (applicant agency), San Francisco Department of Public Health (designated lead agency), San Francisco Police Department, San Francisco Sheriff's Department, Bay Area Rapid Transit Police Department, San Francisco Adult Probation Department, San Francisco District Attorney's Office, San Francisco Public Defender's Office, and the nonprofit Drug Policy Alliance. LEAD SF will also include community-based organizations and a broad network of health and social service providers that represent and serve the individuals most impacted by drug/alcohol abuse and the resulting effects on community health and safety.

The goals of LEAD SF are 1) Reduce the recidivism rate for low-level drug and alcohol offenders in San Francisco's Tenderloin and Mission districts; 2) Strengthen collaboration across city departments and with community-based organizations to better meet the needs of individuals with a history of substance abuse and low-level drug offenses by diverting them from the justice system and into harm reduction based social services; and 3) Improve LEAD participants' health and housing status.

Over the 26-month grant period, police officers will refer 250 individuals to LEAD SF, including 200 pre-booking referrals and 50 social contact referrals. At least 100 of these individuals will work with a case manager from the Glide Harm Reduction Services or the Felton Institute (CBOs) to develop an Individual Intervention Plan and receive access to the city's network of evidence-based social and mental health services. These services are all based in harm reduction principles, and participants will receive ongoing case management to support them on their path to recovery, stable housing and economic stability.

SECTION II: STATEMENT OF NEED

The City and County of San Francisco (population 864,816) has long been a center for criminal justice reform. Between 1994 and 2014, San Francisco decreased the number of offenders sent to prison by 89%, taking advantage of local and state initiatives that sought alternatives to incarceration, increasing discretionary authority and resources to manage offenders, and strengthening re-entry programs.[1] San Francisco has implemented several successful initiatives aimed at reducing crime by rehabilitating offenders, including several collaborative courts, and opened the Sobering Center in 2003 to divert individuals acutely intoxicated by alcohol from County Jail or emergency rooms. The city is now seeking to expand its service network to divert drug offenders to rehabilitation at the first point of contact with the criminal justice process.

With a cost of living at 59% higher than the national average,[2] San Francisco poses serious challenges for those struggling with addiction, mental illness, and poverty. In 2015, 18% of the city's roughly 7,500 homeless people reported drug and alcohol use as the primary reason for their lack of permanent housing, up from 11% in 2013.[3] The city has higher rates of illicit drug use than the national average and other comparable cities. The city's three-year recidivism rate--at 53%--far exceeds the state average of 45%. A staggering 40% of those returning to jail within three years are drug offenders.[4]

San Francisco is proposing to expand its network of harm reduction-based rehabilitation services and further reduce the recidivism rate by implementing the LEAD program for low-level drug and alcohol offenders who have been repeatedly involved in the criminal justice system. For this Board of State and Community Corrections (BSCC) pilot, LEAD SF will focus specifically on drug and alcohol offenders in the city's Tenderloin and Mission districts, which together comprise 37% of drug- and alcohol-related incidents and contain the majority of homeless people in the city. LEAD SF will divert eligible participants at the point of contact with law enforcement from booking into the city's network of harm-reduction based services, including behavioral health services (substance use disorder and mental health treatment), physical health services, transitional

---

[1] Eliminating Mass Incarceration: How San Francisco Did It, James Austin, JFA Institute, 2015.
[2] Addressing Affordability of Health Insurance in San Francisco: Technical Report, Health Management Associates 2015.
[3] San Francisco Homeless Point-In-Time Count and Survey, Applied Survey Research, 2015.
[4] 2015 Outcome Evaluation Report: An Examination of Offenders Released in Fiscal Year 2010-11, California Department of Corrections and Rehabilitation, Office of Research, August 2016.

housing, employment, and other relevant services.

Drug and Alcohol Offenses. In 2016, over 30% of all San Francisco Police Department (SFPD) incidents occurred in the Mission and Tenderloin districts, including 38% of total drug incidents and 31% of incidents of public drunkenness. Of the 1,562 drug incidents in 2016 in these two neighborhoods, 89% resulted in arrest and booking. The most common cause for booking was drug sales and possession, especially for (in order of frequency) methamphetamine, base/rock cocaine, heroin, and marijuana.

Alcohol and drug use is a serious public health issue in San Francisco. Alcohol use disorder is the most problematic addictive disorder in the city's safety net, outstripping heroin. In 2015, 25% of residents reported binge drinking, 11% of residents reported alcohol use disorder, and 2,378 people were admitted for treatment. It is the primary cause of homelessness and the top reported health condition among the chronically homeless in San Francisco.[5] The city is also dealing with the rising abuse of prescription opioids. In 2014, there were 127 fatal opioid overdoses in the city, the vast majority (72%) of them from prescription opioids.[6] The most recent data available (from 2012), suggests there are 15,000-22,000 people who inject drugs in San Francisco.[7] Nearly 10,000 people received methadone treatment from 2000-2015. Substance use disorder (SUD) treatment admissions for methamphetamine have been consistently rising, as have hospitalizations involving methamphetamine and deaths, including methamphetamine as a causal agent. On average, there is a six-week wait for individuals seeking residential treatment and a five-day wait for individuals seeking medical detox.

Racial Disparities. San Francisco's diverse population includes White 53.6%, Asian 35.3%, Hispanic or Latino 15%, African American 5.7%, American Indian or Alaska Native .8%, and Native Hawaiian or Pacific Islander .5%, and two or more races 4.2%.[8] As in many cities across the U.S., people of color in San Francisco face serious racial disparities in the criminal justice system. Latino adults are 1.5 times as likely to be booked as White adults. Although the African American population has dropped from 11% of the

---

[5] Alcohol Management Housing Issue Brief, San Francisco Department of Public Health, May 2016.
[6] San Francisco Heroin Opioid Brief, San Francisco Department of Public Health, March 2016.
[7] San Francisco Sentinel Community Site (SCS) Drug Use Patterns and Trends, National Drug Early Warning System (NDEWS), 2016
[8] US Census, 2015.

city's population in 1990 to 5.7% in 2015, African Americans experience felony drug arrest rates 19 times higher than other races in San Francisco, and 7.3 times higher than African Americans elsewhere in California.[9] African American women comprise only 6% of San Francisco's female population, but they constitute 46% of all female arrests and are arrested at rates 13 times higher than women of other races.[10] Not only are African Americans arrested at higher rates, they also stay in jail longer. In 2015, African Americans comprised 53% of all inmates in SF County jail and their periods of custody were significantly longer than any other race.[11]

Addressing the Need. In 2011, the Sentencing Commission of the City and County of San Francisco (SFSC), an initiative of the San Francisco District Attorney's Office, began a four-year process to study the design and implementation of a formalized, non-punitive law enforcement-assisted pre-booking diversion program for low-level drug offenders and assess the feasibility of replicating the LEAD program in San Francisco. An analysis completed for the SFSC explored the feasibility, benefits, and cost of implementing LEAD and found that, "San Francisco has the necessary tools and systems to meet the challenge of successfully implementing such a program."[12] The SFSC concluded its study in July 2015, echoing the researchers' recommendation that San Francisco implement LEAD as "an evidence-based and fiscally prudent approach to lowering recidivism and increasing public safety."[13]

Separately, a January 2016 Resolution of the Board of Supervisors called for the formation of a workgroup to plan for the permanent closure of two SF county jails and any corresponding investments in new mental health facilities and jail retrofits needed to uphold public safety and better serve at-risk individuals. The resulting Workgroup to Re-envision the Jail Replacement Project included significant community representation including mental health, prisoners' rights and homeless advocates as well as faith-based

---

[9] San Francisco's Arrest Rates of African Americans for Drug Felonies Worsens, Mike Males and William Armaline, Center on Criminal and Juvenile Justice, April 2012.
[10] San Francisco's Disproportionate Arrest of African American Women Persists, Michael Males, Center on Juvenile and Criminal Justice, April 2015.
[11] Issue Brief: Data Review, Work Group to Re-envision the Jail Replacement Project, August 12, 2016.
[12] Diversion Program Alternatives for San Francisco, Feasibility Analysis for Pre-booking and Pre-charging Alternatives, Hollingshead, A., Lievano, M., and Pe, W., UC Berkeley, 2014.
[13] Memo to Honorable Edwin Lee, Mayor of San Francisco, "Law Enforcement Assisted Diversion Pilot Program," San Francisco Sentencing Commission City and County of San Francisco, July 27, 2015.

communities. The workgroup recommended implementing LEAD on a pilot basis in the Tenderloin and 16th Street/Mission neighborhoods.

Incarcerating people suffering from drug addiction, mental illness, and/or homelessness is counterproductive and expensive. LEAD SF will provide access to culturally competent wraparound services that address the basic needs of these vulnerable populations, reduce social inequities associated with criminal justice involvement, promote public safety, enhance the wellbeing of individuals and neighborhoods, and save money. LEAD SF will expand the city's capacity by expanding outreach and case management for individuals who would otherwise cycle through the criminal justice system and ensure they receive an individually-tailored treatment plan through a coordinated system of care. Additional funds from a BSCC Proposition 47 grant (if funded) will add an additional 5 social detox and 32 residential treatment beds at Salvation Army's Harbor Light facility.

Improving Law Enforcement/Community Relations. The high level of drug usage and homelessness in the Mission and Tenderloin districts has frustrated business owners and residents who see frequent drug users arrested and then return to the street over and over again. In 2015, a joint SFPD and Drug Enforcement Administration Task Force was criticized for racially- and sexually-biased policing of low-level drug users in the Tenderloin district. All of the 37 people arrested by undercover SFPD officers for possession of small amounts of drugs were African Americans and, in one sting, 11 of the 18 people arrested were women. In 2016, in response to community outcry after several officer-involved shootings and other high profile incidents, the Mayor and then-Police Chief requested assistance from the Department of Justice (DOJ) to conduct a thorough review of SFPD's policies and practices. Later that year, the DOJ released a series of recommendations for the SFPD, including that the SFPD develop strategic partnerships on key community issues such as homelessness and organizational transparency and demonstrate a greater commitment to procedural justice.[14]

---

[14] Collaborative Reform Initiative: An Assessment of the San Francisco Police Department Executive Summary Findings & Recommendations, October 2016.

LEAD SF will begin to address some of these issues by changing the way law enforcement interacts with repeat drug offenders. Officers will receive training in harm reduction approaches, as well as implicit bias in determining who gets arrested/charged, specifically as these issues relate to the implementation of LEAD. Training objectives are designed to ensure that officers use a more holistic, trauma-informed approach to deal with repeat low-level drug offenders, refer them away from the criminal justice system and into a system of care that seeks to support them on their path to recovery and permanently keep them off the streets. San Francisco Mayor Ed Lee appointed a new SFPD Police Chief, William Scott, in December 2016. Chief Scott is a strong proponent of the LEAD program, having helped to lay the foundation for a LEAD program in Los Angeles in 2015. He has committed to implementing the pilot in San Francisco, as well as addressing the recommendations of the DOJ report. BART Police Department also stepped forward to partner on LEAD in 2014, even traveling to Seattle to see the program in action there. While a single project cannot address all of the deeply-rooted issues related to trust, racism, accountability and transparency between law enforcement and the community, LEAD is committed to changing the way that law enforcement interacts with people who suffer from SUD and mental illness.

Harm Reduction Approach. In 2000, the San Francisco Health Commission was the first in the country to adopt harm reduction as an official policy to provide compassionate, non-judgmental strategies to serve substance users. The policy requires substance use disorder programs to provide harm reduction treatment options and develop guidelines that include collaborative, culturally competent services that respect individual's dignity, personal strength, and self-determination.[15] A few examples of the city's commitment to this approach include naloxone distribution, methadone (on demand), and buprenorphine at all Department of Public Health (DPH) hospitals and clinics; partnership with the Harm Reduction Coalition to provide harm reduction training to DPH-funded agencies; trainings to police precincts on harm reduction; and the Sobering Center, which diverts intoxicated individuals from jails and emergency rooms to a supportive environment where they can be monitored and connected to services.

---

[15] Resolution No. 10-00: Adopting a Harm Reduction Policy For Substance Abuse, STD and HIV. San Francisco Health Commission, September 5, 2000.

LEAD SF will build on the city's robust network of harm reduction-based services and provide participants with access to client-focused treatment, outreach and education services in their own neighborhoods that prioritize equal access and are designed to reduce the physical, social, emotional, and economic harms associated with substance use disorder and other harmful behaviors on individuals and their community. LEAD participants will have access to all relevant services--including shelter, residential treatment, and transitional housing--regardless of their ongoing substance use or possession or subsequent arrests that may occur while they are engaged in LEAD. The treatment model, described in Section V, will put clients at the center of identifying the goals that best support their recovery, with comprehensive case management and a well-coordinated system of care to support their progress.

SECTION III: PROJECT DESCRIPTION

San Francisco envisions a non-punitive, health-centered approach to ensure that individuals struggling with addiction, mental illness and poverty are directed toward alternatives to the criminal justice system while simultaneously lowering recidivism and improving public safety. Consistent with SB 843 and LEAD's Guiding Principles, this 'Health First' model, based in harm reduction principles, seeks to connect high need drug and alcohol offenders to culturally competent, community-based service providers at the earliest law enforcement contact and ultimately keep individuals out of the criminal justice system. Based on Seattle's LEAD program, which has been shown to substantially reduce short- and long-term recidivism,[16] LEAD SF will build on existing City and County efforts to address the complex needs of repeat drug and alcohol offenders through a multi-agency, collaborative initiative based on shared planning, decision-making, data sharing, and evaluation that will 1) expand outreach to eligible individuals in target areas, 2) enhance coordination of service delivery through the existing social service network; 3) expand the city's capacity to treat individuals suffering from substance use and mental health disorders; and 4) improve collaboration and communication among law enforcement agencies and social service providers. The first four months of

[16] LEAD Program Evaluation: Recidivism Report, Collins, S., Lonczak, H., and Clifasefi, Seema, University of Washington, March 27, 2015.

this project will be a "ramp-up" period to hire staff, refine operational procedures, establish evaluation criteria in partnership with the BSCC's external evaluator, and train law enforcement officers, case managers, and other stakeholders.

Program Goals and Objectives. LEAD SF has three main goals. See Section XIII for a detailed Work Plan for the 26-month grant period.

Goal 1: Reduce the recidivism rate for low-level drug and alcohol offenders in San Francisco's Tenderloin and Mission districts.

Objectives: 1.1: By the end of the 26-month pilot, at least 200 pre-booking LEAD contacts will be made. **1.2:** By the end of the 26-month pilot, at least 50 social LEAD contacts will be made. **1.3**: By the end of the 26-month pilot, at least 100 participants will participate in the LEAD program and receive comprehensive case management services, including an Individual Intervention Plan, to address their SUD and other related issues, such as housing, employment, physical and mental health, and legal services. **1.4**: By the end of the 26-month pilot, at least 50% of participants will remain free of additional criminal charges.

Goal 2: Strengthen collaboration across city departments and with community-based organizations to better meet the needs of individuals with a history of substance abuse and low-level drug offenses by diverting them from the criminal justice system and into harm reduction based social services.

Objectives: 2.1. By August 2017, LEAD staff and key stakeholders will develop detailed criteria and protocols that support smooth implementation of the LEAD project. **2.2** By August 2017, LEAD staff, key stakeholders, and Harder + Co. will develop a transparent information sharing mechanism across LEAD governance and advisory workgroups. Stakeholders, on average, will rate this system of information sharing above 4 on a 5 point Likert scale each project year. **2.3** By November 2017, LEAD staff, Hatchuel Tabernik and Associates, and the key stakeholders will develop an enhanced system for data sharing to track participants and collect evaluation data. LEAD partners will rate this system of information sharing above 4 on a 5 point Likert scale each project year. **2.4** By June 2018, LEAD staff will convene and participate in 4 community meetings to educate the broader community members about LEAD and build awareness of and support for the program. **2.5** If proven effective, DPH and LEAD SF partners will sustain the

LEAD approach and scale-up to serve 100 additional individuals/year (2019 onward).

Goal 3: Improve LEAD participants' health and housing status.

Objectives: 3.1 By the end of the of the 26 month LEAD pilot: **3.1.a** 75% of participants not enrolled at the time of referral will be enrolled in Medi-Cal; **3.1.b** 75% of participants experiencing food insecurity will be enrolled in CalFresh; **3.1.c** 80% of participants with SUD will be connected to SUD treatment; **3.1.d** 80% of participants with SMI will be connected to mental health services; **3.1.e** 25% of homeless participants will have obtained permanent housing; **3.1.f** 50% of homeless participants will have obtained shelter; **3.1.g** 50% of jobless participants will be on the employment continuum; **3.1.h** 25% of jobless participants will have a stable income.

Service and Catchment Area. Analyses of drug and alcohol-related incidents and patterns of homelessness across the city have identified the Mission and Tenderloin areas as the police districts with the highest need for LEAD diversion in San Francisco. For this pilot, the LEAD service area will be the City and County of San Francisco. The catchment areas will be the Tenderloin and Mission districts, focused specifically on a defined area around the Civic Center and 16th Street/Mission BART stations. Both of these districts have well-defined geographical boundaries and dedicated SFPD stations (see attached Map of Service Area). The Tenderloin is a triangular 0.3 square mile area bordered by Geary, Market and Larkin streets and has the city's strongest concentration of cocaine, marijuana, and methamphetamine incidents and the highest concentrations of homeless individuals and parolees. Drug activity is particularly concentrated near the Civic Center BART station. The Mission district covers an area of approximately 2.5 square miles, spanning from east of Twin Peaks to the James Lick Freeway, and south of Market Street to Cesar Chavez Street. High concentrations of cocaine, marijuana, and methamphetamine activity occur near the 16th Street BART station. In 2016, 38% (n=1,562) of drug incidents and 31% of alcohol incidents (n=139) reported by SFPD took place in these two districts. Given these numbers, we expect to make a minimum of 200 pre-booking LEAD referrals, 50 social contact referrals, and serve at least 100 participants over the two-year pilot period. These numbers will ensure statistically significant data collection and analysis for evaluation purposes.

Control Study Area. The control group will consist of individuals arrested and booked

or cited for the same categories of drug offenses in the Southern district of San Francisco. The Southern district is a 2.9 square mile area that includes the South of Market, Embarcadero, and China Basin areas, and shares borders with the Tenderloin and Mission districts. Drug- and alcohol-related incidents in this district are comparable to the Mission and Tenderloin: 22% (n=890) of drug-related incidents and 19% (n=84) of alcohol-related incidents occurred in the Southern district in 2016.[17] We expect to easily make at least 200 incident-related contacts over the two-year LEAD pilot period, providing a statistically significant number for evaluation.

LEAD Eligibility Criteria. LEAD-eligible offenses will include: 1) possession for sale/transfer of a controlled substance/other prohibited substance where circumstances indicate that the sale or transfer is intended to provide a subsistence living or to allow the person to obtain or afford drugs for his or her own consumption; 2) sale/transfer of a controlled substance or prohibited substance where circumstances indicate that the sale/transfer is intended to provide a subsistence living or allow the person to obtain drugs for his/her own consumption; 3) possession of a controlled substance/other prohibited substance; 4) being under the influence of a controlled substance/other prohibited substance; 5) being under the influence of alcohol and a controlled substance/other prohibited substance. Priority for LEAD participation will be given to individuals facing felony drug charges. Other eligibility criteria will include the individual's criminal history, current medical condition, and expressed commitment to engage in the program.

Diversion Protocol. SFPD and Bay Area Rapid Transit Police Department (BART PD) patrol officers will hold primary responsibility for diverting individuals to LEAD. For pre-booking referrals, the arresting officer will determine, at the time of initial contact, whether an individual meets the LEAD eligibility criteria. If so, the officer will explain the program requirements to the individual; if the individual agrees to participate, he or she will be transported by the officer or a LEAD outreach team to the Community Assessment and Services Center (CASC), the designated LEAD intake center (described in Section IV). At the point that the arresting officer transfers the individual to LEAD staff, the officer will relinquish custody of the individual and file an arrest report with the SF

[17] SF OpenData. 2014-2016. SFPD Incidents - Previous Year. https://data.sfgov.org/Public-Safety/.

District Attorney's Office (DA), which will be held in abeyance pending the individual's engagement in LEAD, as evidenced by completion of a full assessment within 30 days of referral to the program. The DA's Office will maintain final authority over whether to charge the individual. If the individual does not want to participate in LEAD, he or she will be booked into County Jail or cited and released by the officer. Sheriff's Department (SFSD) officers may also refer eligible individuals to LEAD prior to booking into the County jail.

Police officers and outreach workers typically know the repeat drug users in their districts. For social contact referrals, an officer may refer an individual with prior documented possession or sales of drugs to LEAD if the officer has reason to believe that the individual is at high risk for being arrested in the future. LEAD outreach staff may also make social contact referrals, and individuals may refer themselves or others if they meet the eligibility criteria. These referrals will be contingent upon approval from the law enforcement agency and the Operational Workgroup, which monitors program capacity based on available space. Pre-booking referrals will have priority over social contact referrals. See Section V for a detailed description of intake, case management and services after an individual is referred to LEAD. Further refinement of eligibility criteria and diversion and referral protocols will be determined by the Key Stakeholder Policy Committee and Operational Workgroup (described in Section IV) during the ramp-up period and evaluated and modified as needed through the pilot period.

LEAD Training. A shared understanding of the LEAD program by all agency partners is critical to its success. During the ramp-up period, a training plan will be developed to ensure that all stakeholders have a shared understanding of LEAD goals and procedures. Of particular importance is the ownership and buy-in of law enforcement patrol officers, who are at the front line making referral decisions, as well as Sergeants who will oversee implementation of the program and supervise discretionary decisions. During the ramp-up period, SFPD officers in the Tenderloin and Mission stations, BART PD officers who patrol the Civic Center and 16th Street BART stations, and Sheriffs who handle jail intakes will be trained in the LEAD protocol, including their significant discretionary authority for making street-level referral decisions and where to direct individuals

that are eligible for LEAD. Officers will also participate in a LEAD harm reduction training based on a curriculum developed by the Harm Reduction Coalition, which covers the LEAD philosophy, principles of harm reduction, applying these principles across the spectrum of police-related contacts when dealing with addiction, mental illness, and homelessness, as well as implicit bias and racial disparities related to referral and booking decisions. Training will be provided to additional officers within the first year of the program. The Drug Policy Alliance (DPA) will conduct the training in collaboration with SFPD, BART PD, SFSD and the LEAD National Support Bureau in Seattle. Training will include a site visit to observe Seattle's LEAD program, with costs covered by a LEAD implementation grant from the San Francisco Foundation to DPA.

LEAD case managers and outreach workers will also be trained by DPA staff using the harm reduction curriculum, including a site visit to Seattle, and receive detailed procedural training on case management, service referral procedures, and data entry for tracking LEAD participants through the social service network for evaluation purposes. DPH will coordinate with Glide Foundation and Felton Institute to develop a training for community stakeholders. Staff will outreach to stakeholders (e.g., treatment providers, advocacy groups) and host a town hall for local businesses. In 2019, San Francisco and Los Angeles LEAD sites, in collaboration with the Drug Policy Alliance and the LEAD National Support Bureau, will co-host a one-day conference highlighting the California pilot programs and lessons from other LEAD programs nationally.

Project Management. To ensure efficient project management and ongoing coordination among stakeholders, LEAD SF will be overseen by a full-time Project Manager from DPH. The Project Manager will hold primary responsibility for the administrative operations of LEAD SF; hire, train and supervise the DPH Intake Clinician; develop and oversee the training plan; oversee selection/contracting of service providers; manage the coordination of care; work with the research partner to oversee and coordinate data collection and project evaluation with key stakeholders and the BSCC evaluator; serve as a liaison between the Key Stakeholder Policy Committee and the Operational Workgroup; maintain fiscal oversight and responsibility; and manage all grant reporting requirements. The Project Manager will be a licensed clinician with experience addressing mental health and SUD, and will report to the DPH Clinical Services Manager.

LEAD SF will be guided by a Key Stakeholder Policy Committee and an Operational Workgroup. The membership, responsibilities, and operational structure of these groups are described in Section IV. To ensure equal representation and shared decision making among all stakeholders, group meetings will be organized and convened by Harder + Company Community Research (Harder + Co.), an SF-based research and evaluation agency with extensive experience facilitating complex, cross-agency collaborations. Harder + Co. will maintain a neutral, independent role focused solely on facilitating communication within and among key stakeholders groups.

SECTION IV: PARTNERSHIP AND COLLABORATION

LEAD SF is a multi-agency collaborative partnership between the San Francisco Mayor's Office, San Francisco Department of Public Health (DPH) (designated lead agency), San Francisco Police Department (SFPD), San Francisco Sheriff's Department (SFSD), Bay Area Rapid Transit Police Department (BART PD), San Francisco Adult Probation Department (APD), San Francisco District Attorney's Office (SFDA), San Francisco Public Defender's Office (PD), and the nonprofit Drug Policy Alliance (DPA). LEAD planning, project design, and implementation also involves neighborhood- and community-based organizations and a broad network of health and social service providers that represent and serve the individuals most impacted by drug/alcohol use and the resulting effects on the community.

As noted above, the city has engaged in a multi-year process of inter-departmental planning and community engagement to research the efficacy of LEAD for San Francisco. In the process, a widespread commitment to fundamentally changing the system-wide response to addressing the needs of the LEAD target population in a more compassionate, constructive, and cost-effective manner has emerged. Notably, this includes strong support from SFPD, BART PD, and SFSD, who will hold front line responsibility for referrals. All stakeholders have committed to shared decision-making, enhanced information/data sharing, and a coordinated and collaborative approach to identification, referral, and service provision for the target population. (See attached MOU.)

LEAD SF will be overseen by a Key Stakeholder Policy Committee and an Operational Workgroup. These groups will be convened and facilitated by Harder + Co., an in-

dependent agency that will play a neutral role to ensure equitable and transparent representation of all stakeholders. Harder + Co. will work with the groups to develop a management plan that identifies roles and key tasks, and outlines procedures for decision making, providing input, identifying overlapping issues, ensuring that policy, operational and community issues are addressed, and tracking progress toward project goals and objectives. The management plan will also develop procedures for sharing information among groups and with the community at large, including sharing meeting minutes, developing a project website for posting information to stakeholders and the community, and hosting a dedicated LEAD email address for gathering community input.

The **Key Stakeholder Policy Committee** (KSPC) will be comprised of high-level representatives of each participating public agency and contracted service provider to develop a shared vision and process for diverting individuals away from the criminal justice system, taking into account each agency's responsibilities and objectives. To ensure representation of those most impacted by LEAD, two community representatives who serve on the Jail Workgroup, and one community member each from the SF Sentencing Commission (which advises the city on sentence reform) and the Reentry Council (which coordinates local efforts to support adults exiting SF County Jail) will be nominated by their group's co-chairs to serve on the KSPC. Additional community representation will come from community organizations that advocate for homeless people, criminal justice system involved individuals, and substance users. Community members will receive a stipend for participation. (See Section IX: Key Stakeholder Committee Roster.)

The KSPC will meet at least quarterly and be responsible for overseeing the design, implementation, and evaluation of project goals and outcomes. During the ramp-up period, the KSPC will establish LEAD eligibility criteria, referral/case management protocol, service provision, data systems/data sharing, evaluation measures, and fiscal monitoring. Regular meetings over the 26-month pilot period will enable ongoing troubleshooting, refinement, reflection, and evaluation of project operations and policies. HTA (LEAD research partner) will provide formative feedback on progress meeting project goals, outcomes, and quality of data management. All decisions will be made by modified consensus to ensure mutual involvement and shared decision making.

The **LEAD Operational Workgroup**--comprised of direct service providers, LEAD case managers, law enforcement agencies, criminal justice department representatives, and the LEAD Project Manager--will meet at least monthly to review and evaluate overall project implementation and service delivery, operationalize policy decisions made by the KSPC, review individual LEAD participants' progress and challenges, and ensure a coordinated system of care. The workgroup will identify and troubleshoot issues related to pre-booking and social contact referrals, intake procedures, caseload capacity, access to and quality of service providers, data entry and data sharing, and progress toward meeting overall project goals and objectives. The ramp-up period will be used to refine details related to implementation, such as how best to identify the target population, drop-off and intake procedures, roles of the CASC and service providers, how LEAD integrates with existing services and systems, and ensuring police/partner buy-in.

The Operational Workgroup will also operate as a multidisciplinary case conference to ensure holistic, coordinated, and integrated services across systems and providers and to reduce duplication. Members will discuss individual LEAD participants who may be struggling to meet their goals, or who have relapsed or been arrested for subsequent incidents. This collaborative approach between law enforcement, criminal justice, and health and social service providers will ensure that participants are given the greatest opportunity for treatment and recovery rather than punishment and incarceration. For these meetings, the Project Manager will run reports on each LEAD participant from DPH's Coordinated Case Management System, a composite database of integrated medical, psychological, and social information about high risk, complex, and vulnerable populations served by DPH. These reports will provide further data on the coordination of services for each participant and avoid duplication.

Communication between the KSPC and the Operational Workgroup will be maintained by regular reporting between the two groups. The Project Manager will participate in both groups and report on meeting outcomes and decisions, and the co-chairs of both groups will meet quarterly. The KSPC will refer procedural implementation of its policy decisions to the Operational Workgroup which will in turn refer ongoing issues or challenges to the KSPC for their input and guidance.

Key Stakeholder Roles (Positions in bold will be funded by this BSCC grant.)

Public Agencies

SF Department of Public Health (DPH) has been designated by the Mayor's Office to serve as lead agency for LEAD SF and oversee project coordination and grant administration, be an active participant in ongoing planning and discussions, and facilitate connections to services offered by the DPH system of care. DPH will provide five staff positions for LEAD SF. The **Project Manager** (1.0 FTE) will be responsible for day-to-day operations of LEAD (described in Section III). An **Intake Clinician** (1.0 FTE) and two Behavioral Health Access Center intake staff (2.0 FTE, match) will conduct LEAD intake assessments at the CASC receiving center. A Clinical Services Manager (.25 FTE, match) will hire and supervise the Project Manager; serve on the Operational Workgroup; and participate in the development of LEAD training and operational and data sharing protocols.

SF Police Department (SFPD) will provide part-time services (in-kind) to support the day-to-day operations of the program; ensure appropriate implementation of LEAD by SFPD officers; provide officer training on referral criteria and protocol; and serve on the KSPC and Operational workgroups.

San Francisco Sheriff's Department (SFSD) will provide a **Program Coordinator (1.0 FTE)** to handle jail-based referrals, provide officer training on referral criteria and protocol, provide access to SFSD's post-release programs (e.g., Five Keys Charter School, Narcotics/Alcoholics Anonymous) for LEAD participants who were previously incarcerated, and participate in the KSPC and Operational Workgroup.

Bay Area Rapid Transit Police Department (BART PD) will train officers patrolling the Civic Center and 16th Street/Mission BART stations on LEAD protocol. The agency will also provide part-time services to support the day-to-day operations of the program, ensure appropriate implementation of LEAD by BART PD officers, and serve on the KSPC and Operational workgroups.

San Francisco District Attorney's Office will provide a dedicated **LEAD Attorney** (1.0 FTE) and a **Paralegal** (1.0 FTE) to work with participants on pending legal issues, serve on the KSPC and Operational Workgroup, and assist with data collection/sharing. LEAD staff in the DA's office will be supervised by a Managing Attorney (.10 FTE, match).

San Francisco Public Defender's Office will assign an **Attorney** (1.0 FTE) and a **Legal Assistant** (1.0 FTE) to represent the interests of LEAD participants, advocate for individuals who seek to become a part of LEAD, and advise potential participants of legal ramifications of the program and communicate with other LEAD stakeholders. A Deputy Public Defender (.125 FTE, match) will oversee LEAD staff in the PD's office, manage policy and operations, serve on the KSPC, and attend all planning meetings.

San Francisco Adult Probation Department will oversee operations at the CASC and participate in the KSPC and Operational Workgroup. The CASC, a partnership of SF Adult Probation and nonprofit Leaders in Community Alternatives, is a one-stop center that provides a wide range of reentry services for formerly incarcerated adults, including case management, mental health and substance use disorder services, treatment groups, vocational training, and transitional aftercare planning. This grant will allow the CASC to expand its hours to serve as an intake center for LEAD referrals 24 hours a day. Three **Deputy Probation Officers** (3.0 FTE), one **Probation Assistant** (1.0 FTE), and several other staff (match) will be stationed at the CASC to staff the extended weekend and evening hours and provide access to services for LEAD participants, including care coordination, classes, employment, vocational training, and drug testing.

Community-based Organizations and Contractors

Glide Harm Reduction Services is a program of Glide Foundation, which has been providing compassionate health care in the Tenderloin district since the 1960s. Glide Foundation serves a diverse cross-section of homeless, low-income and marginalized people with programs including free meals, rental assistance and shelter reservations, domestic violence counseling, substance use recovery, childcare, harm reduction services, a drop-in legal clinic, access to primary and mental health care, and remedial education. For LEAD, Glide will provide outreach, transportation, and case management to 50 LEAD participants in the Tenderloin district. Two **Outreach Workers/Drivers** (2.0 FTE) and two **Case Managers** (2.0 FTE) will serve LEAD participants, and a **Project Coordinator** (.50 FTE) will oversee LEAD service provision and supervise LEAD staff.

Felton Institute is a 126-year-old social services organization that delivers evidence-based social/mental health services, including intensive case management, outpatient

services, and home visits. Felton will provide outreach, transportation, and case management to LEAD participants in the Mission. Two **Outreach Workers/ Drivers** (2.0 FTE) and three **Case Managers** (2.5 FTE) will serve LEAD participants, and a **Program Director** (.3 FTE) will oversee LEAD service provision and supervise LEAD staff.

San Francisco Public Health Foundation (SFPHF) provides fiscal sponsorship for a variety of San Francisco-based community health projects, and will serve as the fiscal sponsor for LEAD SF. SFPHF will manage payment for project-related expenses such as food, office supplies, travel vouchers and document support for LEAD clients, and stipends for community members of the KSPC, under the direction of DPH.

Harder + Co.: Harder + Co. is a research and evaluation company with extensive experience facilitating multi-sector initiatives for social change. Harder + Co. will serve as an independent, neutral convener of the KSPC and Operational Workgroup.

Hatchuel Tabernik and Associates (HTA) will serve as the local evaluation partner for the LEAD project and will be responsible for data collection and analysis and working with the LEAD evaluation team at CSU Long Beach. HTA has extensive experience evaluating reentry, diversion, jail reform, inmate education programs, and community oriented support for behavioral health care.

Drug Policy Alliance (DPA) is the nation's leading organization promoting drug policies that are grounded in science, compassion, health and human rights. DPA has advocated for LEAD in SF and nationally, including implementing it in Santa Fe, NM and Albany, NY. For this grant, DPA will participate in the program planning, communicate with other cities developing LEAD, advocate for continued funding, and provide the harm reduction training for law enforcement officers and case managers, as well as coordinating and funding site visits to Seattle for key stakeholders and staff as needed.

Project Evaluation/Research. Data collection, analysis and reporting will be conducted by HTA. HTA will be responsible for gathering and analyzing quantitative data from key stakeholders, generating evaluation reports, and working with CSULB evaluators to ensure data aligns with statewide evaluation objectives. HTA will also conduct interviews and focus groups with LEAD leadership, key stakeholders, program staff, and program participants and family/community support systems. Formative data will be provided on a semi-annual basis to help LEAD leadership make midcourse corrections as

needed. An annual report and data files will be provided to CSULB evaluators for further analysis. The local LEAD annual report will include information required by the BSCC, as well as data to address our local research questions. (See Section III.)

SECTION V: SERVICES

LEAD is envisioned as a more effective portal into San Francisco's complex network of evidence-based health care and social services for high-risk individuals who would otherwise be caught in the criminal justice system. LEAD participants will receive a well-coordinated plan of care that takes a holistic approach to addressing SUD, physical and mental health, and/or related needs such as housing, employment and vocational training, education, and legal support. All services are based on harm reduction principles, will largely be provided in the neighborhoods in which the participant is located, and prioritize housing for homeless individuals. All staff will be selected to ensure cultural diversity and competency, gender sensitivity, language capacity, and experience with individuals experiencing trauma, SUD and mental health challenges.

Initial Intake. Directly upon referral to LEAD and transfer to the CASC (described in detail in Section III), LEAD participants will be assessed by an Intake Clinician for their immediate needs, assuming the individual is not severely intoxicated/mentally distressed. For this assessment, CASC staff will use a modified version of the Addiction Severity Index (ASI), which is a widely used semi-structured interview for substance use assessment and treatment planning that assesses a client's level of stability and identifies ten areas in which individuals may need support: cultural (e.g., language capacity), educational, housing, medical, employment and income, drug/alcohol use, legal, family/social, and psychiatric needs. Participants who meet Medical Necessity will be referred for treatment and services through partner agencies.

Whenever possible, the intake clinician will communicate with Felton Institute (in the Mission) or Glide Harm Reduction Services (in the Tenderloin), so that their staff can have immediate contact with the individual. Individuals needing overnight shelter can stay at the CASC or be referred to a shelter until morning, when they will have a comprehensive assessment. Those needing psychiatric stabilization will be referred to Dore Street Urgent Care Center, and severely intoxicated people will be referred to the Sobering Center. During intake, all participants will be asked to sign an informed consent

form to allow protected health and criminal justice information (e.g. medical, mental health, substance use, arrest and charging history) to be shared with key stakeholder agencies and LEAD service providers for case management and project evaluation purposes. Participation in LEAD SF will be voluntary and will not require abstinence from drug or alcohol use as a condition of continued participation.

Referral and Assessment. The case manager's first interaction with the individual is critical to establishing a relationship that will support the recovery process. LEAD will strive to begin providing services to participants as quickly as possible, preferably within 24 hours and no later than 72 hours. Based on identified needs and the catchment area from which they are referred, participants will be contacted by a LEAD case manager from the Felton Institute or Glide. Once LEAD participants are referred to a provider, the case manager will have 30 days to complete a comprehensive intake assessment and develop an Individual Intervention Plan (IIP) with the individual, at which point they are considered to be officially enrolled in LEAD. During this period, the case manager and outreach workers will work diligently to engage the individual to link them to services. If an individual does not complete the assessment within 30 days, the Operational Workgroup will determine whether to continue trying to serve the individual through LEAD or pursue criminal charges for the original offense (for pre-booking contacts).

The IIP will feature a strengths-based care coordination and treatment plan that considers criminogenic thinking and dynamic risk factors. The IIP will include meaningful goals and objectives, developed collaboratively between the participant and the case manager. For instance, if a participant's goal is to reduce opioid use, objectives might include receiving buprenorphine, participating in two recovery groups/week, and developing a self-designed Wellness Recovery Action Plan. The frequency and intensity of services will be driven by individual needs. The case manager will meet with the participant as clinically indicated to provide support, ensure that he/she is receiving appropriate services to meet the goals and objectives outlined in the IIP, and modify the treatment plan, if necessary. When they are the primary care coordinator, the LEAD case manager will have/attempt contact with the participant at least once per month. Consistent with the harm reduction approach, case managers will support the participant's overall wellness, rather that focusing exclusively on treating SUD. Case managers will

provide hands-on, practical support that has meaningful and immediate impact in participants' lives (e.g., helping find jobs, transporting to appointments, helping secure resources such as food and clothing). If a participant relapses, the case manager will work to help the individual get back on track with their treatment plan. LEAD participants will not be removed from the program due to relapse or re-arrest, but may be removed if the Operational Workgroup determines they are not making good use of the services.

Access to Services. Once enrolled in LEAD, participants will have streamlined access to DPH's Behavioral Health Services (BHS), a full spectrum of client-centered, culturally competent, gender-informed, evidence-based mental health and SUD treatment services that range from prevention to crisis, acute and long-term care. With an annual budget of $350 million, BHS' system of care includes 20 DPH mental health clinics and programs, and 300 contracted programs that provide behavioral health education, prevention, early intervention, wellness centers, outpatient treatment, intensive case management, day treatment, acute and transitional residential treatment, emergency and urgent care psychiatric services, psychiatric hospitalization and long-term institutional care, for children and adults through DPH and CBOs. Outpatient services include individual and group treatment with a counselor, psycho-social case management and wrap around services (housing, income, food, clothing, quality of life issues), medication support, peer support, outreach, day treatment, and transitional residential treatment.

LEAD participants will have access to the wide range of services available at the CASC, including adult education, GED and high school diploma completion, anger management, Cognitive Behavioral Therapy, employment readiness and placement through America Works, gender responsive programs, parenting skills, relapse prevention, substance use education, and a daily food program. The CASC houses public sector services such as the Human Services Agency, for CalFresh, Medi-Cal and other benefits, and the Department of Child Support Services, which assists with child support and wage garnishment issues. The CASC incorporates principles of restorative justice, and helps participants build confidence, resiliency, and self-sufficiency skills needed to permanently exit the criminal justice system. DPH has staff and services at the CASC.

LEAD SF will prioritize housing homeless participants as quickly as possible. San Francisco's Direct Access to Housing (DAH) program, started by DPH in 1998, provides

permanent supportive housing for low-income residents who are homeless and have special needs. DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance use problems, and/or complex medical conditions. DAH provides a range of housing options that all provide independent living units and access to on-site support services. Currently, DAH houses over 1,700 formerly homeless people at 36 sites. Further expanding housing capacity, a pending BSCC Proposition 47 grant would fund 36 residential treatment beds and 10 transitional living units at Salvation Army's Harbor House and Harbor Lights facilities, which provides detoxification services, and residential and outpatient treatment options.

Evidence Base. DPH-funded services in San Francisco are trauma informed, client centered, and based in principles of recovery and wellness. In order to accomplish this, providers have training in a variety of evidenced-based and promising practices, including, but not limited to: Seeking Safety, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Assertive Community Treatment, Harm Reduction, Wellness Recovery Action Plan, and Thinking for a Change. All treatment providers are required to use treatments that are indicated for the individual they are working with and are evidence-based and/or promising practices that have been demonstrated to improve outcomes for persons with SUD, mental health, co-occurring disorders, as well as other treatment needs related to criminal justice system involvement. Treatment providers must be proficient at delivering the interventions and be supervised regularly by their organizations to ensure continuous fidelity to the treatment models.

Trauma-Informed Services. We anticipate that many participants will have been exposed to trauma and exhibit trauma-related symptoms that require specific, trauma-informed services. beginning with initial contact and continuing throughout the participant's engagement in the program. Individuals with criminal justice system involvement with PTSD are nearly 1.5 times more likely to reoffend than those without PTSD.[18] Participants with PTSD also are at much greater risk of dropping out of SUD treatment.[19] For this reason, all LEAD staff/service providers will receive trauma-informed training.[20]

Overdose Prevention and Referral. Unintentional overdose deaths from illicit and

---

[18] Note: References 18-30 are included as endnotes at the end of this proposal.

prescribed opiates has tripled over the last fifteen years.[21] Studies in Scotland and the United States have demonstrated that educating at-risk persons and their significant others about how to prevent or reverse an overdose significantly reduces overdose deaths.[22] LEAD participants will be offered overdose prevention training and naloxone.

Peer Support. Whenever possible, peer staff and/or peer driven activities will be used to support clients in their recovery. Participation in self-help or peer-support groups is consistently associated with better long-term outcomes following a SUD treatment episode.[23] Successful outcomes are more likely if participants attend self-help groups and engage in recovery-relevant activities like a sober-support social network,[24] engaging in spiritual practices,[25] and learning effective coping skills from peers.[26]

Criminal Thinking Interventions. There are several evidence based cognitive behavioral interventions to address criminal-thinking patterns, which is considered a dynamic risk factor for contact with the criminal justice system. Evidence based programs that demonstrate improved outcomes include Moral Reconation Therapy,[27] Thinking for a Change,[28] and Reasoning & Rehabilitation.[29] Studies suggest that the most beneficial time to introduce these interventions is after participants are stabilized in treatment and are no longer experiencing acute symptoms of withdrawal.[30] Given this, criminogenic cognitions may not be directly addressed by LEAD case managers and will instead be a distal goal for ongoing treatment interventions.

Case Management and Supervision. Felton Institute and Glide Foundation both have long histories of working with individuals who are struggling with substance use disorder, mental illness, and related issues of homelessness and poverty. For the LEAD project, Felton and Glide will each dedicate two full-time case managers and two full-time outreach workers (who will also serve as drivers) to work with LEAD participants, at a ratio of 25:1. A third Felton case manager will work with participants with serious mental illness at a ratio of 17:1. For street outreach and participant pick up, case managers will work with an outreach worker in a two-person team for safety.

Case managers must be trained in culturally competent, trauma-informed care and harm reduction approaches to SUD and be comfortable working closely with active drug users. LEAD outreach workers will be peer specialists who have personal experience with mental health and SUD recovery, or involvement with the criminal justice system

and have been trained to provide peer support to assist individuals to engage in treatment. LEAD case managers will receive clinical supervision from their respective organizations and will receive support and operational direction from the LEAD Project Manager, with oversight from the DPH Clinical Services Manager. They will receive training in the LEAD harm reduction philosophy, and data entry procedures to track participants through the system. Monthly Operational Workgroup meetings will coordinate services and address LEAD implementation and operational issues.

Non-displacement. LEAD is designed to benefit the entire community, not just the participants in LEAD. To that end, participants will not receive priority for housing or services over other eligible individuals. LEAD participants will not be given priority for services that have a waiting list, such as residential treatment slots. LEAD case managers have extensive knowledge of the city's resources, particularly in the Tenderloin and Mission, and will direct participants to existing services with available capacity.

BSCC funding will expand the capacity of Felton Institute and Glide to serve participants in their home neighborhoods, expanding use of the underutilized services at the CASC, and ensuring that LEAD participants are connected to services/benefits for which they are eligible but not aware of or ready to utilize. Case managers will ensure that eligible participants are enrolled in Medi-Cal, CalFresh and other benefits so that related expenses are not drawing from BSCC resources.

SECTION VI: DATA COLLECTION

LEAD stakeholders are committed to working with external evaluators from CSULB throughout the pilot. At submission date of this proposal, the evaluators' methodology has not been made available. The LEAD Project Manager and HTA, the research partner, are committed to working closely with state evaluators and other grantees during the ramp-up period to reach a common understanding of the evaluation protocol, timelines, measures and outcomes. This understanding will be shared with LEAD workgroups, staff, and other partners as it impacts their data collection. HTA will hold primary responsibility for local-level data collection, analysis, and reporting, and will share reports and findings with CSULB evaluators, and all stakeholders throughout the project.

Stakeholders have identified the need to establish effective data entry and data

sharing procedures to track LEAD participants through law enforcement, criminal justice, public health and social services, and to monitor internal and external evaluation measures. All key stakeholders have agreed, through a signed MOU (attached), to provide all relevant data on LEAD participants and identified peers (for the comparison study). Meetings of the KSPC and the Operational Workgroup will allow time for refinement and troubleshooting of data collection and sharing procedures, as well as on-going reflection on progress toward meeting project measures and outcomes.

The LEAD collaborative involves multiple stakeholders, each with its own data system. Data collection systems are robust in DPH; less so in the criminal justice and social services sectors. DPH utilizes three different data systems with varying levels of permissions: Avatar (individual contacts with behavioral health services throughout the DPH system of care); Lifetime Clinical Record (medical/psychiatric treatment at SF General Hospital); and Coordinated Case Management System (contacts with psychiatric emergency services, the homeless outreach team, and current provider). The Probation Department tracks history of probation terms, SFPD tracks citations and contact with police, and the District Attorney tracks history of charging and convictions. The Sheriff's Department's tracks arrest, charges, convictions, prison terms, and recidivism, and links to Jail Health Services (inmate health and psychiatric services) and Jail Information Management (mental health/substance use disorder treatment while in custody).

During the ramp-up period, HTA and the LEAD Project Manager will facilitate the creation of data use and sharing agreements for LEAD partners to determine which data will be shared and with whom, and procedures for protecting participants' confidentiality, honoring privacy laws (including but not limited to criminal offender record Information and HIPAA), and securely transmitting data to the evaluator. The release of criminal justice data must be approved by the JUSTIS Governance Council, comprised of San Francisco criminal justice and law enforcement agency representatives. These data agreements are critical as some LEAD participants may access services outside the DPH system of care which would not automatically be tracked through existing systems and be subject to current protocols and agreements. No data will be shared about participants who have not signed an informed consent form.

SECTION VII (a): BUDGET NARRATIVE

LEAD will provide a streamlined portal into San Francisco's robust behavioral health treatment network for a population that often unnecessarily ends up in the criminal justice system rather than receiving treatment in the community. In addition to new services and treatment capacity for LEAD participants, DPH's existing system of behavioral health care will also be available to LEAD participants. With an annual operating budget of approximately $350 million, this system includes prevention and early intervention services, outpatient treatment, residential treatment, crisis programs, hospitalization and involuntary treatment, and locked facilities through conservatorship. This system provides care to approximately 25,000 clients every year at an average cost of $14,000 per client. These services are funded primarily through Medi-Cal, Mental Health Service Act, and local general fund resources. Based on 100 individuals served, this program will leverage $1.4 million in program services to LEAD participants. LEAD partners have committed an additional $1.5 million in in-kind staff resources that will be dedicated to LEAD participants' treatment and LEAD governance. (See MOUs and Section VII (b)).

BSCC grant funds will be used to expand the existing network of SUD and mental health services and will not supplant existing funds. In fact, expanding the service population will leverage additional funding for individuals who meet Medi-Cal medical necessity criteria. Whenever possible, participants will be enrolled in Medi-Cal, which will cover their medical and health care costs. LEAD participants will be referred to services for which they are already eligible but will not supplant other clientele of partner organizations. To avoid supplanting funds: 1) LEAD funds will leverage additional Medi-Cal funds for health and behavioral health services; 2) LEAD and Prop 47 funds will increase capacity in the public and nonprofit sector to serve LEAD participants in addition to their existing clientele; and 3) LEAD will prioritize use of existing, unused capacity at the CASC and referral programs such as the Sobering Center and Salvation Army.

Program Sustainability. The Mayor's Office, DPH and other stakeholders have been committed to implementing LEAD in SF for several years. This grant will provide the opportunity to pilot the program, refine policies and procedures, and monitor and evaluate its effectiveness. Based on the Seattle program, we anticipate that LEAD will create cost savings for the criminal justice system and reduce the need to construct new

jail beds in San Francisco, thereby saving huge capital expenditures. Many of the services for LEAD participants will be billable to Medi-Cal, Mental Health Services Act and other county homeless programs, CalFresh, and General Assistance. Case managers will work to ensure that all eligible participants are enrolled in these programs. Assuming favorable outcomes from this pilot, DPH will prioritize LEAD as a part of its comprehensive network of services and identify additional funding to support the program. Funding sources may include public resources from the county, state, and federal government, and/or philanthropic organizations that oppose criminalization of vulnerable populations.

SECTION VII (b): BUDGET TABLES AND DETAIL

Instructions: Complete the following table for the grant funds being requested. Report amounts in whole dollars. While recognizing some jurisdictions may use different line items in the budget process, the categories listed below are the ones that funded projects will use when invoicing the BSCC for reimbursement of expenditures.

All funds must be used consistent with the requirements of the BSCC Grant Administration Guide. Applicants should reference this Guide for definitions and other guidance in preparing a budget. The BSCC Grant Administration Guide can be found on the BSCC website: http://bscc.ca.gov/s_correctionsplanningandprograms.php.

Budget Table

Budget Line Item	**A. Grant Funds**	**B. Hard Match Funds (minimum 10%)**	**C. Total Project Value**
1. Salaries and Benefits *(Applicant Agency only)*	$0	$0	$0
2. Services and Supplies	$2,000	$0	$2,000
3. Professional Services/Public Agency Contracts	$2,904,422	$1,035,336	$3,939,758
4. Community-Based Organization Contracts	$2,246,744	$0	$2,246,744
5. Indirect Costs *(not to exceed 10% of grant funds)*	$590,000	$0	$590,000
6. Data Collection	$156,834	$0	$156,834
7. Fixed Assets/Equipment	$0	$0	$0
8. Other (Travel, Training, etc.)	$0	$0	$0
TOTALS	**$5,900,000**	**$1,035,336**	**$6,935,336**

Budget Detail

Salaries and Benefits:

a. **Total Grant Funds Requested: $0**

Narrative Detail: NA

b. **Cash Match: $0**

Narrative Detail: NA

Services and Supplies:

a. **Total Grant Funds Requested: $2,000**

Narrative Detail:

Community outreach— community engagement and education materials, facility rental for community meetings.	2 Mos. Planning: Year 1: Year 2:	$0 $1,000 $1,000

Community Outreach	Year 1	Year 2
Space rental	$250	$250
food and bev	$500	$500
printing	$250	$250

b. **Cash Match: $0**

Narrative Detail: NA

Professional Services/Public Agency Contracts:

a. **Total Grant Funds Requested: $2,437,043**

Narrative Detail:

Department of Public Health		
Project Manager (2593 Health Program Coordinator III)—Provide daily oversight of the program, staff, and grant requirements. *100% FTE x $88,474 annual salary x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $81,101 $92,898
Intake Clinician (2390 BH Clinician)— Intake staff at receiving center *100% FTE x $81,276 annual salary x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $74,503 $85,340

Item	Period	Amount
Benefits Rate— Including medical, retirement, worker's comp, etc. @ *40%*	2 Mos. Planning: Year 1: Year 2:	$0 $62,242 $71,295
District Attorney		
Assistant District Attorney (8177)— Staff for DA's Office dedicated for LEAD caseload. *100% FTEx $138,814 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $178,145 $204,056
Paralegal (8132)— Staff for DA's Office dedicated LEAD caseload. *100% FTE x $63,934 annual salary plus 40% benefits.*	2 Mos. Planning: Year 1: Year 2:	$0 $0 $89,508
Public Defender's Office		
Attorney - Public Defender's Office (8177)— Staff for Public Defender's Office dedicated for LEAD caseload. *100% FTE x $111,462 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $143,043 $163,849
Legal Assistant (8173)— Staff for DA and Pub Def dedicated LEAD caseload. *100% FTE x $72,800 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $93,427 $107,016
SFSD— Program coordinator to handle referrals; participate in workgroups and committee meetings. *100% FTE x $100,000 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $128,333 $147,000
Adult Probation Department		

Deputy Probation Officer (8534)— 3 FTE DPOs for evening and weekend LEAD work at CASC. *300% FTE x $100,000 annual salary plus benefits x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $385,000 $420,000
Probation Assistant (8529)— 1 FE Probation Assistant to serve in intake, receiving and navigation role at CASC.. *100% FTE x $60,000 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1)*	2 Mos. Planning: Year 1: Year 2:	$0 $77,000 $84,000
Harder & Co Project Manager— Project manager, convenes stakeholder groups, facilitates meetings. etc. *100% x $100,000 annual salary, including benefits*	2 Mos. Planning: Year 1: Year 2:	$16,667 $100,000 $100,000

b. Cash Match: $1,035,336

Narrative Detail:

Department of Public Health
Clinical Services Manager (2574 Behavioral Health Clinician)— Provide supervision for all program staff. *25% FTE x $114,332 annual salary plus 40% benefit x 5% COLA (for 11 months in year 1) = $78,699 for the entire grant period*
District Attorney
Head Attorney (8182)— Supervision for LEAD program and operations. *10% FTE x $260,000 annual salary plus 40% benefit x 5% COLA = $74,620 for the entire grant period*
Public Defender's Office
Deputy Public Defender— Oversee LEAD staff in Pub Def's Office and manage policy and operations; will serve on executive committee and policy coordinating body; will attend all planning meetings. *12.5% FTE x $195,234 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1) = $67,193 for the entire grant period*

Adult Probation Department
Clinicians (DPH – 2930) @ CASC—Daytime assessments, collaboration, BH coordination. (2)x 20%FTE x $81,276 annual salary plus 40% benefit x 5% COLA (for 11 months in year 1) = $89,512 for the entire grant period
Social Work Supervisor (DPH – 2932)— Since 2012, APD's workorder has included an unfilled 2932 Social Work Supervisor. We can leverage this position to oversee everyone who is transitioning as part of BHAC (inclusive of existing 2930's, and 2586's), and to take on LEAD coordination/administration/ implementation role. $62,360.32 annual salary plus 40% benefits x 5% COLA *(for 11 months in year 1) = $171,699* for the entire grant period
Care Coordinators (DPH – 2586) @ CASC— Time to broker placements into Sal. Army/Prop 47 capacity. $30% FTE x $53,508 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1) = $44,198 for the entire grant period
Deputy Probation Officer (DPO - 8534)— APD has DPOs on site. This reflects 100% FTE of any combinations of PO's who could be asked to assist with a LEAD client. *$96,824 annual salary plus 40% benefits x 5% COLA (for 11 months in year 1) =* $266,589 for the entire grant period
Job/Employment Training @ CASC— 12 LEAD clients, placement, 30-, 90-, 180-day follow-up. 100% FTE x $53,508 annual salary plus 40% benefits x 5% COLA *(for 11 months in year 1)* = $147,325 for the entire grant period
Cog behavioral classes— Facilitators of a variety of cog behavioral classes at the CASC: T4C, Seeking Safety, Recovery Groups. (2) x 10% FTE x $81,276 *annual salary plus 40% benefits x 5% COLA (for 11 months in year 1)* = $45,799 for the entire grant period
Drug testing (as needed/requested)— 20 people X $5.50 per unit x 4 times in LEAD program = $880 for the entire grant period
HSA Employment and Training Specialist at the CASC - 9703— funded by HSA at CASC - All LEAD clients can access healthcare, CalFresh enrollments, and start process for GA enrollment. 20% FTE x $88,660 annual salary plus 40% benefits x 5% COLA *(for 11 months in year 1)* = $48,822 for the entire grant period

Community-based Organization (CBO) Contracts:

a. Total Grant Funds Requested: $2,246,744

Narrative Detail:

Glide Foundation		
Project Coordinator— Project coordination and staff supervision. *50% FTE x $70,000 annual salary*	2 Mos. Planning: Year 1: Year 2:	$5,833 $35,000 $35,000
Outreach Worker/Driver (1 month to hire)— Outreach / Driver. *200% FTE x $50,000 annual salary*	2 Mos. Planning: Year 1: Year 2:	$8,333 $100,000 $100,000
Case Manager (1 month to hire)— Case management. *200% FTE x $65,000 annual salary*	2 Mos. Planning: Year 1: Year 2:	$10,833 $130,000 $130,000
Benefits @ 25%	2 Mos. Planning: Year 1: Year 2:	$6,250 $66,250 $66,250
Van Purchase— Vehicle used for outreach and client pick-up/transportation to intake site.	2 Mos. Planning: Year 1: Year 2:	$50,000 $0 $0
Program Supplies— phones, laptop, van operation.	2 Mos. Planning: Year 1: Year 2:	$2,950 $17,700 $17,700
Indirect @ 10%	2 Mos. Planning: Year 1: Year 2:	$8,420 $34,895 $34,895
Felton Institute		

Item	Period	Amount
Program Director— Oversees program and staff. *30% FTE x $130,000 annual salary*	2 Mos. Planning:	$6,500
	Year 1:	$39,000
	Year 2:	$39,000
Outreach Worker/Driver (1 month to hire)— Outreach / Driver. *200% FTEx $45,000 annual salary*	2 Mos. Planning:	$7,500
	Year 1:	$90,000
	Year 2:	$90,000
Case Manager (1 month to hire)— Case management *200% FTE x $55,000 annual salary*	2 Mos. Planning:	$9,166
	Year 1:	$110,000
	Year 2:	$110,000
Clinical Case Manager (1 month to hire)— Clinical supervision of staff. *50% FTE x $60,000 annual salary*	2 Mos. Planning:	$2,500
	Year 1:	$30,000
	Year 2:	$30,000
Benefit @ 29.9%	2 Mos. Planning:	$7,674
	Year 1:	$80,431
	Year 2:	$80,431
Van purchase— Vehicle used for outreach and client pick-up/transportation to intake site.	2 Mos. Planning:	$50,000
	Year 1:	$0
	Year 2:	$0
Transportation— Cost associated with van maintenance and operation in order to transport clients to/from intake site.	2 Mos. Planning:	$0
	Year 1:	$10,000
	Year 2:	$10,000

Transportation	Year 1	Year 2
Gas	$3,500	$3,500
Parking	$4,000	$4,000
Maintenance	$1,500	$1,500
Insurance	$1,000	$1,000

Item	Period	Amount
Occupancy— Cost of additional rental space needed to conduct intake and case management on-site. $833.33/month	2 Mos. Planning:	$0
	Year 1:	$10,000
	Year 2:	$10,000

Item	Period	Amount
Office Supplies— $308.33/month in year 1, $166.67/month in year 2.	2 Mos. Planning:	$0
	Year 1:	$3,700
	Year 2:	$2,000
Staff Communications: (Internet, Fax, Telephone)— Mobile phones and laptops for outreach/driver and case management staff in the field. $266.67/month (for 11.25 months in year 1)	2 Mos. Planning:	$0
	Year 1:	$3,100
	Year 2:	$3,100
Staff training— Ongoing trainings to build staff capacity	2 Mos. Planning:	$0
	Year 1:	$3,000
	Year 2:	$3,000

Staff training		Year 1	Year 2
supplies		$1,500	$1,500
food and beverage		$150	$150
technology + equipment		$1,350	$1,350

Item	Period	Amount
Indirect @ 10%.	2 Mos. Planning:	$8,334
	Year 1:	$37,913
	Year 2:	$37,763
SF Public Health Foundation		
Office supplies—*$166.67/month*	2 Mos. Planning:	$0
	Year 1:	$2,000
	Year 2:	$2,000
Document support— client ID cards, legal services, client paperwork processing. *$6,062.15/month*	2 Mos. Planning:	$0
	Year 1:	$72,745
	Year 2:	$72,746
Travel vouchers— client transportation. *$833.33/month*	2 Mos. Planning:	$0
	Year 1:	$10,000
	Year 2:	$10,000
Food and beverages— for receiving center. *$2,500/month*	2 Mos. Planning:	$0
	Year 1:	$30,000
	Year 2:	$30,000

Stakeholder Committee stipends— community representative stipends / incentives. *$250/month*	2 Mos. Planning: Year 1: Year 2:	$0 $3,000 $3,000
Client support— bills, clothing, meals, other necessitites. *$7,500/month*	2 Mos. Planning: Year 1: Year 2:	$0 $90,000 $90,000
Incidentals— Staff work-related travel to meetings *$200/month*	2 Mos. Planning: Year 1: Year 2:	$0 $2,400 $2,400
Overhead— @ 10%		$0' $21,015 $21,015

b. **Cash Match: $0**

Narrative Detail: NA

Indirect Costs:

a. **Total Grant Funds Requested: $590,000**

Narrative Detail:

Administrative costs related to processing payroll, benefits, and documentation associated with managing partner contracts and staff; building maintenance to support these activities.

DPH	2mos	Year 1	Year 2
Labor + Administration (salaries, wages, benefits)	$ 16,118	$ 189,355	$ 207,527
Occupancy	$ 3,454	$ 40,578	$ 44,470
Insurance	$ 1,151	$ 13,525	$ 14,823
Communication equipment	$ 1,151	$ 13,525	$ 14,823
Postage	$ 690	$ 8,115	$ 8,895
Printing	$ 461	$ 5,410	$ 5,929

2 Mos. Planning: $23,025
Year 1: $270,508
Year 2: $296,467

b. **Cash Match: $0**

Narrative Detail: NA

Data Collection:

a. Total Grant Funds Requested: $156,834

Narrative Detail:

HTA Consulting— To support the data collection and analysis needs for the pilot. This person will work with the program manager and act as liaison with the evaluator and program manager, and support reporting requirements.

2 Mos. Planning:	$6,264
Year 1:	$78,725
Year 2:	$71,845

Planning/Start-Up

July 2017 – August 2017

- *Start Up $825*
- *Literature / Document Review $850*
- *Develop Scenarios / Models $1,100*
- *Project Management, Meetings/Facilitation, Travel $3,350*
- *Printing/Mileage $139*

Total Cost: $6,264

Planning & Implementation

July 2017 – June 2018

- *Start Up $1,000*
- *Evaluation Plan $5,750*
- *Instr. Design $4,500*
- *Data Coll. $19,300*
- *Data Anal. $21,600*
- *Reporting $16,050*
- *TA $2,000*
- *Project Mgmt $7,875*
- *Other Misc $650*

Total Cost: $78,725

Implementation & Final Reporting

July 2018 – June 2019

- *Instr.Design $1,325*
- *Data Coll. $19,300*
- *Data Analysis $21,600*
- *Reporting $19,600*
- *TA $2,000*
- *Project Mgmt $7,350*
- *Other Misc $670*

Total Cost: $71,845

b. Cash Match: $0

Narrative Detail: NA

Equipment/Fixed Assets:

a. Total Grant Funds Requested: $0

Narrative Detail: NA

b. Cash Match: $0

Narrative Detail: NA

Other (Travel, Training, etc.):

a. **Total Grant Funds Requested: $**0

Narrative Detail: NA

b. **Cash Match: $0**

Narrative Detail: NA

SECTION VIII: LEAD Grant Project Work Plan

Each applicant must develop a 26-month Project Work Plan as part of this RFP process. A Project Work Plan identifies measurable goals and objectives, a timeline for the project (including primary phases of implementation and the implementation milestones associated with each phase), activities and services, and the processes and responsible parties necessary to accomplish the goals and objectives. For definitions and examples of goals and objectives, see Attachment F. Clearly detail pre-implementation or ramp-up activities occurring in the first four (4) months of the project. The Project Work Plan does not count toward the 25-page limit.

Project Work Plans should be SMART: Specific, Measurable, Attainable, Relevant Project Work Plans should be SMART: Specific, Measurable, Attainable, Relevant and Time-Bound.

To build the LEAD Project Work Plan, complete one (1) table for each goal identified in the proposal. Applicants should copy and paste the following tables into a separate document. Continue the numbering sequence started below (1, 2, 3, etc.). Applicants are to complete chart using 12-point Arial font.

Goal 1:	**Reduce the recidivism rate for low-level drug and alcohol offenders in San Francisco's Tenderloin and Mission districts.**
Objectives:	**1.1**: By the end of the of the 26 month LEAD pilot, at least 200 pre-booking LEAD contacts will be made. **1.2:** By the end of the of the 26 month LEAD pilot, at least 50 social LEAD contacts will be made. **1.3**: By the end of the of the 26 month LEAD pilot, at least 100 participants will participate in the LEAD program and receive comprehensive case management services, including an Individual Intervention Plan, to address their substance use disorder and other related issues, such as housing, employment, physical and mental health, and legal services. **1.4**: By the end of the 26 month LEAD pilot, 50% of participants will remain free of additional criminal charges.

Project activities that support the identified goal and objectives	**Responsible staff/ partners**	**Timeline**	
		Start Date	**End Date**
Hire or assign Project Manager	SFDPH Clinical Services Manager	July 2017	August 2017
Hire or assign LEAD Case Managers and Outreach Staff	Felton Institute, Glide	July 2017	August 2017

Finalize contracts with contracted service providers and agencies	SFDPH Clinical Services Manager, Felton Institute, Glide, Harder + Co., Hatchuel Tabernik and Associates (HTA), San Francisco Public Health Foundation	July 2017	August 2017
Develop detailed criteria for LEAD project implementation, including referrals, intake, service pathways, and case management	Key Stakeholder Policy Committee facilitated by independent convener from Harder + Company	July 2017	August 2017
Develop and implement training plan for law enforcement officers, LEAD staff, and key stakeholders, including site visit to Seattle.	Drug Policy Alliance, Project Manager, SFPD, BART PD, SFSD	July 2017	August 2017
Purchase vans, laptops, cell phones and other supplies for LEAD staff	Felton Institute, Glide	July 2017	August 2017
Extend Community Assessment and Services Center (CASC) hours to 24/7	Adult Probation Department	July 2017	Sept 2017
Implement LEAD pilot: Refer 30 individuals to LEAD; complete intake and Individual Intervention Plan for at least 15 of these individuals	Entire LEAD Team	August 2017	Nov. 2017
Provide intensive case management for first 15 LEAD participants	Entire LEAD Team	August 2017	June 2019
Provide intensive case management for at least 50 LEAD participants	Entire LEAD Team	Feb 2018	June 2019

Provide intensive case management for at least 100 LEAD participants	Entire LEAD Team	June 2018	June 2019
Provide LEAD training to additional law enforcement officers	Drug Policy Alliance, Project Manager, SFPD, BART PD, SFSD	July 2018	August 2018
Attend Reducing Racial and Ethnic Disparity training	Project Manager, LEAD Case Managers and Outreach Workers	TBD	TBD
Identify evaluation measures with external evaluator	Hatchuel Tabernik and Associates, Project Manager, CSU Long Beach Evaluator	July 2017	August 2017
Prepare and submit Progress Reports	Project Manager, Hatchuel Tabernik and Associates	Quarterly	July 2017 – June 2019

Goal 2:	**Strengthen collaboration across city departments and with community-based organizations to better meet the needs of individuals with a history of substance abuse and low-level drug offenses by diverting them from the criminal justice system and into harm reduction based social services.**
Objectives:	**2.1.** By August 2017, LEAD staff and key stakeholders will develop detailed criteria and protocols that support smooth implementation of the LEAD project. **2.2** By August 2017, LEAD staff, key stakeholders, and Harder + Co. will develop a transparent information sharing mechanism across LEAD governance and advisory workgroups. Stakeholders, on average, will rate this system of information sharing above 4 on a 5 point Likert scale each project year. **2.3** By November 2017, LEAD staff, Hatchuel Tabernik and Associates, and the key stakeholders will develop an enhanced system for data sharing to track participants and collect evaluation data. LEAD partners will rate this system of information sharing above 4 on a 5 point Likert scale each project year. **2.4** By June 2018, LEAD staff will convene and participate in 4 community meetings to educate the broader community members about LEAD and build awareness of and support for the program.

	2.5 If proven effective, DPH and LEAD SF partners will sustain the LEAD approach and scale it up to serve 100 additional individuals per year from 2019 onward.

Project activities that support the identified goal and objectives	Responsible staff/ partners	Timeline	
		Start Date	End Date
Convene Key Stakeholder Policy Committee meetings quarterly	Key Stakeholder Policy Committee, Project Manager, Harder + Co.	July 2017	June 2019
Identify and nominate representatives from relevant commissions and councils and community advocates to serve on Key Stakeholder Policy Committee	Key Stakeholder Policy Committee	July 2017	July 2017
Convene Operational Workgroup meetings at least monthly	Project Manager, Clinical Services Manager, LEAD Case Managers, SFPD, BART PD, SFDA, SFSD, Harder + Co.	July 2017	June 2019
Develop data sharing and collection protocols among agencies and community-based organizations to be responsive to CSU Long Beach evaluator's needs	Key Stakeholder Policy Committee, Operational Workgroup, Project Manager, Hatchuel Tabernik and Associates	July 2017	Nov 2017
Develop protocol for sharing information between KSPC and Operational Workgroup	Key Stakeholder Policy Committee, Operational Workgroup, Project Manager, Harder + Co.	July 2017	August 2017
Identify data sharing and collection issues and troubleshoot to refine to be responsive to evaluator's needs	Key Stakeholder Policy Committee, Operational Workgroup, Project Manager, Hatchuel Tabernik and Associates	August 2017	June 2019

Goal 3:	Improve LEAD participants' health and housing status.		
Objectives:	**3.1** By the end of the of the 26 month LEAD pilot: a. 75% of LEAD participants not enrolled at the time of referral will be enrolled in Medi-Cal b. 75% of LEAD participants experiencing food insecurity will be enrolled in CalFresh c. 80% of LEAD participants with substance use disorder will be connected to SUD treatment d. 80% of LEAD participants with severe mental illness will be connected to mental health services e. 25% of homeless LEAD participants will have obtained permanent housing f. 50% of homeless LEAD participants will have obtained shelter g. 50% of jobless LEAD participants will be on the employment continuum h. 25% of jobless LEAD participants will have a stable income		

Project activities that support the identified goal and objectives	**Responsible staff/ partners**	**Timeline**	
		Start Date	**End Date**
Conduct acute needs assessment of LEAD participants, preferably within 24 hours but in all cases within 72 hours, of referral from law enforcement	CASC Intake Clinician, LEAD Case Managers	August 2017	June 2019
Connect LEAD participants to a LEAD Case Manager provider within 30 days of referral to LEAD	CASC Intake Clinician, LEAD Case Managers	August 2017	June 2019
Complete an Individual Intervention Plan with each LEAD participant within 30 days of LEAD referral	LEAD Case Managers	August 2017	June 2019
Monitor each participant's progress toward meeting the goals and objectives of their Individual Intervention Plan	LEAD Case Managers, Operational Workgroup	August 2017	June 2019
Enter all participant data into data system to ensure appropriate tracking	LEAD Case Managers	August 2017	June 2019

Supervise LEAD Case Managers and Outreach Workers to ensure participants are being provided evidence-based services that best meet their needs	Project Manager	August 2017	June 2019

SECTION IX: LEAD Key Stakeholder Committee Roster

Applicant Agency: San Francisco Department of Public Health

Individual Name	Job Title	Agency/Organization
Barbara Garcia	Director of Health	Department of Public Health
Vicki Hennessy	Sheriff	Sheriff's Department
George Gascon	District Attorney	Office of the SF District Attorney
Bill Scott	Chief of Police	Police Department
Jeff Adachi	Public Defender	Public Defender's Office
Karen Fletcher	Chief Adult Probation Officer	Adult Probation Department
Benson Fairow	Deputy Chief	BART Police
Kyriell Noon	Senior Director of Programs	Glide Harm Reduction
Al Gilbert	President and Chief Executive Officer	Felton Institute
Laura Thomas	Deputy State Director	Drug Policy Alliance
TBD, as nominated by the Reentry Council	TBD	Reentry Council
TBD, as nominated by the Tenderloin Health Improvement Partnership	TBD	Tenderloin Health Improvement Partnership
TBD, as nominated by the Roadmap to Peace	TBD	Roadmap to Peace
TBD, as nominated by the SF Sentencing Commission	TBD	SF Sentencing Commission
TBD, as nominated by the Work Group to Re-envision the Jail Replacement Project	TBD	Work Group to Re-envision the Jail Replacement Project
TBD, as nominated by the Work Group to Re-envision the Jail Replacement Project	TBD	Work Group to Re-envision the Jail Replacement Project

SECTION X: List of Partner Agencies and Services

Public Agency Partners

	Name of Agency	2-3 sentence description of services to be provided
1.	SF Department of Public Health	DPH agrees to participate in LEAD policy and operations meetings, be an active leader and contributor in ongoing discussions and planning, and facilitate connections to services offered by the DPH system of care. DPH will serve on the Key Stakeholder Policy Committee (KSPC) and the Operational Workgroup.
2.	SF Police Department	The SFPD is dedicated to training all personnel in the LEAD pilot and process, including in principles of harm reduction and applying these principles across the spectrum of police related contacts when dealing with addiction, mental illness, and homelessness. The SFPD Police will provide the part-time services to support the day to day operations of the program and serve on the KSPC and the Operational Workgroup.
3.	BART Police	The BART Police is dedicated to training all personnel in the LEAD pilot and process. Personnel will be knowledgeable in California's drug laws, search and seizure case law, local, state and federal criminal history records, warrant records, and principles of harm reduction and will have the authority to make street level decisions on where to direct those individuals that are eligible for the LEAD pilot program. The BART Police will provide the part-time services of staff to support the day-to-day operations of the program and serve on the KSPC and the Operational Workgroup.
4.	SF Sheriff's Department	The Sheriff's Department will provide a Program Coordinator to handle LEAD referrals and participate in the KSPC and the Operational Workgroup.
5.	SF Office of the District Attorney	The District Attorney's Office will provide staffing to the pilot program and serve on the KSPC. The District Attorney's Office will also assist in data collection and sharing. Though the District Attorney's Office will be informed by the KSPC, the District Attorney retains the ultimate and exclusive authority to make filing decisions in all criminal cases.
6.	SF Public Defender's Office	The Public Defender will participate as needed to support the development of the program. After the LEAD program is commenced, the Public Defender's Office will have an attorney assigned to all meetings to represent the interests of participants, advocate for individuals

		who seek to become a part of the LEAD Program, advise potential participants of legal ramifications of the program and communicate with other LEAD stakeholders to ensure that the program accomplishes the goals set forth in the Memorandum of Understanding, and serve on the KSPC.
	SF Adult Probation Department (APD)	Adult Probation will oversee operations at the Community Assessment and Services Center (CASC), the LEAD intake center. APD will also participate in the KSPC and Operational Workgroup. Three Deputy Probation Officers and one Probation Assistant will be stationed at the CASC during weekend and evening hours to serve LEAD participants. The CASC will also house several staff that will provide care coordination, life skills classes, employment and vocational training, and drug testing.

Non-Governmental, Community-Based Partners (if known)

	Name of Organization	**2-3 sentence description of services to be provided**
1.	Glide Harm Reduction	Glide will provide outreach, transportation, and case management to LEAD participants in the Tenderloin district. Glide staff will include two Outreach Workers/Drivers and two Case Managers to serve LEAD participants, and a Project Coordinator to oversee LEAD service provision and supervise LEAD staff. Glide staff will also serve on the KSPC and Operational Workgroup.
2.	Felton Institute	The Felton Institute will provide outreach, transportation, and case management to LEAD participants in the Mission district. Felton Institute staff will include two Outreach Workers/Drivers and three Case Managers to serve LEAD participants, and a Program Director to oversee LEAD service provision and supervise LEAD staff. Felton Institute staff will also serve on the KSPC and Operational Workgroup.
3.	Drug Policy Alliance	DPA will participate in the program planning, communicate with other cities developing LEAD, serve on the KSPC, advocate for continued funding, and provide the harm reduction training for law enforcement officers and case managers, as well as coordinating and funding site visits to Seattle for key stakeholders and staff as needed.
4.	San Francisco Public Health Foundation	SFPHF will serve as fiscal agent for LEAD and manage payment for project-related expenses such as food, office supplies, travel vouchers and document support for LEAD clients, and stipends for community members of the KSPC.
5.	Harder + Company	Harder + Co. will serve as an independent, neutral convener of the KSPC and Operational Workgroup. Harder + Co. will work with both groups to develop a management plan that identifies each group’s

		roles and key tasks, and outlines procedures for decision making, providing input, identifying overlapping issues, ensuring that policy, operational and community issues are addressed, and tracking progress toward project goals and objectives.
6.	Hatchuel Tabernik and Associates (HTA)	HTA will serve as the local evaluation partner for the LEAD project and will be responsible for data collection and analysis and working with the LEAD evaluation team at CSU Long Beach.

**Use the Tab key to add additional rows as needed.*

ATTACHMENTS

- **End Notes**
- **Memorandum of Understanding (MOU) signed by key partners:**
    - San Francisco Department of Public Health
    - San Francisco Police Department
    - Bay Area Rapid Transit Police
    - San Francisco District Attorney's Office
    - San Francisco Public Defender's Office
    - San Francisco Adult Probation Department
    - San Francisco Sheriff
    - Glide Foundation
    - Felton Institute
    - Drug Policy Alliance
- **Letter from the Mayor of San Francisco**
- **Geographical Map of Service Area**

ENDNOTES (References 1-17 are included as footnotes in the proposal narrative.)

18 Sadeh, N., & McNiel, D.E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. Criminal Justice and Behavior, 42(6), 573–586.

19 Read, J.P., Brown, P.J., Kahler, C.W.. (2004). Substance use and posttraumatic stress disorders: Symptom interplay and effects on outcome. Addictive Behaviors, 29(8), 1665–1672.

20 Bath, H. (2008). The three pillars of trauma-informed care. Reclaiming Children and Youth, 17(3), 17–21.

21 Meyer, R., Patel, A.M., Rattana, S.K., Quock, T.P., & Mody, S.H. (2014). Prescription opioid abuse: A literature review of the clinical and economic burden in the United States. Population Health Management, 17(6), 372–387.

22 Strang, J. (2015). Death matters: Understanding heroin/opiate overdose risk and testing potential to prevent deaths. Addiction, 110(S2), 27–35.

23 Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. Alcoholism: Clinical & Experimental Research, 30(8), 1381–1392.

24 Kelly, J.F., Stout, R.L., Magill, M., & Tonigan, J.S. (2011a). The role of Alcoholics Anonymous in mobilizing adaptive social network changes: A prospective lagged meditational analysis. Drug & Alcohol Dependence, 114(2), 119–126.

25 Kelly, J.F., Stout, R.L., Magill, M., Tonigan, J.S., & Pagano, M.E. (2011b). Spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. Alcoholism: Clinical & Experimental Research, 35(3), 454–463.

26 Kelly, J.F., Magill, M., & Stout, R.L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. Addiction Research & Theory, 17(3), 236–259.

27 Heck, C. (2008). MRT: Critical component of a local drug court program. Cognitive Behavioral Treatment Review, 17(1), 1–2.

28 Lowenkamp, C.T., Hubbard, D., Makarios, M., & Latessa, E. (2009). A quasi-experimental evaluation of Thinking for a Change: A real world application. Criminal Justice & Behavior, 36(2), 137–146.

29 Tong, L.S.J., & Farrington, D.P. (2006). How effective is the "Reasoning and Rehabilitation" programme in reducing reoffending? A meta-analysis of evaluations in four countries. Psychology, Crime & Law, 12(1), 3–24.

30 Milkman, H., & Wanberg, K. (2007). Cognitive-behavioral treatment: A review and discussion for corrections professionals (NIC No. 021657). Washington, DC: National Institute of Corrections, U.S. Dept. of Justice.