Bernalillo County Behavioral Health Initiative: LEAD Process Evaluation

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Abbreviations

ACSD – Albuquerque Community Safety Department
APD – Albuquerque Police Department
BCFD – Bernalillo County Fire Department
BCSO – Bernalillo County Sheriff's Office
COSSAP – Comprehensive Opioid, Stimulant, and Substance Abuse Program
CIUS – Crisis Intervention Units
DBHS – Department of Behavioral Health Services
FMD – Frequent Mental Distress
HUD – Housing and Urban Development
ICM – Intensive Case Management
IIP – Individual Intervention Plan
LEAD – Law Enforcement Assisted Diversion
LEO – Law Enforcement Officer
MAT – Medication Assisted Treatment
MICE – Multiple Imputation Through Chained Equations
MOU – Memorandum of Understanding
OLS – Ordinary Least Squares Regression
OWG – Operational Workgroup
PCG – Policy Coordinating Group
PIT – Point-In-Time
SMI – Severe Mental Illness
SOP – Standard Operation Procedures
SUDs – Substance Use Disorders

Introduction

In 2019, Bernalillo County and the City of Albuquerque implemented the Law Enforcement Assisted Diversion (LEAD) program, a harm reduction-centered pre-booking diversion program for individuals who are at risk of becoming involved with, or those that have previously been involved with, the criminal justice system. LEAD is an incarceration alternative that focuses on addressing individuals' underlying criminogenic needs by rerouting at-risk individuals at the point of police contact into trauma-informed community-based health and social services.

LEAD originated in Seattle, Washington in 2011 and has since diffused to over fifty-five sites across the United States including Bernalillo County, New Mexico in 2019 (LEAD National Support Bureau, 2021). Most of the evaluation literature on LEAD consists of outcome evaluations where researchers have evaluated the effects of LEAD participation on recovery support service utilization, recidivism rates, housing status, employment status, hospitalization rates, and quality of life (Clifasefi et al., 2017; Collins et al., 2017; Magana et al., 2021; Perrone et al., 2020). These studies have generally found that participation in LEAD reduced participant recidivism rates, improved participant socio-economic outcomes, and increased participant life satisfaction, though the evidence-base linking LEAD program implementation processes to participant outcomes is still under development. Comparatively less is known about LEAD program implementation including facilitators of and barriers to program implementation, the effect of officer buy-in on referral rates, stakeholder involvement with the LEAD planning process, prospects for program scalability, and evidence-based best practices for arrest diversions and social referrals.

In Bernalillo County, LEAD was initialized through a partnership between Bernalillo County, the City of Albuquerque, the Albuquerque Police Department (APD), the Bernalillo County Sherriff's Office (BCSO), the Office of the Second Judicial District Attorney's Office, the Law Office of the Public Defender, the Drug Policy Alliance, and the LEAD Santa Fe Program in July 2019 (CCN 2018 – 0749). LEAD has recently expanded to include partnerships with the Bernalillo County Fire Department (BCFD) and other community stakeholders such as the Albuquerque Community Safety Department (ACSD) as part of an expansion plan sponsored by a grant from the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) of the Bureau of Justice Assistance (CFDA #16.838). The present report is the first process evaluation of LEAD's implementation in Bernalillo County and covers the early stages of program implementation and maturation from July 1, 2019 through March 1, 2022.

In this evaluation, we detail the development, operations, and maturation of LEAD's implementation in Bernalillo County by relying on a review of policy documents, existing program participant data, surveys of sworn field officers at APD and BCSO, and semi-structured interviews with program stakeholders (i.e., program management staff at the Department of Behavioral Health Services (DBHS); LEAD case managers; LEAD-trained police officers at APD; staff attorneys at the Law Offices of the Public Defender and Second Judicial District Court). We use this data to evaluate fidelity to the underlying theoretical model on which LEAD is based, using the peer-reviewed literature on intensive case management (ICM), LEAD - Seattle, LEAD - Santa Fe, and LEAD National Support Bureau recommendations as reference points for fidelity comparisons.

By triangulating data across multiple sources, we are able to assess a number of process outcomes including (1) the characteristics of those who were referred to and enrolled in the program, (2) the geographic distribution of LEAD referrals, (3) participant use of LEAD case management services, (4) the predictors of case management engagement, (5) how familiar officers are with the LEAD program, (6) which factors predict officers' likelihood of referring eligible participants to LEAD, (7) perceptions of inter-agency stakeholder collaboration, and (8) perceptions of successes and deficits of program implementation.

In what follows, we first survey the peer-reviewed literature on LEAD. We proceed to discuss the design, data sources, and methodology of the process evaluation. We then review a series of program documents, participant-level data from multiple databases, data from a survey of police officers at APD and BCSO (N = 68; Response Rate = 16.5%), and interview data from ten stakeholders of Policy Coordinating Committee (PCG) separately (N = 10; Response Rate = 45%). We proceed to identify evidence-based improvements to facilitate program growth and sustainability. We conclude by offering a set of recommendations to sharpen elements of data-collection and facilitate case management-participant connections as LEAD - Bernalillo County enters a maintenance phase of program operation.

Literature Review

LEAD is a policing intervention designed to intercept individuals – typically those with substance use disorders (SUDs) who have committed low-level drug offenses or prostitution offenses – at the point of law enforcement contact and reroute them from the criminal justice system into a suite of social and behavioral health services, mediated through participant engagement in ICM. We now describe the process flow used in the LEAD - Seattle model to provide context into the flagship program's implementation procedures as a reference point for subsequent fidelity comparisons.

In LEAD - Seattle, when an individual in the commission of a low-level divertible offense is encountered by an officer, the officer exercises discretion to either arrest or divert the individual to the LEAD program and uses site-established eligibility criteria as well as perceptions of the participant's interest in participating in LEAD to inform that decision[1]. If the officer refers the individual to LEAD and the individual consents to enroll in the program, the officer contacts a harm reduction-trained case manager who arrives on scene or links case managers with prospective program enrollees at the referring officer's precinct as part of a warm handoff procedure. The referring officer forwards the potential participant's arrest record to relevant judicial actors in the program catchment area tasked with prosecuting misdemeanor and felony cases. Prosecutors then decide whether to divert the referred individual to LEAD. Typically, barring failure to meet site-specific exclusion and inclusion criteria, prosecutors do not file charges if the individual referred to LEAD completes both an initial screening and intake assessment with LEAD case managers within a specified time window after the initial diversion. However, if either the initial screening and intake assessment are not completed, the prosecuting attorney retains the right to file the original charges associated with the arrest that triggered diversion. If a referral is not ruled out due to failure to meet eligibility criteria and the referral completed the initial program intake documentation, the referral's pending charges for the LEAD-related offense are dropped: notably, the LEAD model does not condition charge dismissal on active program participation.

[1] See Appendix A for the inclusionary and exclusionary criteria for LEAD - Seattle (Beckett, 2014) and LEAD - Santa Fe from New Mexico Sentencing Commission [NMSC] 2018.

If a prospective LEAD participant is determined to be eligible by the prosecutor's office, the case manager is contacted and follows up with the participant, if possible, within a few days to create an individual intervention plan (IIP) designed to identify the participant's unmet psychosocial and behavioral health needs such as shelter, food, and emergency medical care. The case manager helps the participant resolve any immediate needs (e.g., access to photo identification, reliable transportation, or housing services) and refers the participant out, as needed, to appropriate behavioral health, substance use, and social services.

One of the hallmarks of the LEAD model, given high rates of SUDs and the prevalence of homelessness among the target population, is provision of harm reduction services[2] such as Medication Assisted Treatment (MAT) to participants. As LEAD is a Housing First model (LEAD National Support Bureau, 2021; Tsemberis, 2011) and significant proportions of LEAD participants are unhoused at the point of program entry (Beckett et al., 2014), case managers additionally work with eligible unhoused participants to help them access permanent supportive housing.

As the model for LEAD uses an ICM approach which emphasizes low participant to case manager ratios – typically a ratio of 1:15-20 participants (Burns et al., 2007; Dietrich et al., 2017) – frequent contact between case managers and high-need participants is encouraged. For instance, in LEAD - Seattle, participants, on average, logged 19.3 contacts with their case managers over the duration of program enrollment, though there was considerable variation in contact frequency (Collins et al., 2017). Similarly, in LEAD - Santa Fe, participants, on average, logged 46 case management appointments with their case managers (NMSC, 2018). Case managers track participant progress achieving goals identified in the IIPs over time.

At regularly held Operational Working Group (OWG) meetings and Policy Coordinating Group (PCG) meetings, LEAD partners representing each stakeholder group – typically, rotating LEAD law enforcement officers (LEOs), case managers, program management staff, prosecutors, and occasionally, participants with lived experience – collaborate to troubleshoot program implementation issues and to provide updates on the status of referred participants, though the two groups vary in composition, function, and meeting frequency. Specifically, the primary functions of the OWG are to develop and amend referral and diversion protocols, review active diversion and referral cases, and provide operational support to case managers, whereas the primary functions of the PCG are to resolve big picture questions centering on personnel matters and program budgeting.

In addition to arrest diversions, LEAD features another referral pathway: social contact referrals, sometimes referred to as community referrals or social referrals. While social contact referrals were not a part of the initial LEAD - Seattle model when first implemented, social referrals were introduced soon after program implementation to increase the number of women being served by the program and expand program reach (Beckett, 2014). In a social contact referral, officers and individuals within partnering community agencies (i.e., local businesses, stores, or nonprofits) refer to LEAD individuals encountered within the program catchment area who are suspected of recent drug or prostitution activity but who are not actively referred in the commission of a crime. For the most part, the enrollment experience for participants

[2] Harm reduction policies are generally those which "attempt to diminish the damaging effects of a particular behavior without aiming to eliminate the behavior itself. Thus, harm reduction policies and interventions consider a broader set of outcomes than would be considered in an approach that aims solely to reduce prevalence." (Eaton et al., 2018, p. 548)

referred through the social referral pathway mirrors that of arrest diversion referrals with the primary distinctions relating to the cost of participant noncompliance (i.e., the risk of charges being filed exists for diversion referrals but not for social referrals) as well as the timeline of processing participants (i.e., typically, social referrals have a longer processing window after being referred before being discharged).

The argument for LEAD rests on the assumption that by providing at-risk individuals with access to and consistent engagement with harm-reduction centered social and behavioral health services – specifically, a Housing-First ICM model – participants will be more likely to secure stable long-term housing, be less likely to overdose and to die from overdoses if and when they do occur, be less likely to recidivate, and be more likely to report a higher quality of life relative to similarly-situated individuals who are booked, prosecuted, and incarcerated or otherwise processed through the system as usual (Lead National Support Bureau, 2021).

Advocates of LEAD, in highlighting the need for pre-booking diversionary programs, cite evidence which suggests that imprisonment is not related to recidivism (Dobbie et al., 2018; Loeffler & Nagin, 2022; Nagin & Snodgrass, 2013), that arrest can amplify deviant attitudes and increase delinquency risk (Wiley & Esbensen, 2016), that substance use and severe mental illness (SMI) comorbidities are significant risk factors for crime commission, crime victimization, and recidivation (Bennet et al., 2008; Dean et al., 2018; Van Dorn et al., 2012), that rates of SUDs in the general population have increased in recent years (Carpenter et al., 2017), that the prevalence of substance use in carceral environments is higher than general population base rates (Chang et al., 2015), that the availability of prison-based chemical dependency treatment and cognitive behavioral interventions is comparatively low, though often effective when utilized (Duwe, 2017; Fazel et al., 2016), that harm-reduction approaches reduce overdose fatality rates (Stancliff et al., 2015), and that mortality outcomes for recently-released prisoners with SUDs are elevated in the immediate time frame following release (Bukten et al., 2017; Chang et al., 2015; Joudrey et al., 2019; Merrall et al., 2010).

Additionally, the use of ICM – a model of case management which emphasizes high frequency case manager contacts with high-acuity participants and smaller caseloads compared to other case management models such as Assertive Community Treatment – has generally been an effective case management approach for improving participant outcomes such as system utilization, housing status, and employment status (Dieterich et al., 2017). However, the evidence-base evaluating the effects of ICM on this set of outcomes varies in terms of methodological quality (Dieterich et al., 2017), and some studies have found mixed or null effects of ICM relative to other models of case management (de Vet et al., 2013). LEAD advocates also highlight evidence that frequent participant interactions with service providers positively correlate with reductions in psychiatric and criminal recidivism risk (Morgan et al., 2012). For these points, there appears to be a methodologically rich data-based justification.

The LEAD National Support Bureau recommends the use of warm handoffs in which officers connect prospective participants to case managers at the referral site. However, while this is a practice which has been highlighted in focus groups as an important process-piece to LEAD's success in San Francisco (Perrone et al., 2020) and while warm handoffs seem to be an intuitive way to increase enrollment rates, it is worth noting that there is a limited evidence-base on the effectiveness of warm handoffs versus other strategies designed to promote program enrollment and appointment adherence. For instance, Pace et al. (2018) present evidence that patients referred through warm handoffs were not statistically more likely to attend initial healthcare appointments. A 2021 meta-analysis presents evidence that warm handoff

interventions do not outperform other interventions designed to increase attendance at healthcare appointments, including the use of SMS messaging, provision of ride-sharing services to participants, telephone reminder calls, or having patients sign appointment contracts (Crabble et al., 2021). While the peer-reviewed evidence on the effectiveness of warm handoffs is mixed, we note that the typical characteristics of those served by LEAD (i.e., housing transiency; inconsistent phone access; lack of photo identification) might make the warm handoff strategy more effective for LEAD-eligible individuals relative to the comparison groups considered in prior peer-reviewed work.

The evidence-base on LEAD and related diversionary programs is still developing. However, a few outcome evaluations exist. The five studies featured in Table 1 find positive effects of LEAD program enrollment on recidivism rates, housing status, employment outcomes, duration of time served, and usage of emergency services.

Table 1.

Review of Outcome Evaluations of LEAD

Study Authors	Site Location	Outcomes Observed in LEAD Participants
Collins et al., (2017)	Seattle	• 60% lower odds of arrest • 39% lower odds of felony charges
Clifasefi et al., (2017)	Seattle	• 89% more likely to be housed • 33% more likely to receive increases in income/benefits • 46% more likely to be on employment continuum • 17% less likely to be arrested • Case management contact moderated increases in participant housing status, benefit reception, employment outcomes and criminal justice outcomes
NMSC (2018)	Santa Fe	• Reduced detention length • 54% reduction in the total number of participants using heroin • Eight-day average increase in the number of days of methadone maintenance therapy
Collins et al., (2019)	Seattle	• 41 fewer days in jail • 1.4 fewer average yearly jail bookings • 88% lower odds of incarceration
Perrone, Malm, and Magana (2020)	San Francisco	• 257% lower incidence of felony arrests • 623% lower incidence of misdemeanor arrests

Moreover, a few process evaluations of LEAD exist (Beckett et al., 2014; Magana, Perrone, and Malm, 2021; Perrone et al., 2020; Rouhani et al., 2019). Process evaluations help assess what program implementation looks like in practice compared to theory, why departures from an intervention's theoretical model, where they do exist, occur, and what influence those departures might have on the program's likelihood of converting program participation into intended outcomes. In other words, process evaluations help us understand the conditions which optimize and constrain a given intervention's likelihood of success as well as a given intervention's likelihood of being successful at scale (Al-Ubaydli et al., 2019; Bauer & Kirchner, 2020).

To date, process evaluations of LEAD have identified a few common facilitators and barriers to program implementation. For instance, common facilitators of program implementation include the use of collaborative decision-making across stakeholder groups, the collaborative development and clear articulation of protocols and adaptations to protocols over program maturation, repeated officer engagement in harm reduction trainings, and the presence of high-level program champions within respective police agencies (Beckett, 2014; Magana et al., 2021; NMSC, 2018; Perrone et al., 2020; Rouhani et al., 2019). Common cross-site barriers to program implementation include policy and procedural ambiguity, a lack of communication detailing the justification for proposed policy changes, perceptions that participant noncompliance with LEAD is unpunished, and low levels of officer buy-in to the program (Beckett, 2014; Magana et al., 2021; NMSC, 2018; Perrone et al., 2020; Rouhani et al., 2019). Across all process and outcome evaluations, the question of officer buy-in is one of the most cited constraints on program implementation.

To date, three articles have explored which factors predict police diversion decisions for LEAD-eligible participants and which, more broadly, correlate with levels of agency buy-in (Worden and McClean, 2018; Rouhani et al., 2019; Schaible et al., 2021). Worden and McClean (2018) present evidence that 50% of surveyed officers expressed somewhat or mostly positive views toward LEAD in their process evaluation of LEAD - Albany. The authors reason that the lack of more widespread institutional support reflects broader occupational cynicism toward reintegrative policing as well as concerns that officers have many competing time demands (see also Skogan, 2008). Rouhani et al. (2019), in their evaluation of LEAD - Baltimore, find that while longer-tenured officers were more skeptical about treatment programs for offenders, longer-tenured officers also believed that pre-arrest diversion programs were likely to reduce crime and improve public safety, suggesting that officer tenure-length positively conditions support for LEAD. Schaible et al. (2021) present evidence that officers who hold an optimistic view toward offender rehabilitation are more likely to divert offenders into LEAD. However, despite the conditional and limited support of LEAD within agencies, it is worth underscoring that statistically high proportions of officer involvement in LEAD are neither necessary nor sufficient conditions for program effectiveness: to this point, only 3% of Seattle's officers made LEAD referrals or were otherwise involved in LEAD despite early evidence of the program's effectiveness (Collins et al., 2015).

Study Design and Methodology

To conduct this process evaluation, we first detail the development and maturation of LEAD's implementation in Bernalillo County by reviewing a set of relevant policy documents and contrasting these documents against LEAD National Support Bureau recommendations, LEAD - Seattle, and LEAD - Santa Fe practices. We then review participant-level data obtained for 313 participants who were referred to LEAD from July 1, 2019 through January 15, 2022 to assess descriptive characteristics of the referred

population, the geographic clustering of LEAD referral sites, the dosage of case management services provided to the enrolled sample, and the predictors of case management service use. We proceed to review survey data from surveys of sworn field officers at APD and BCSO designed to assess officer awareness of LEAD, participation in LEAD trainings, and the likelihood of making a referral to LEAD. Finally, we review data from 10 semi-structured interviews with program stakeholders from the PCG. We briefly detail the scope of the data collection for each data source below as well as limitations.

Document Review

We obtained a number of documents from program inception through February 2022 which allow us to trace the chronology of LEAD and to compare codified protocols against other sites' protocols and LEAD National Support Bureau recommendations for best practices. Specifically, we made use of foundational documents [e.g., the authorizing New Mexico Senate Bill (SB 216, 2019), the original MOU, flow charts and logic models created by the DBHS in February 2019[3], original copies and updates to APD and BCSO's LEAD SOPs, a 2020 report published by Bernalillo County on the first year of LEAD implementation, a 2021 gap analysis of the City of Albuquerque and Bernalillo County behavioral health system by Via Positiva, the Bernalillo County DBHS LEAD Program Handbook completed in March 2021, and the Bernalillo County LEAD Expansion Plan proposal completed in September of 2021]. We also examined documents which highlight relevant aspects of the evolving socio-political landscape of Bernalillo County, including the APD Consent Decree with the Department of Justice and recent local news articles on the topic of LEAD and diversionary programs in Bernalillo County, which allowed us to capture how environmental factors may influence program implementation.

Together, these documents allowed us to sequence substantive changes in program operations including modifications to eligibility criteria, changes in referral procedures, and program phase state-changes and to make sense of these changes against the backdrop of broader political dynamics unique to Bernalillo County. One of the inherent limitations to document review, however, is that we might not pinpoint precisely when specific modifications to program procedure took effect in practice. Relatedly, the codification of rules and procedures, while a necessary precondition for program success, is not sufficient for ensuring that rules and procedures get implemented as intended in practice: how those rules and procedures get communicated to broader audiences and the degree of resistance to proposed rule and procedure changes among implementing agents might influence their impact on program implementation (Bowen, 2009).

Participant-Level Data

We received participant-level data from several sources. We extracted data from DBHS' NetSmart CareManager care coordination and data sharing platform in January 2022 and February 2022. From this data, we were able to assess the following process variables of interest: (1) the type and number of LEAD referrals (i.e., social contact referrals versus arrest diversion referrals); (2) the enrollment rate; (3) the dosage of case management services provided to participants from September 2021 through January 2022 (i.e., the number of case manager contacts with clients; percent of successful contacts; type of contact; duration of contacts); (4) participant characteristics at intake (i.e., age; sex; ethnicity; housing status;

[3] Logic models help to visualize via flow-chart the program's underlying causal assumptions relating processes to outcomes.

substance use) and variability in participant characteristics by referral source; (5) the distribution of referrals by agency and officer, and (6) the geographic distribution of LEAD incident locations. Where possible, we cross-referenced this data with similar data being collected under the purview of the COSSAP grant which includes additional data on (1) participant quality of life, (2) frequency of substance use, and (3) participant stages of change. The chief limitations to the participant-level data extracted from the NetSmart CareManager platform were that (1) most logged participant-level data covers a five-month window from September 2021 through January 2022, or 16.7% of the intervention's life, and that (2) a number of implementation questions such as which services participants received or what goals participants identified in their IIPs are unexamined due to either the lack of data collection on these variables to date or the storage of this data in non-usable formats (e.g., .pdfs; text-fields in case notes). The chief limitation to the participant-level data extracted from the two COSSAP databases was that there was some data missing for unclear reasons (i.e., enrollment disposition outcomes; harm reduction services received).

Surveys of Sworn Field Officers

We conducted surveys of 68 sworn field officers at APD and BCSO in December 2021. The purpose of these surveys was to assess (1) officer attitudes toward offenders with mental illness and beliefs about the merits of rehabilitative programs, (2) awareness of the LEAD program, (3) participation in LEAD training, (4) perceptions of the ease of making LEAD referrals, (5) officer demographic characteristics, and (6) officers' likelihood of making a LEAD referral. Given access issues common to academic surveys of officers (Nix et al., 2019; Skogan, 2015), lieutenants at both agencies distributed the survey through email listservs to sworn field officers at APD and BCSO. Email reminders were sent every week for five weeks between December 1, 2021 and January 15, 2022. 52 of 304 sworn field officers at APD (Response Rate: 17.1%), and 16 of 108 sworn field officers at BCSO completed the survey (Response Rate: 14.8%). While many assume low response rates are problematic because they are assumed to increase the likelihood of nonresponse bias[4], research on response rates in police surveys by Nix et al., (2019) and by survey methodologists find that low response rates do not, in isolation, threaten the validity of a given study's conclusions since the response rate does not reveal the reasons why one may choose to participate nor does it provide a sense of how participation-related variables correlate with outcomes of interest (Groves et al., 2009; Peytchev, 2013; Wagner, 2012).

Interviews of Policy Coordinating Group (PCG) Members

From September 2021 through October 2021, we conducted 10 interviews with members of the LEAD - Bernalillo County PCG. We conducted three interviews with project management staff, three interviews with case management administrators and case managers, two interviews with legal staff, and two interviews with frontline officers (Response Rate = 45%). On average, interviews lasted 42 minutes though interviews varied in duration based off of an interviewee's role in the PCG. For instance, case management staff answered an extra set of questions designed to assess perceptions of service delivery to LEAD participants. The purpose of these interviews was to (1) understand PCG members' roles in LEAD, (2) their beliefs about program successes and deficits, and (3) their perceptions of working group collaboration. One of the limitations of the interviewing data was that only a subset of PCG members were

[4] Nonresponse bias occurs when the characteristics of individuals who refuse to take part in a survey or who drop out of a survey are both (a) different from the characteristics of individuals who complete the survey and (b) when these characteristics are correlated with the specified outcome variables studied.

represented; thus, it is difficult to assess whether attitudes expressed by those interviewed typify the general attitudes of the broader PCG network. Specifically, BCSO PCG members did not participate in the interview.

Document Review Analysis

The core pillars of the LEAD model consist of active collaboration across program partners, the application of harm reduction and Housing First principles, the use of intensive, streets-based case management, and the establishment of meaningful police relationships (LEAD National Bureau, 2021). The core principles of LEAD - Bernalillo County, as outlined directly in program goals in the original MOU, the LEAD Program Handbook, and the Bernalillo County Expansion Plan proposal, are consistent with these pillars and were created in consultation with representatives from the evaluation team of LEAD - Santa Fe. However, in what follows, we center our discussion on key points of contrast between Bernalillo County's implementation of LEAD to date and LEAD - Seattle, LEAD - Santa Fe, and LEAD National Support Bureau recommendations.

We center our discussion of implementation fidelity on intervention eligibility criteria and case management processes[5]. As a starting point, we invite readers to examine LEAD - Bernalillo County's intervention procedures, logic models, and program flow charts, replicated in Appendix B, to get a sense of the program's structure, process flow, and guiding principles. We note that the LEAD National Support Bureau identifies several core principles for various LEAD stakeholder groups. More detail on these core principles are provided in the following links: Core LEAD Principles for Policing, Core LEAD Principles for Community Public Safety Groups, Core LEAD Principles for Prosecutors, Core LEAD Principles for Case Managers, and Core Principles for Successful LEAD Implementation.

Since implementation in July 2019, LEAD - Bernalillo County partners have updated arrest diversion and social contact criteria as occurred both in Seattle and Santa Fe. However, there are some fundamental differences in the eligibility criteria between Seattle, Santa Fe, and Bernalillo County as well internal changes to Bernalillo County's eligibility criteria over time. For instance, while all sites have similar inclusionary criteria for LEAD-eligible offense-type (e.g., low-level property crimes committed to secure money for illicit drugs; prostitution; vagrancy or loitering) and have similar eligibility qualifiers (e.g., perceived amenability to treatment; whether the referral's drug-related activity involves delivery or possession with intent to deliver; promotion of prostitution; exploitation of minors), the sites differ in the exclusionary criteria related to quantity of drug possession. Per Collins et al. (2015), LEAD - Seattle defined an upper-bound exclusionary drug threshold of three grams per participant whereas LEAD - Bernalillo County and LEAD - Santa Fe (NMSC, 2018) defined an upper-bound drug threshold of six grams. Furthermore, there are some cross-site distinctions in how the programs define a disqualifying criminal history. For instance, LEAD - Seattle defines a disqualifying criminal history as:

> *Without time limitation: Any conviction for Murder 1 or 2, Arson 1 or 2, Robbery 1, Assault 1, Kidnapping, Violation of the Uniform Firearms Act (VUFA) 1, Any sex offense, or attempt of any of these crimes. Within the past 10 years: Any conviction for a domestic violence offense, Robbery 2,*

[5] We use LEAD - Seattle as a reference point given that this is the site where the LEAD model originated. We use LEAD - Santa Fe as a reference point given that state-level characteristics are held constant in comparison to LEAD - Bernalillo County which minimizes the role that state-level variation in criminal justice policies may play in explaining deviations in implementation across sites.

> *Assault 2 or 3, Burglary 1 or 2, or VUFA 2. The individual was already involved in King County Drug Diversion Court or Mental Health Court.* (Beckett et al., 2014).

LEAD - Santa Fe defined disqualifying criminal history as follows:

> *The individual has a conviction in the last 10 years for homicide, vehicular homicide, aggravated arson, aggravated burglary, all robbery, all kidnapping, all sex offenses, and any conviction involving firearms or deadly weapons (or attempt of any crime listed here).* (NMSC, 2018)

However, while LEAD - Bernalillo County initially defined the disqualifying criminal history similarly to LEAD - Santa Fe, the project team updated the definition of disqualifying criminal history in April 2021 with the primary difference relating to whether any crimes made an individual automatically ineligible and the limitation of time passed since crime commission. Specifically, per the Bernalillo County Metropolitan Court Outreach Court Program Partnership with LEAD document, the updated definition of disqualifying criminal history included:

> *In the last 3 years, any conviction for homicide, aggravated arson, aggravated burglary, all robbery, aggravated battery/ assault, kidnapping/ false imprisonment. All sex offenses, Stalking, Any sustained violations for a protective and/or restraining order, All crimes against children, Any conviction involving firearms or deadly weapons, Crimes of Violence (misdemeanor), Any Violent Felony not listed above, Trafficking a Controlled Substance (NMSA 30-31-20), Registered sex offenders.*

Evaluator notes at PCG meetings suggested that the reduction in the exclusionary time limit for past offenses came about because of shared stakeholder expectations that the 10-year limit was too prohibitive, resulting in individuals who would stand to benefit from program participation unnecessarily being barred from eligibility and a related expectation that recidivism risk was, in effect, similar for participants who had committed the relevant crime three years ago or ten years ago. The reduction in the exclusionary time limit was, in part, designed to increase the number of program referrals. Across all sites, the District Attorney has discretion to waive any exclusions, permitting the individual to enter LEAD, though, in practice, the waiving of exclusions is rarely used.

Our document review additionally revealed other structural points of departure between the three programs with respect to various components of program implementation and service delivery. For instance, LEAD - Seattle and LEAD - Santa Fe had clearly defined distinctions between the PCG and OWG groups whereas LEAD - Bernalillo County, despite mentioning this distinction formally in existing program documents as well as in training materials for officers, collapsed the groups into a single group which met for one hour biweekly due to limited stakeholder time and the perception that the meetings served both functions of the OWG and PCG. Per evaluator meeting notes, attendance at biweekly PCG meetings was not always universal, specifically among LEO partners. A core cluster of three officer liaisons from APD and BCSO attended a majority of PCG meetings; however, beyond the core cluster, other field officers who made LEAD referrals rarely attended and thus did not receive direct updates on their referred participants' progression through the program. Additionally, only one PCG meeting from March 2021 through March 2022 included a participant with lived experience in the program.

In the Essential Principles for Successful LEAD Implementation document, the LEAD National Support Bureau notes that the hiring of a dedicated program manager is essential as program managers help to "troubleshoot stakeholders' concerns, work to identify resources, facilitate meetings, develop

information-sharing systems, and streamline communication. Because LEAD is a consortium of politically independent actors, it is desirable for the project manager to be primarily loyal to the program itself, independent from all political and operational stakeholders" (National Support Bureau, 2021; p 1). However, LEAD - Bernalillo County did not hire a program manager until 20 months after program implementation in March 2021.

LEAD National Support Bureau staff advise the use of warm handoff procedures between arresting officers and case management staff. However, the LEAD National Support Bureau does not directly mention the use of warm handoffs nor do they formally articulate the procedures governing the use of warm handoffs on their website. The procedures governing the use of warm handoffs in LEAD - Bernalillo County have not always been clearly communicated, and the use of warm handoffs is a relatively recent program adaptation. Per evaluator notes at PCG meetings, warm handoffs were not used as a program practice until July 2021 and per data from the COSSAP SmartSheet data dashboard, the rate of warm handoffs between referring partners and case managers, covering the time period of September 2021 through February 2022, was approximately 25%.

Per PCG evaluator meeting notes from August 2021, PCG attendees identified low-levels of case management and officer staffing as one explanation for the low rate of warm handoffs. DBHS' formal protocol on warm handoffs, taken from guidelines outlined in both Expansion Plan documentation and the LEAD Program Handbook, is for officers to give case managers a call at the referral site and wait for the case manager to arrive on scene or, if contact is not made with the case managers, instructing officers to drop off prospective participants at the DBHS CARE Campus. While the procedures for using the warm handoff are not directly mentioned in the training slides, program management and case management staff at the DBHS reported disseminating materials on the warm handoff process to officers and community partners during training events in the form of brochures and pocket cards which make explicit the warm handoff procedures.

Despite presumptive receipt of this documentation in the context of trainings, officers and community referring partners tended to send emails to case managers with attached referral forms after they released the referred individual back into the community instead of conducting a warm handoff. It is not obvious why this was the most common program practice. Relatedly, the DBHS case management staff noted that individuals referred by officers and community partners would occasionally arrive at the CARE Campus a few days after being verbally referred by the referring partner, though LEAD case management staff at the DBHS had not yet received referral paperwork. There appears to be ambiguity on the process of conducting warm handoffs across different stakeholder groups which limits their use in practice, despite being a protocol mentioned in the Expansion Plan documentation and detailed in training materials.

Documentation from PCG meeting notes in June 2021 and July 2021 highlight the importance of the warm handoff and identify barriers to establishing repeated engagement of participants with case managers. Specifically, when referrals arrive through email after an officer loses contact with a referred individual, it becomes more difficult for case managers to locate participants in the field. Per conversations with the case management staff, this difficulty emerged because referrals occasionally provided inaccurate phone numbers and addresses at intake which were not verified at the point of intake. Additionally, because there is often a lack of photo identification with the exception of referrals originating from the Metropolitan Detention Center, case managers reported that identifying clients in the field was difficult due to participant transiency.

As LEAD - Bernalillo County has matured, the program has expanded its referral stream to include other community partners and has allowed self-referrals into the program as well, though per participant-level data analysis, a majority of referrals continue to originate with LEO partners, primarily APD. Per the Training Log and Outreach Events 2021 document, LEAD trainings and outreach efforts began expanding out from officer swing shift and field briefings at APD and BCSO in August 2021 to include outreach with community partners such as Mobile Crisis Teams (MCTs), ACDS, YDI, and the Public Defender's Office. Per the Training Log and Outreach Events 2021 document and between March 2021 through January 2022, 418 unique individuals at APD and BCSO as well as community partner groups within the program's catchment area such as the Public Defender's Office, MCTs, and staff at ACSD, have received a formal in-person training in LEAD. Per training presentation slide decks, the training curriculum typically reviewed the history of the War on Drugs, local 20-year trends in property and violent crime rates, the neurophysiological substrates of chemical dependency and drug addiction, and previous outcome evaluations of LEAD.

Despite its recommendation as a best practice, the administration of pre-post training tests to officers was rarely deployed throughout the evaluation window, and thus, we cannot directly report on how officers' or other community partners' attitudes toward LEAD changed causally as a function of training participation. Prior to the hiring of a program manager in March 2021, the scope of LEAD - Bernalillo County training was more limited, consisting of officers viewing a short video created by staff at the DBHS which was distributed to officers through the PowerDMS system. One of the LEAD National Support Bureau Recommendations is that officers receive repeated training in harm reduction principles; however, it is not clear that re-training has been prioritized as the program has been focused on increasing the absolute number of officers trained. LEAD - Bernalillo County does use the recommended practice of using a "train-the-trainer" model with swing-shift field briefings making use of this approach. Additionally, documentation from the Independent Monitor's November 2021 "Compliance Levels of the Albuquerque Police Department and the City of Albuquerque with Requirements of the Court-Approved Settlement Agreement" report suggest that there are high-levels of agency-wide training in behavioral health topics and conflict de-escalation at APD, even if these trainings are not LEAD-specific.

A few other process variables unique to the document review are worth brief comment. First, LEAD - Bernalillo County received a $14,000 Urban Institute grant effective July 2021 for the distribution of phones to eligible LEAD clients as a tool for increasing contact between case managers and participants once enrolled. LEAD clients were told about the opportunity to receive a phone for their participation in LEAD at the point of program intake. However, as of March 15, 2022, only five phones had been distributed to LEAD participants. The cited reason for the level of phone distribution relates to Bernalillo County's procurement rules and the eligibility criteria for receipt of a phone (e.g., in order to receive a phone, a participant must have repeated contact with case management staff beyond the intake appointment and not already have a phone).

Moreover, it is worth considering how characteristics of the broader socio-political environment in which LEAD - Bernalillo County is embedded shape participant engagement and broader community attitudes toward LEAD. For instance, the 2019 Bernalillo County Community Health Profile Report identified a 27.3% drug overdose rate and high rates of polysubstance use, specifically of opioids and methamphetamine, within Bernalillo County. This report – paired with the June 2021 System Gap Analysis by Vita Positiva – suggest high need for a program like LEAD within Bernalillo County. However, Vita Positiva's Gap Analysis of LEAD - Bernalillo County noted the following challenges:

> *The County has invested in a LEAD program that is not being utilized appropriately. Challenges that have been cited include the pandemic slowing of opening the program; fewer interactions with officers (this is disputed by opposing interests) because of the pandemic; lack of knowledge about the program in the Albuquerque Police Department and the Bernalillo County Sherriff's Department; persons not being accepted into the diversion program because of exclusionary criteria, resulting in officers declining to try to engage persons in the program because they have not been successful doing so in the past; and the lack of staff. At one point in 2021 the two (2) case manager positions in the program were vacant. There were several months with no referrals.*
>
> *The national average for a client caseload in a LEAD program is 15 – 22 persons, meaning that if the LEAD program in the County was operating effectively, a potential of 44 individuals could be served at one time. Since the program began, 95 referrals have been made. Of those, almost half did not complete an intake or had charges filed (eliminating them from the program). A point in time count on May 5, 2021 indicated nine (9) active clients and 10 who had been discharged. It has been proven nationally that an effective LEAD program can influence behavioral health and homeless needs in the same manner as permanent supportive housing.* (Ericson et al., 2021; p .31)

As the participant-level, survey, and interview data detailed later in this report indicate, some of the implementation difficulties of LEAD - Bernalillo County identified in the gap analysis appear to have improved since the publication of the report (e.g., enrollment and referral counts; agency-level awareness of LEAD) whereas others (e.g., staffing concerns; lack of permanent supportive housing) are still present to varying degrees.

Speaking to context of the broader integrated behavioral health system in Bernalillo County, the 2021 Gap Analysis also noted:

> *There is a dramatic need for the City and County to increase their efforts in developing Permanent Supportive Housing options for citizens. As noted in the service gaps sections earlier, both entities are aware that without further development of such housing resources they cannot hope to ever effect significant change in the behavioral health and homeless programs attempting to assist individuals across the region. More emphasis must be placed on rental assistance, long term housing vouchers (and accompanying support for job training and employment), and protections for individuals and families at risk of eviction and additional efforts are underway. Targeted investments in the most significant social determinants of health – a safe, affordable place to live with requisite assistance to assure that those housing options remain secure – increases the likelihood of eliminating behavioral health needs or reducing them to a level manageable in the currently available system of care. There are multiple housing partners – public and private – with whom the City and County must collaborate to leverage assistance. The belief that government alone can secure all of the necessary resources and supports to assist the unhoused is ineffective and fails, often, to take into account those persons of lower socioeconomic status or persons of color who are already marginalized and may not be aware of or seek such services. Partnerships need to be enhanced quickly.* (Ericson et al., 2021; p .54)

While the question of inadequate access to housing in Bernalillo County mirrors recent national trends (Acosta & Gartland, 2021), the limited supply of housing resources, the lengthy waitlists for housing vouchers, and the limited supply of community behavioral health providers are site-level factors which

potentially threaten program effectiveness downstream given the centrality of the Housing-First approach to the intervention's theoretical core.

Finally, it is worth considering how increasing violent and property crime rates in Bernalillo County observed over the past two years might condition broader public attitudes toward diversionary programs as well as the attitudes of instrumental community-partners. For instance, an article from June 2021 in the *Albuquerque Journal* provided a negative assessment of LEAD - Bernalillo County which primarily focused on the low volume of referrals into the program at that time point (Uyttebrouck, 2021). Similarly, a news article from December 2021 by KRQE on diversion programs in Bernalillo County quoted APD Police Chief Harold Medina as stating:

> *Recently I think it's gotten to the point that things have swung so far one way [towards diversion] that now we're hearing the public cry out, "We want people to be held accountable" …There has to be a balance with a lot of the social service programs and law enforcement. And we have to be able to say that we want to help individuals who have substance abuse problems, but as a community, we need to draw a line.* (Segarra, 2021)

It is worth considering that broader public support for diversionary programs and support within committed LEAD advocates is not immune to the tone of media coverage used to describe the program, that recent increases in the violent crime rate in Bernalillo County may correlate with increased public support for punitive criminal justice policies (see, for instance, Jennings et al., 2016), and that mixed signals from high-level leadership within police agencies can generate mixed reception of the program by line officer staff.

Participant-Level Data

From January 2022 through February 2022, we obtained participant-level data from the DBHS' NetSmart CareManager platform. This data included information on referral type, source, date, and location, the demographic profiles of program participants, participant substance use, and case management contacts. In February 2022, we also obtained data collected by the DBHS case managers as a part of the COSSAP-funded cross-site evaluation of LEAD in New Mexico including Baseline and Enrollment Form data taken at the point of program intake as well as Monthly Client Services Form data recorded at monthly intervals following the initial enrollment date. This data shares some overlap with NetSmart CareManager data but includes more specific data on the frequency of participant substance use, participant perceptions of quality of life, and the specific recovery support services participants were linked to throughout their enrollment in the program. This data only covers participants enrolled from September, 1 2021 through January 15, 2022.

Referral Sources – NetSmart Care Manager Data

After cleaning and merging the data to remove duplicate clients, from July 1, 2019 through January 15, 2022, LEAD - Bernalillo County received a total of 313 referrals. Of the 313 referrals, 63.3% were arrest diversions (n = 198), 36.1% were social contact referrals (n = 113), and less than 1% were of unknown origin (n = 2). Of those referrals, 69.6% were from APD (n = 218), 15.7% were from BCSO (n = 49), and the remaining 14.7% were from other sources including Crisis Intervention Units (CIUs), MCTs, ACSD staff, and other community referral sources (n = 46). 71.5% of program referrals occurred after the hiring of a program manager in March 2021 (n = 224; 22.4/month). 41.2% of program referrals occured after the

official start date of the COSSAP Expansion Plan on September 1, 2021 (*n* = 129; 32.5/month). From program inception through January 15, 2022, 61 distinct officers made either an arrest diversion or social referral, 39.3% of referring officers made more than one referral (*n* = 24), and 8.2% of referring officers made more than 10 referrals from July 1, 2019 – January 15, 2022 (*n* = 5). Four officers were singularly responsible for 111 referrals which represents 35.4% of LEAD referrals from all sources and 44.4% of overall referrals from officers.

Figure 1 is a heatmap of LEAD referral locations from July 2019 through January 2022 which uses kernel density estimation procedures to estimate the spatial clustering of LEAD referral sites (Hart & Zandbergen, 2014). Due to lag in the retrospective entry of incident site locations into the NetSmart Care Manager database, Figure 1 represents approximately 30% of overall LEAD referral sites. Noting this caveat, Figure 1 suggests that there has been a high density of recent LEAD referrals from Coronado Skate Park [301 McKnight Ave, Albuquerque, NM 87102], the intersection of Central Avenue and Pennsylvania Street, and the intersection of Zuni Road and Kentucky Streets. We also received documentation on hotspot mapping from APD in January 2021 which highlights the density of LEAD-relevant call codes [27-5 (Burglary); 10-40 (Mental Patient); 10-57 (Narcotic)] generated by the Crime Analysis Unit of the Real Time Crime Center at APD from October 1, 2021 – December 31, 2021. However, due to data-sharing agreements, we cannot replicate that figure in the present report. We also requested CAD call-for-service (CFS) data from APD and BCSO in January 2022 on all LEAD-eligible offense CFS from program inception through January 2022 so that we could identify spatial overlap and discrepancies between referral locations and potentially fruitful recruiting hotspots; however, as of the writing of this report, we have not received this data.

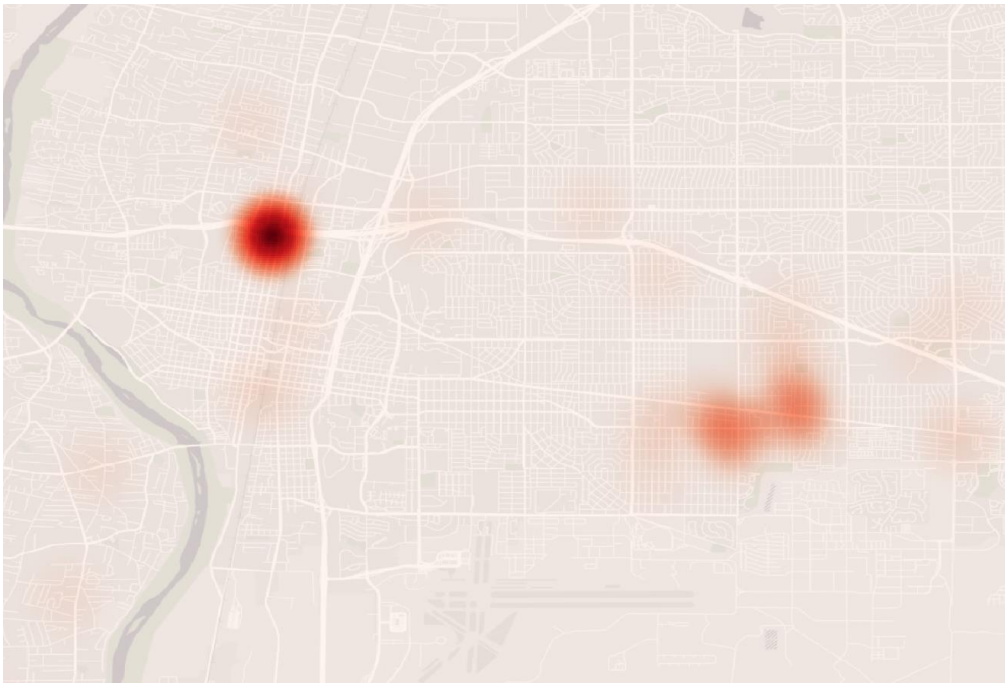
Characteristics of LEAD - Referred Individuals

Of the 85.9% of LEAD referrals with recorded age data (*n* = 269), the average referral age was 37.4 years (*s.d.* = 10.4). Of referrals, 55.5% identified as male (*n* = 149), a plurality identified as Hispanic (44.9%; *n* = 122), 28.3% as Caucasian (*n* = 77), 13.2% as Native American (*n* = 36), and 3.6% as Other Ethnicity (*n* = 10). 58.1% of participants were unhoused at the point of program intake (*n* = 158). Of the 44.1% referrals with reported marital status (*n* = 138), 76.1% reported having never been married (*n* = 105), 16.7% reported being divorced (*n* = 23), and 7.2% reported being married (*n* = 10). Of the 23.6% referrals with recorded employment status at the point of program intake (*n* = 74), 85.1% were unemployed (*n* = 63). We do not report data on the distribution of participant religion or education-level given high rates of item-level missingness for these variables (Rate of Missingness: 98.1% and 82.7% respectively).

It is important to consider whether there are meaningful differences in participant profiles by referral type given that the original introduction of social contact referrals in LEAD - Seattle was motivated by a desire to reduce sex-based disparities in program participation and expand program reach. To this end, we conducted a regression to assess whether there were any statistically significant differences in the demographic and socioeconomic profiles of referred individuals by referral type. As our primary outcome variable is binary (0 = Social Referral; 1 = Arrest Diversion), we employ logistic regression with quarterly-fixed effects to assess the independent effects of a referred individual's sex (0 = Female; 1 = Male), ethnicity (0 = Nonwhite; 1 = White), housed-status (0 = Housed; 1 = Unhoused), drugs used (0 = Not Used; 1 = Used for methamphetamine, fentanyl, and heroin, respectively), referring agency (0 = APD; 1 = BCSO; 2 = Other), and program quarter on referral type.

Figure 1.

Heatmap of LEAD Referral Site Locations



After holding all other predictor variables constant, we found that APD had 160% greater odds of making an arrest diversion compared to BCSO (95% CI: [1.25, 5.40]). We also found that, after holding all other predictor variables constant, referred individuals who indicated using fentanyl (95% CI: [2.38, 48.67]), heroin (95% CI: [1.48, 10.76]), methamphetamine (95% CI: [1.86, 13.47]), and general opiates (95% CI: [1.52, 160.28]) had statistically higher odds of getting referred to LEAD through an arrest diversion instead of through a social referral. For instance, fentanyl users had 1,070% higher odds, heroin users had 400% higher odds, methamphetamine users had 500% higher odds, and general opiate users had 1,560% higher odds of being referred into LEAD through arrest diversion over the social referral pathway. Additionally, men had 97% higher odds (95% CI: [1.02, 3.79]) of being referred through arrest diversion than women which is consistent with findings from LEAD - Seattle that social referrals increase the ratio of women in the LEAD participant pool (Beckett, 2014). We present a cross tabulation of referral sex by referral pathway in Table 1 to more intuitively illustrate the bivariate differences in referral pathway by sex. A chi-square test revealed marginally significant differences at the bivariate level (*p-value* = 0.09).

Table 1.

Cross Tabulation of Sex with Referral Pathways

	Frequency (Arrest Diversion)	**Frequency (Social Referral)**	**Totals**
Sex: Male	92 [52.6%]	54 [42.9%]	146
Sex: Female	83 [47.4%]	72 [57.1%]	155
Total	175	126	301

We did not observe statistically significant differences in referral type by either a referred individual's ethnicity or housed status. The odds of making an arrest diversion instead of a social diversion increased over time with a 10% average increase in the odds of making an arrest diversion for each subsequent quarter of program history.

We cross-referenced the referral data from DBHS' NetSmart Care Manager system against referral and enrollment data tracked through the SmartSheet and RedCap databases as part of the COSSAP cross-site evaluation. The data we review covers the period from the start of the COSSAP granting period on September 1, 2021 through January 15, 2022 and is derived from the LEAD Enrollment and Baseline .csv files. Per the referral data entered into SmartSheet, in this time period, 102 referrals were received of which 55.9% were arrest diversions (n = 57), 33.3% of which were social community referrals (n = 34), and 10.8% of which were social law enforcement referrals (n = 11). Of the referrals received in this timeframe, 92.3% were first-time referrals (n = 96), and 8.7% were second-time referrals which occurred after a previously enrolled participant was classified as inactive, a classification which occurred after a month of lost contact with the participant following enrollment (n = 8). Of the 85 recorded enrollment outcomes from this time period which represents 81.7% of the total enrollment count, 58.8% of referred participants enrolled in LEAD (n = 50), 34.1% missed the deadline for enrolling (n = 29), 4.7% were determined to be ineligible for LEAD (n = 4), and 2.4% declined to enroll (n = 2). Of the 102 referrals with recorded sex data, 38.2% were female (n = 39), 60.8% were men (n = 62), and 1% identified as other (n = 1). Of those referred, 42.2% identified as Hispanic (n = 43), 23.5% identified as White (n = 24), 18.6% identified as Native American (n = 19), 12.7% identified as Black (n = 13), and 2.9% identified as other (n = 3). 59.4% of referrals came from APD (n = 60), 31.4% came from partnering agencies (n = 32), and 8.8% came from BCSO (n = 9). The demographic profile of LEAD participants tracked within the COSSAP databases roughly mirrors the demographic profile derived from the NetSmart CareManager database. Of the 87 eligible LEO referrals and as of March, 2, 2022, 75% of LEAD referrals did not involve the use of the warm handoff with a case manager (n = 65).

When we merged data from the Baseline and Enrollment form with data collected from the Monthly Client Services Form, we noticed disparities in the degree of data collection. Specifically, at the time we received data, only 78% of participants (n = 39) had complete information logged on both the Baseline and Enrollment form and Monthly Client Services Form whereas 14% of referred participants had complete information logged on the Monthly Client Services Forms yet did not have completed Baseline and Enrollment form entries despite the collection of the latter preceding the former in time (n = 7). Of the 39 participants with complete data, 43.6% of participants identified as female (n = 17), and 56.4% identified as male (n = 22). Among female participants, 0% indicated they were currently pregnant. 51.2% of participants identified as Hispanic (n = 20), 30.8% as White (n = 12), 10.3% as Black (n = 4), 5,1% as Native American (n = 2), and 2.6% as multi-racial (n = 1). 18.0% of participants indicated they had stable, adequate, and consistent housing at the point of program intake (n = 7). 41.0% of participants indicated that during the prior 30 days, they most frequently slept outside and were unsheltered (n = 16), 17.9% reported living at a friend or family member's house (n = 7), whereas only 5.1% of participants indicated living in their own home (n = 2). 61.5% of participants indicated that they were not employed and not looking for work (n = 24), 30.8% indicated they were not employed and looking for work (n = 12), and 7.7% indicated that they were working full-time (n = 3). Participants could also report on their quality-of-life (QOL) using a seven-point Likert scale where 1 = "Terrible" and 7 = "Excellent". Both the median and mode QOL scores of participants were a 3 - "Poor" ($s.d.$ = 1.17).

Participants reported whether they received any employment, housing, alcohol treatment, MAT (suboxone/subutex), MAT (methadone), inpatient substance use treatment, intensive outpatient substance use treatment, syringe/needle exchange, or other services in the prior 30 days. 43.6% of participants reported using at least one service in the prior 30 days (n = 17). The most used service was MAT – Methadone services which were used by 12.8% of participants (n = 5). 7.6% of participants reported receiving two services in the prior 30 days (n = 3). 39.4% of participants indicated that they had a primary care physician (n = 15) whereas 60.5% of participants did not (n = 23).

43.5% of participants indicated that they had experienced an overdose in their lives (n = 17) compared to 56.4% of participants who had not (n = 22). Of participants who had overdosed at least one time in their lives, the median number of total lifetime overdoses was two (*s.d.* = 11.60). 79.5% of participants indicated using substances in the prior 30 days (n = 31). The three most used substances among reporting participants were: (1) methamphetamine (86.7%; n = 26), (2) cannabis (63.3%; n = 19), and fentanyl (56.7%; n = 17). The median number of substances used in the prior 30 days was two (*s.d.* = 2.85), and approximately 79.4% of participants used more than one substance (n = 31), consistent with high rates of polysubstance use observed within the program catchment area per 2020 data from the New Mexico Department of Health (see Figure 2).

The Addiction Severity Index (McLellan et al., 1992) was used to assess participants' frequency of substance use. The median using-participant reported using methamphetamine on 45% of the prior 30 days (n = 13.5 days), cannabis on 26.7% of the prior 30 days (n = 8 days), and fentanyl on 100% of the prior 30 days (n = 30 days). An 11-item substance use severity scale indicated that 76.7% of participants self-reported no severity issues with alcohol (n = 23) whereas only 13.3% of participants endorsed six or more items on the scale (n = 4). Conversely, the 11-item substance use severity scale indicated that 26.7% of participants self-reported no severity issues with drugs (n = 8) whereas 60% of participants endorsed six or more items on the scale (n = 18). Finally, participants also responded to a question asking about stages-of-change (Prochaska et al., 2015) which asked participants to consider which substance they used the most over the prior 30 days and then to evaluate the extent to which they were considering making change to their substance use (1 = "I am not thinking about making changes in my substance use"; 5 = "I have made changes to my substance use, and I am working to maintain those changes."). 6.67% of participants indicated they were not thinking about making changes in their substance use (n = 2), 33.3% of participants indicated that they were thinking about making changes in their substance use (n = 10), 10.0% of participants indicated they were preparing to make changes in their substance use (n = 3), 33.3% of participants indicated they were actively making changes in their substance use (n = 10), and 16.7% of participants indicated they had already made changes to their substance use and were working to maintain those changes.

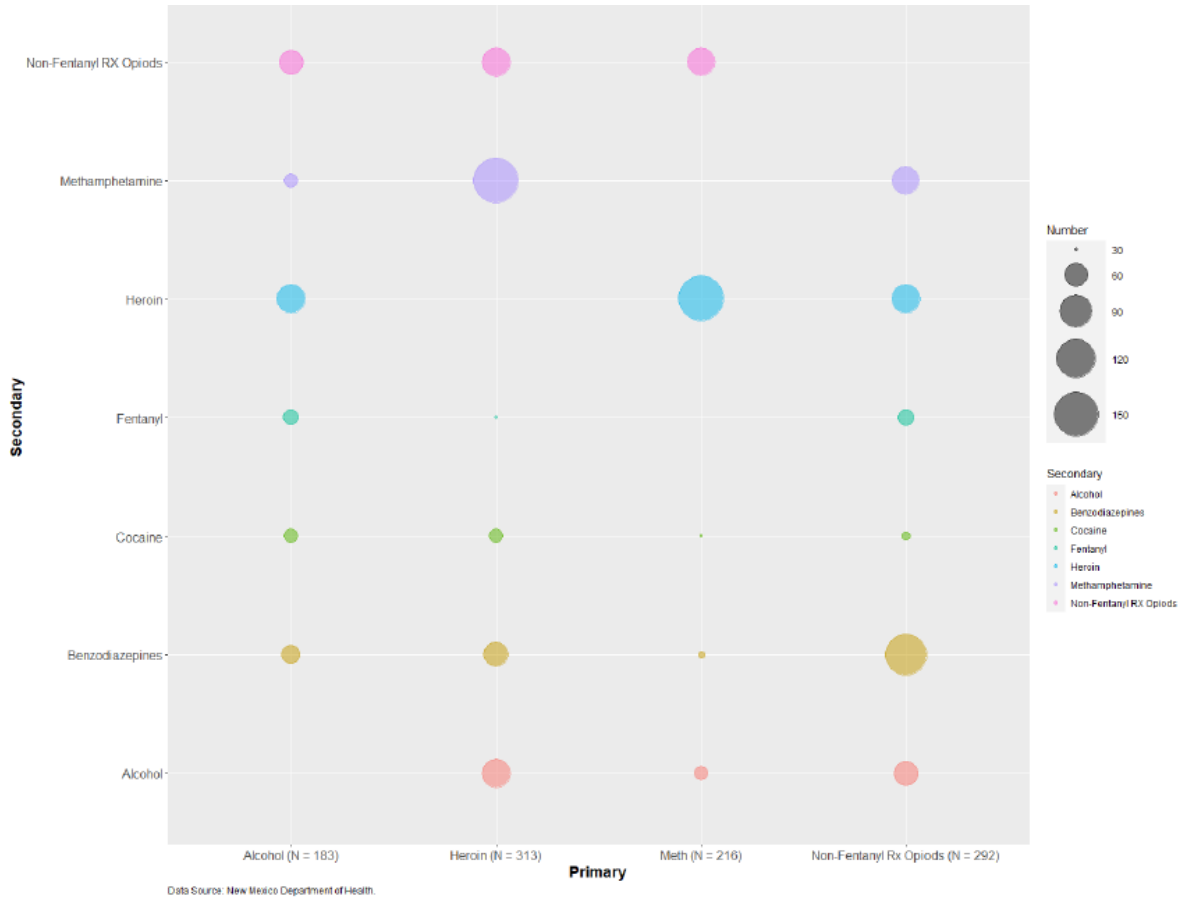
Case Management Service Provision

One of the core causal mechanisms through which LEAD is theorized to influence participant criminal justice and behavioral health outcomes is through active participant engagement with their case managers using an ICM approach which emphasizes low case manager to participant ratios, typically in the range 1:10-20, though the National Support Bureau advises caseloads of up to 25 participants (Burns et al.,

2007; Dietrich et al., 2017)[6]. We consider the dosage of case management services in this section. We want to note that case management records provided by the DBHS only cover four months of case management data and that the records do not allow us to assess case manager to client ratios accurately given churn in case management staff. We provide frequency tables of case management contact data in Tables 2, 3, and 4. Table 2 presents the distribution of attempted case management contacts from September 2021 through December 2021. Table 3 presents the frequency of different case management contact strategies used. Table 4 presents a cross tabulation of how successful different case management contact types were.

Figure 2.

Bubble Chart of Polysubstance Use Deaths in Bernalillo County in 2020



[6] However, a February 2022 email correspondence with the LEAD National Support Bureau addressing the question of case manager caseloads noted: "Our guide is 20-25; with some flexibility in there depending on how active participants are and ability to take on more if there are many who are pretty inactive of minimally engaged. 15 ACTIVE is about right, with maybe 5-10 more who are less active. As you likely know already, there is no hard/fast rule it'll vary by situation."

Table 2.
Attempted Case Management Contacts (September 2021 – December 2021)

	Count	Frequency
Contact Achieved	437	42.2%
Left a Message	301	29.1%
Unable to Reach Participant	178	17.2%
No Entry	118	11.4%
Total	1,034	100%

Table 3.
Case Management Contact Type of Successful Contacts (September 2021 – December 2021)

	Count	Frequency
Face-to-Face	223	21.6%
Telephonic	211	20.4%
Email	193	18.7%
Text Message	161	15.6%
Video Visit	1	0.10%
N/A or Missing	245	23.7%
Total	1,034	100%

Table 4.
Cross Tabulation Analysis of How Case Management Contact Success Varies by Type of Contact (September 2021 – December 2021)

	Email	Face-to-Face	Telephone	Text Message	No Entry
Contact Achieved	69	177	109	42	39
Left Message	111	2	75	109	4
Unable to Reach	4	38	24	2	108
No Entry	9	6	3	8	92
Success Rate	35.8%	79.3%	51.7%	26%	N/A

In tandem, Tables 2 - 4 suggest that 42.2% of the 1,034 attempted case management contact attempts between September 2021 and December 2021 were successful (n = 437), that the most frequently logged contact strategy used was to meet clients face-to-face either in the field or at the CARE Campus (n = 223), and that face-to-face meetings had a higher success rate than passive strategies of case management outreach (e.g., phone calls; emails). However, we emphasize that the higher success rate of face-to-face contact over other engagement strategies might occur because there is a higher probability of successfully establishing contact with a participant when a meeting is scheduled – which signals some baseline level of participant interest prior to the point of contact – whereas the other engagement strategies do not require interest in engaging by the participant prior to contact being made.

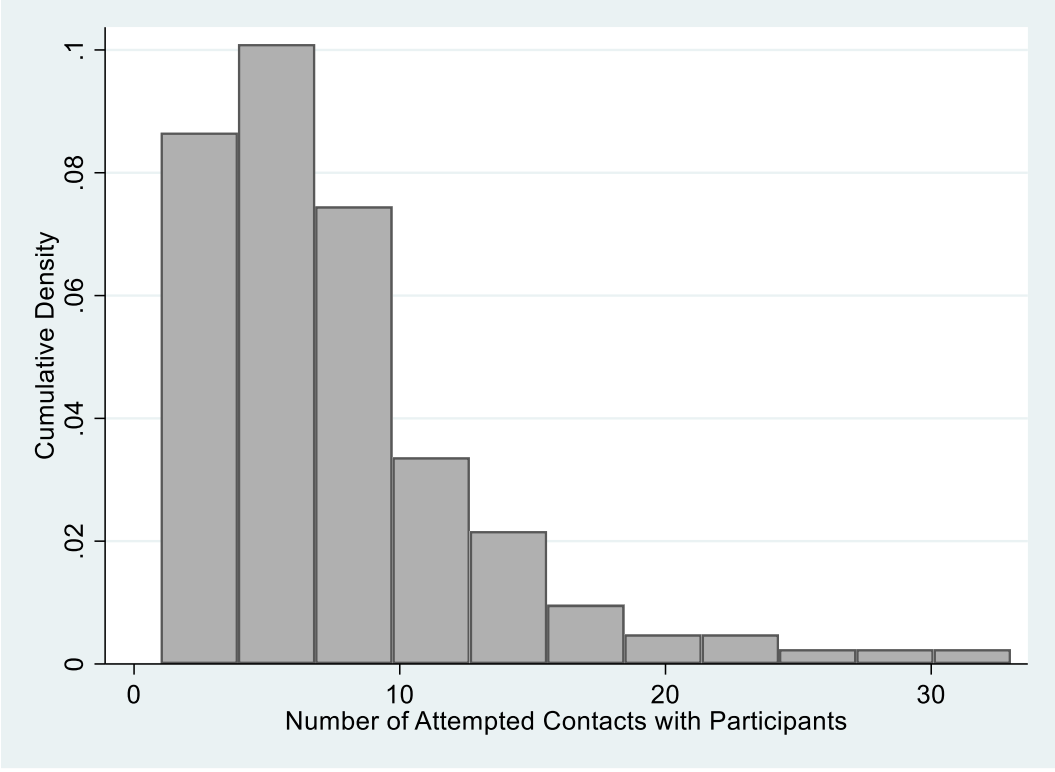
In order to see which factors predict how much case management program participants receive, we explore four related outcome variables: (1) a count of the number of case management contact attempts with program enrollees (Model 1), (2) a count of the number of case management contact attempts with

program enrollees which were successful (Model 2), (3) the success rate of case management contact, defined as the ratio of successful case management contacts to total case management contact attempts (Model 3), and (4) the duration of case management meetings (Model 4). To test which factors predict the count of attempted and successful case management contacts, we use a negative binomial regression model which is typically advised in the presence of overdispersed count data[7] (Likelihood Ratio Test for Dispersion Parameter: $\chi 2 = 154.9$ and 153.9). To assess which factors predict the success rate of contact and the average duration of case management contacts, we use ordinary least squares (OLS) regression given the continuous nature of the dependent variables and their normal distribution.

Specifically, we assess the effect of referral type (0 = Social; 1 = Diversion), referral source (0 = APD; 1 = BSCO; 2 = Other), participant age, participant sex (0 = Female; 1 = Male), participant race-ethnicity (0 = Nonwhite; 1 = White), participant marital status (0 = Unmarried; 1 = Married), participant housing status (0 = Housed; 1 = Unhoused), and participant's drug usage (0 = Non-User; 1 = User) on the number of attempted and successful case management contacts in Model 1 and Model 2. In Models 3 and 4, we explore how the success rate and average duration of case management services received are further influenced by the number of attempted contacts made and the average within-participant duration of time between attempted contacts. We visualize the distribution of attempted and successful case management contacts through histograms in Figures 3 and 4 which helps convey the rightward skew of these variables, and we present the results of all four models in Table 5.

Figure 3.

Histogram of Number of Attempted Case Management Contacts with Participants



[7] Overdispersion occurs when the variance of a given variable exceeds its mean.

Figure 4.

Histogram of Number of Successful Case Management Contacts with Participants

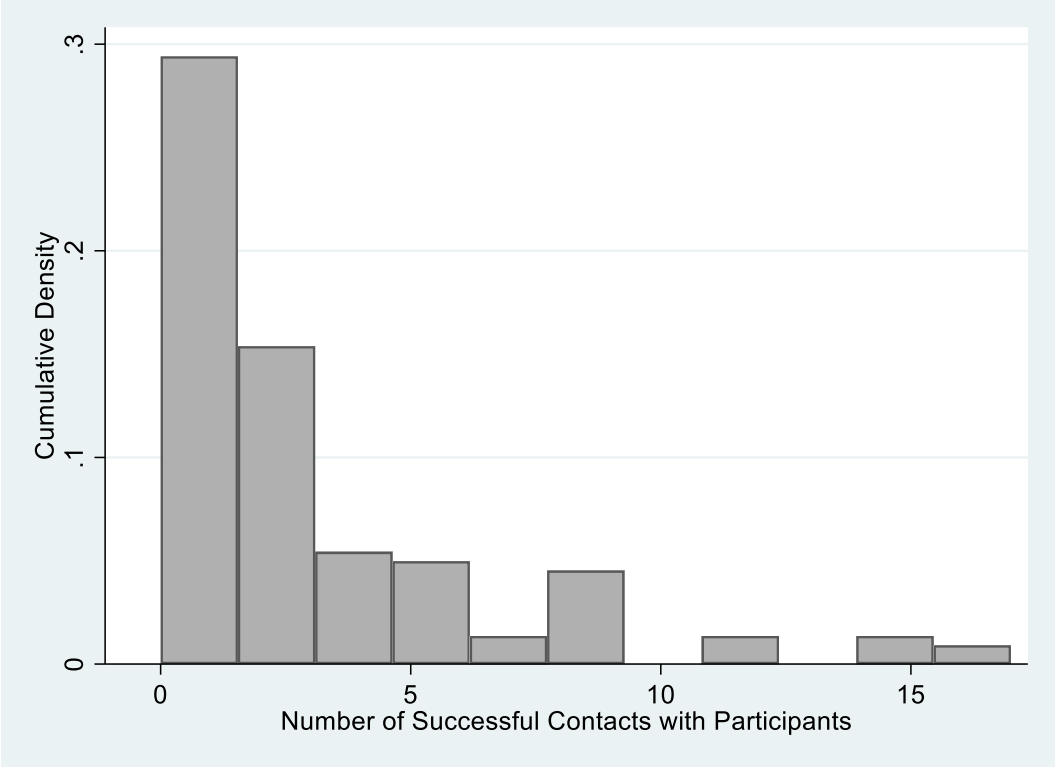


Table 5.

Which Factors Predict Various Dimensions Case Management Dosage?

	Model 1	Model 2	Model 3	Model 4
Referral Type: Diversion	-0.00	-0.21	-0.04	-0.09
	(0.13)	(0.21)	(0.05)	(0.15)
Age	-0.00	0.00	0.00*	0.01**
	(0.01)	(0.01)	(0.00)	(0.01)
Sex: Male	-0.29**	-0.36*	0.02	-0.00
	(0.12)	(0.21)	(0.05)	(0.14)
Race: White	0.20	0.27	-0.03	0.24
	(0.13)	(0.21)	(0.06)	(0.16)
Marital Status: Married	0.88**	1.04*	-0.18	-0.03
	(0.37)	(0.60)	(0.17)	(0.53)
Housing Status: Homeless	-0.27**	-0.41**	-0.02	-0.05
	(0.13)	(0.21)	(0.05)	(0.15)
Fentanyl User	-0.15	-0.28	0.03	0.11
	(0.16)	(0.27)	(0.06)	(0.18)
Methamphetamine User	0.19	0.31	0.05	0.19
	(0.12)	(0.19)	(0.05)	(0.14)

Heroin User	0.14	0.23	0.01	0.33**
	(0.15)	(0.25)	(0.06)	(0.17)
Number of Attempted Contacts	--	--	0.02***	--
Days Between Contacts	--	--	--	-0.00
			(0.00)	(0.00)
Constant	2.31***	1.31***	0.10	2.50***
	(0.25)	(0.40)	(0.11)	(0.31)
Observations	143	143	143	126
R-squared			0.12	0.11

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

We note that the average number of attempted contacts with active program participants was 7.2 *(s.d.* = 5.7), and the average number of successful contacts with active program participants was 3.1 (*s.d.* = 3.6). The coefficients reported for negative binomial estimation in Model 1 and Model 2 are not intuitively interpretable. To ease aid of interpretation, we report the marginal effects (i.e., the predicted count totals) for statistically-significant variables from Model 1 and Model 2 in Table 6. We caution against drawing inferences from the seeming substantive and statistical significance of the marital status variable as the degree of statistical significance may be an artifact of the small total count of married participants within our sample (*n* = 12) and a higher tendency to commit Type-1 errors (i.e., inaccurately rejecting the null hypothesis of no effect) given the small cell size (Leppink et al., 2016).

Table 6.

Average Marginal Effects (AMES) from Negative Binomial Regressions

	Predicted Attempted Contact Count (Model 1)	**Predicted Successful Contact Count (Model 2)**
Sex: Female	8.40	3.75
Sex: Male	6.29	2.60
Marital Status: Unmarried	6.98	2.96
Marital Status: Married	16.77	8.41
Housing Status: Housed	8.49	3.93
Housing Status: Unhoused	6.46	2.61

From Table 6, we note that the same factors across Models 1 and 2 predict the count of attempted and successful case management contacts: male participants, unmarried participants, and homeless participants had significantly lower levels of attempted and successful case management contacts.

As Models 3 and 4 use OLS regression, the coefficients presented in both models can be interpreted as the effect of a one-unit increase in the independent variable on the value of the dependent variable, all else equal. Given the addition of two independent variables in Models 3 and 4 – specifically, the inclusion of variables for the number of attempted case management contacts and the average number of days

between case management contacts – before proceeding, we wanted to note that the average number of days between contacts within participants is approximately 16.0 days (*s.d.* = 14.6), and the median number of days between contacts within participants is 12.8 days.

From Model 3, we note that while age is a statistically significant predictor of the success rate of contact, the coefficient of 0.00 suggests that the effect of age is not substantively significant. Additionally, the most significant predictor of the success rate of contact is the number of attempted contacts. Specifically, each attempted contact significantly increases the success rate of contact by approximately 2%. However, while one might be tempted to conclude that this finding speaks to the importance of high-volume contacts, it is worth considering an alternative possibility. For instance, participants with higher attempted contact rates may have a higher volume of contact precisely because these participants have been successfully contacted before and have higher odds of being reachable (i.e., they might be more likely to have stable Internet access). Thus, we caution against the temptation to assume that a higher contact volume necessarily causes more successful contact as this question cannot be answered with the present data.

Finally, from Model 4, we note that the only significant predictors of average case management meeting length are age (*p-value* = 0.05) and heroin use (*p-value* = 0.05). All else equal, a decade increase in participant age (i.e., comparing an otherwise similar 20 and 30-year-old participant) is correlated with a statistically significant 0.12 unit increase in average contact time, and the use of heroin corresponds to a 0.33 unit increase in average contact time. It is worth noting that contact time was recorded in the original NetSmart CareManager dataset in the following 15-minute intervals: 0-15 minutes, 15-30 minutes, 30-45 minutes, 45-60 minutes, 60-75 minutes. We recoded these intervals ordinally (0-4) and then averaged within participants across all successful contacts to generate a continuous scale. Thus, when converted, a 0.12 increase in contact duration by decade corresponds to an additional 2 minutes of case management per contact when using the interval midpoint (7.5 minutes on the 15-minute scale) to convert. Similarly, a 0.33 unit increase in contact time for heroin users corresponds to approximately an additional 5 minutes of case management per contact compared to a non-heroin user when using the interval midpoints (7.5 minutes on 15-minute scale) to convert.

Moreover, we report on different components of service utilization and case management dosage using referral and enrollment data tracked through RedCap data platform as part of the COSSAP cross-site evaluation. Of the 39 participants who had the number of encounter days with a case manager recorded, 82.0% had 0 encounter days logged with their case managers (n = 32). However, despite this, 51.3% of participants had a count of total case management encounters greater than 0 (n = 20). This appears to be an artifact of delays in retrospective data entry or misunderstanding of the variable coding since if a participant has a case management encounter, they should additionally have at least one day logged as a case management encounter day.

The COSSAP data from the Monthly Client Services Form data form indicates which types of case management strategies case managers used to engage participants. Examples of case management strategies include activities such as visiting a participant's living place, contacting their family or friends, calling or texting the participant, checking to see if the participant was incarcerated, checking with other service providers to see if the service provider had contacted the participant, and checking with law enforcement agencies to try to find the participant. We summed the count of these strategies within each participant to

get a sense of the diversity of strategies used. Of the 35 participants with recorded case management strategy data, case managers did not use a strategy in 22.9% of cases (n = 8), used one strategy in 28.57% of cases (n = 10), used two strategies in 40.0% of cases (n = 14), and used three strategies in 8.6% of cases (n = 3). The predominant strategy used to engage with clients consisted of attempting to contact the participant through telephone or email. On the Monthly Client Services Forms, case managers could log whether a suite of harm reduction services – including provision of antibiotic ointment or other first aid supplies, condoms, Covid-19 messaging, provision of food or water, HCV referrals, Narcan/Naloxone, OD prevention education, personal hygiene supplies, pipes and safer smoking supplies, and referral to syringe exchange programs – were offered to a participant in the prior month. Per this data, 0% of participants were offered harm reduction services (n = 0). Case managers could similarly log whether participants were referred to any other case management services including alcohol treatment, employment services, housing services, inpatient substance use treatment, outpatient substance use treatment, MAT Methadone services, MAT Suboxone/Subutex services, primary health care, or therapy and counseling. Per this data, 89.8% of participants were not referred to any of these services (n = 35). Case managers could also log whether participants were referred to any of the following services: child care, dental care, ID card, legal services, Medicaid or other health insurance, social services, or other. Per this data, 69.2% of participants were not referred to any of these services (n = 27) and 18.0% were referred to one (n = 7), most typically to assistance in securing identification.

Officer Surveys

In December 2021, we conducted a survey of 68 sworn-LEOs at APD (N =52; Response Rate: 17.1%) and BCSO (N = 16; Response Rate: 14.8%) using an email distribution[8]. The purpose of the survey was to assess officer attitudes toward offenders with behavioral health issues (i.e., stigmatizing beliefs), familiarity with the LEAD program, participation in virtual and in-person LEAD training sessions, perceptions of the ease of making a LEAD referral and of the understandability of LEAD exclusion and inclusion criteria, officers' likelihood of diverting eligible participants to LEAD, and the basic demographic profile of surveyed officers. We wanted to investigate the overall distribution of LEAD awareness and familiarity across officers and the factors which predict diversion likelihood. We present descriptive statistics for all quantitative survey variables in Table 7.

Table 7.

Descriptive Statistics of Variables in Officer Survey

Statistic	N	Mean	St. Dev.	Min	Pctl(25)	Pctl(75)	Max
Likelihood of Making a LEAD Referral	64	4.11	1.78	1	3	6	7
Agency: BCSO	64	0.23	0.43	0	0	0	1
Rehabilitation Attitude	63	2.70	1.13	1	2	4	5
Offenders Changeability Attitude	63	2.56	0.98	1	2	3	4
Offenders with BHI as Burden Attitude	64	3.14	1.12	1	2	4	5

[8] Because of the potential for selection biases (Bethlehem 2010), we caution readers against assuming that the results which follow typify the characteristics of, or attitudes held by, field officers at the department and to avoid making agency-level inferences about the generalizability of these results. However, we also caution against drawing the opposite inference of discounting the generalizability of results in the case of somewhat low response rates (see Nix et al., 2019).

Familiarity with LEAD	64	5.22	1.61	1	5	6	7
Ease of Making a LEAD Referral	62	4.32	1.62	1	3	6	7
Clarity of LEAD Inclusion/Exclusion Criteria	59	4.59	1.64	1	4	6	7
Officer Attended Training (0 = No; 1 = Yes)	64	0.78	0.05	0	1	1	1
Number of Trainings an Officer Attended	51	1.24	0.79	0	1	2	3
Officer Attended In-Person Training (0 = No; 1 = Yes)	64	0.47	0.06	0	0	1	1
Number of Trainings Officer Attended In-Person	52	0.83	0.88	0	0	1	4
Perception of Officer Support	59	3.71	1.59	1	3	5	6
Perception of Cooperation with Judicial Actors	40	3.85	1.41	1	4	4	7
Years Working as Officer	61	2.28	1.56	0	1	3	5
Age	53	40.40	9.70	21	34	46	71
Sex: Female	58	0.17	0.05	0	0	0	1
Education-Level	50	1.06	1.00	0	0	2	3

From Table 7, we note that among surveyed officers, average levels of familiarity with the LEAD program were moderately high ($\bar{X}$ = 5.22 on 7-point scale where 1 = "Very Unfamiliar" and 7 = "Very Familiar"). 79% of surveyed officers indicated that they had attended a LEAD training, and 47% of surveyed officers indicated attending a LEAD training in-person. On balance, surveyed officers indicated a moderate willingness ($\bar{X}$ = 4.10 on 7-point scale where 1 = "Very Unlikely" and 7 = "Very Likely") to make a LEAD diversion for a LEAD-eligible participant. However, it is also worth noting that, on balance, perceptions of agency-wide support of LEAD were more mixed ($\bar{X}$ = 3.71 on 7-point scale where 1 = "Very Unsupportive" and 7 = "Very Supportive"), perceptions of the degree of cooperation with LEAD judicial actors (specifically, the Second Judicial District Court) were mixed ($\bar{X}$ = 3.85 on 7-point scale where 1 = "Very Unsupportive" and 7 = "Very Supportive"), and that training coverage was not universal as 21.9% of surveyed officers reported not participating in any LEAD trainings.

Officers also had the opportunity to expand on why they provided some of the ratings that they did in open-ended text-fields following the quantitative rating questions. We provide a sampling of representative comments of officers who reported that the referral process was difficult below:

> *My understanding is that a LEAD referral requires a report and the establishment of charges. It basically involves doing all the work one would do to succeed in court. Why would I do all that work and not get a PAD or deferred sentence?* – APD Officer

> *It seems to be a waste of officers' time. Offenders see it as a get out of jail free card and the DA [District Attorney] doesn't take the necessary follow up to ensure prosecution for non-compliance.* – APD Officer

> *Because crime is very high and letting criminals have an easy way out of jail is not going to help our crime crisis. Offenders know that they can get out of jail free by LEAD and will take advantage of this program.* – BCSO Officer

> *If the offender does not follow-through with the program/requirements, the process becomes difficult for the officer, especially in a patrol status. Many of those charged after not following thru were never issued warrants for their arrest.* – APD Officer

Thus, among officers who perceived that the LEAD referral process was difficult, there was concern that (1) the referral process was too laborious and inconsistent with officer's perceived role expectations and (2) noncompliance with LEAD was unpunished. Given existing agency-level data, we cannot falsify these claims in either direction (i.e., the average amount of time it takes for an officer to make a LEAD referral at APD or BCSO compared to booking an individual through typical arrest; the prevalence of the "get-out-of-jail free card" belief among the offending population).

Some officers expressed hesitancy to refer a LEAD-eligible client to LEAD when asked about their likelihood of making a LEAD referral. To this end, we provide a sampling of officer comments below which spotlight the multifaceted nature of officer hesitancy:

> *We do not have enough officers to respond to calls for service. Officers do not have time to have additional duties put upon them when there are 20-60 calls holding in one area command on a regular basis and officers are quitting every day.* – APD Officer

> *Due to the severe manning issues with APD, very few officers are making contact with low level narcotics cases. Chances are good that if an officer is making contact, the issue is severe and not an appropriate use of LEADS.* – APD Officer

> *There are not enough APD officers to handle Albuquerque's call-for-service volume effectively and therefore, proactive policing is difficult to accomplish. LEAD cases generally involve proactive - related citizen contacts. Officers struggle to find time to follow-up with LEAD-related cases/coordination/correspondence due to low manpower. The organizations involved in the LEAD process are under-staffed and don't have the capacity to follow through with LEAD cases.* – APD Officer

> *I liked the idea at the start. But after no follow up on noncompliance or the DA coming down and expecting me to relocate and transport the offender to the CARE campus rather then issue a warrant for their arrest, I no longer have faith in the program and do not see it as an effective means of diversion.* – APD Officer

> *I think the LEAD program would be better suited to be implemented at the courts or DA review, where the history of the offender is more readily apparent and can be assessed in a non-biased environment. A simple form letter telling the arresting officer of the disposition of the case would also help in ensuring referrals if kept in the current form.* – BCSO Officer

> *I think LEADS is potentially a great program to divert young, low-level narcotics offenders. However, LEADS does not apply to me or my team as we specifically address recidivist narcotics offenders involved in significant crimes. APD initiated the LEADS program to units similar to mine. I applauded the program but it was initiated by units that have no use for LEADS.* – APD Officer

The sampling of officer quotes suggests that there are systemic factors which disincentivize LEAD referrals among officers. First, officers at both agencies reported that recent increases in officer resignations and consequent officer turnover reduce the ability of retained officers to dedicate time to proactive policing

work. The reported reduction in staffing levels, while not directly accessible given access to agency-data, is consistent with nationwide elevated agency turnover and resignation rates in police departments following the George Floyd protests (Mourtgos et al., 2022). Additionally, officers who indicated a low likelihood of referral often identified a perceived lack of procedural accountability on the judicial backend of cases and suggested that the paperwork-oriented tasks officers are expected to complete as a part of LEAD are inconsistent with their self-perceived roles. Finally, a subset of referral-resistant officers indicated that some of the field units trained in LEAD, by dint of their unit's area of specialization, had lower likelihoods of encountering LEAD-eligible clients in the course of their typical policing work and because of low exposure to LEAD-eligible clients, were less likely to make referrals.

To assess which factors significantly predicted the likelihood of officers making a referral to LEAD, we ran a series of OLS regressions. We ran multiple regression models because we noticed high rates of item-level nonresponse. Item-level nonresponse occurs when survey questions are not answered by all respondents. Specifically, in the context of our survey, two variables – officer ethnicity and officer perceptions of judicial cooperation – had high rates of item missingness (39.1% and 37.5% missingness respectively.) One of the most common approaches to dealing with item-level nonresponse is to delete observations from the dataset where any missingness is present; this is called case-wise deletion. However, despite the common use of this practice, statisticians have cautioned that case-wise deletion of observations reduces statistical power (i.e., the ability of a hypothesis test to detect true underlying effects) by increasing the size of standard errors and unnecessarily discards potentially informative data which can, in consequence, introduce bias into effect size estimates (Peng et al., 2006).

To address the issue of item non-response for high-missingness predictor variables, we used the Multiple Imputation through Chained Equations (MICE) method. The MICE procedure is a robust, informative method of dealing with missing data in datasets (White et al., 2011). Specifically, the MICE procedure simulates missing data in a dataset through an iterative series of predictive models. In each iteration, each specified variable in the dataset is imputed using the other variables in the dataset on the basis of correlations observed within completed fields. These iterations are run until convergence has been met; this typically takes five simulations. Because of the statistical advantages of the MICE procedure over case-wise deletion and single imputation approaches (Azur et al., 2011), while we present results from a non-imputed and imputed-model, we center our discussion on Model 6 which deploys the MICE procedure.

Table 8.

Which Factors Best Predict Officer Diversion Decisions?

	Model 5	**Model 6**
Agency: BCSO	0.99 (0.85)	0.37 (0.45)
Rehabilitation is Waste of Time	-0.59 (0.56)	-0.18 (0.20)
Offenders Never Change	-0.23 (0.39)	-0.10 (0.20)
Offenders with MI as Burden	0.41 (0.25)	0.11 (0.18)
Familiarity with LEAD	0.16 (0.38)	0.15 (0.13)
Ease of Making LEAD Referral	0.13 (0.37)	0.10 (0.14)
Clarity of Inclusion/Exclusion Criteria	-0.25 (0.36)	0.10 (0.13)

Perception of Agency-Wide Support of LEAD	0.26 (0.29)	0.28** (0.13)
Perception of Cooperation with Second Judicial District Court	0.52 (0.38)	0.29* (0.15)
Attended a Training	0.88 (0.69)	-0.26 (0.41)
Attended Training In-Person	-0.18 (1.09)	-0.42 (0.38)
Years at Agency	-0.06 (0.37)	0.15 (0.19)
Sex: Female	0.35 (1.09)	0.32 (0.44)
Age	0.01 (0.05)	-0.02 (0.03)
Ethnicity: Non-Hispanic	0.03 (0.83)	0.05 (0.33)
Education	-0.75* (0.38)	-0.67*** (0.21)
Constant	1.23 (3.70)	2.30 (1.90)
Observations	27	64
R^2	0.85	0.68
Adjusted R^2	0.60	0.57
Residual Std. Error	1.15 (df = 10)	1.17 (df = 47)
F Statistic	3.44** (df = 16; 10)	6.23*** (df = 16; 47)
Note:		*p**p***p<0.01

From Model 6 in Table 8, we note that, all else equal, officers who perceived that their peers were generally unsupportive of the LEAD program, officers who perceived low levels of cooperation from judicial actors, and officers who were more educated were significantly less likely to make LEAD referrals. To aid in interpretation, we present Figure 5 which demonstrates how going from the lowest end of the scales to the highest end substantively influences the level of agreement with these three statements[9].

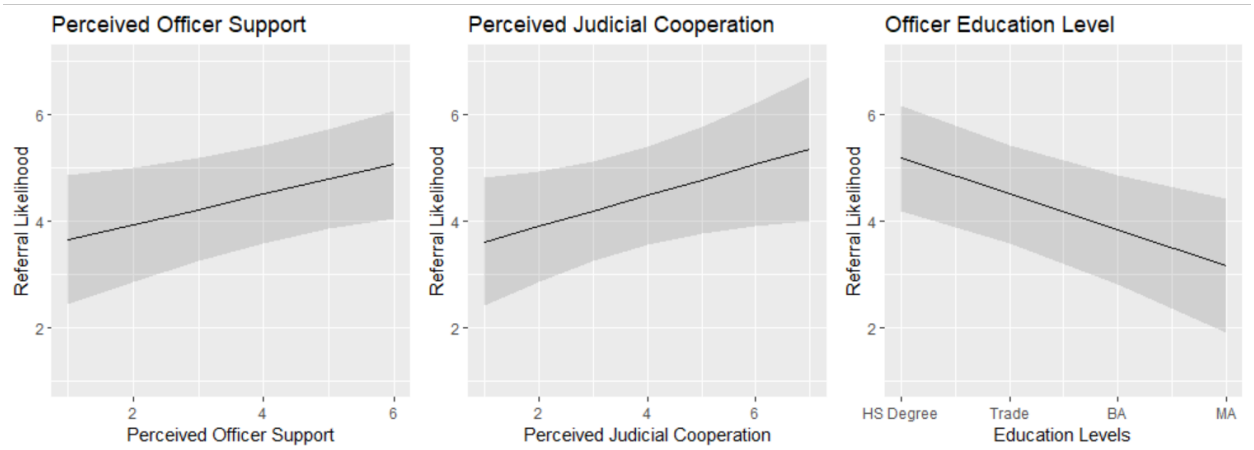
Of note and in contrast to previous studies published on LEAD (Rouhani et al., 2019) as well as some of our semi-structured interviewing data, officer training attendance, frequency, and mode, officers' beliefs about the utility of rehabilitative programming, officers' beliefs about the blameworthiness of offenders with mental illness, officer sex, ethnicity, age, and tenure length did not significantly predict likelihood of referral.

In sum, we present suggestive evidence that, all else equal, officers who perceive high levels of officer support for LEAD within the agency, officers who perceive higher levels of cooperation with judicial stakeholders, and officers with less formal education were statistically significantly more likely than officers who perceive low levels of officer support for LEAD within their agency, officers who perceive lower levels of cooperation with judicial stakeholders, and officers with more formal education, respectively, to refer hypothetical eligible participants into LEAD.

[9] Some readers may observe a visual overlap of the confidence intervals in Figure 5 and infer a lack of statistical significance. We note that the visual degree of overlap of the confidence intervals at the scale end-points does not imply a lack of significance, as noted by Austin & Hux (2002).

Figure 5.

Effect of Perceived Officer Support, Judicial Cooperation, and Education Levels on Referral Likelihood



Staff Interviews

Between October 2021 and November 2021, we conducted 10 semi-structured interviews through Zoom with a purposive sample of stakeholders representing five stakeholder groups of the PCG including three case management staff at the DBHS, three program management at the DBHS, two field-officers at APD, and two staff attorneys of the New Mexico Second Judicial District Court and Law Offices of the Public Defender. Notably, no LEO partners from BCSO responded to our requests to participate in an interview. The interviews were designed to assess stakeholder perceptions of the facilitators and barriers to LEAD program implementation, perceptions of the likelihood of the LEAD program succeeding, and the quality of interagency collaboration. Interviews with case management staff focused on these questions as well but also assessed perceptions of service delivery and the populations served by the LEAD program.

All interviews were video-recorded and automatically transcribed using Zoom's built-in transcription feature. On average, interviews lasted 41 minutes, though median interview length varied by role in the PCG given the interview's skip logic (i.e., case managers were asked 24 more questions than other types of program staff). The content of the interviews varied by job title and role in the PCG but linearly progressed through the following topics: (1) training in harm-reduction, (2) role in LEAD, (3) perceptions of program successes and deficits to date, (4) recommendations on ways to change program implementation going forward, and (5) perceptions of the quality of interorganizational collaboration. A thematic analysis of these interviews allowed us to understand the nature of collaborative decision-making and organizational challenges to LEAD implementation over time. We highlight stakeholder perceptions of the facilitators and barriers to program implementation and present these in summary form in Table 9.

We begin by highlighting perceptions of implementation facilitators. First, there was general consensus across stakeholders on higher-level program goals with all interviewees identifying the reduction of incarceration for low-level offenses or specific harm reduction principles as important ends for the program to pursue. Relatedly, all interviewed staff indicated receiving some form of training, however informal, in behavioral health related topics; higher volumes of behavioral health training – with a specific

focus on LEAD-specific training – were reported among interviewed LEO staff and DBHS staff than judicial actors.

Table 9.

Facilitators of and Barriers to LEAD Program Implementation[10]

Facilitator	*Barrier*
There was consensual agreement on the purpose and goals of LEAD with all stakeholders identifying harm-reduction goals or goals related to reducing pressure on the criminal justice system.	There was general agreement that the onset of the Covid-19 pandemic in March 2020 and subsequent social distancing guidelines impeded the delivery of street-based case management.
All stakeholders reported receiving either some form of crisis intervention or harm-reduction training at least once.	Some stakeholders reported that the supply of housing resources (i.e., vouchers) was limited and wait-times for housing-related services long.
There was general agreement that the LEAD program has been moderately successful ($\bar{X}$ = 4.5 on 7-point scale where 1 = "Very Unsuccessful" and 7 = "Very Successful").	There was some agreement across agencies that bureaucratic barriers to program implementation impeded service delivery (i.e., receiving approval for requested case management equipment; reassignment of case managers to non-LEAD tasks; role ambiguity; training incorporation).
There was general agreement that the hiring of a program manager in March 2021 was instrumental in establishing connections with LEO-partners, increasing training among LEOs and community partners, and in increasing referrals into the program.	There was some agreement that there was a lack of leverage and follow-through with program participants (e.g., high rates of participant attrition and lost contact; not enough updates on participants in PCG meetings; participant provision of inaccurate contact information).
There was some agreement across stakeholders that there were incremental increases in levels of officer buy-in over time.	Some stakeholders noted concerns that reductions in case management staffing levels at the DBHS and sworn field officer staff at police agencies constrain program growth and results in patchwork service delivery.
Some stakeholders noted that the use of warm handoffs have increased over time.	Some stakeholders noted that there was a constant churn in paperwork, documentation, and new systems which was perceived as overly burdensome.
Some stakeholders noted that the program eligibility screening process by the Office of the Second Judicial District Attorney was quick as was the speed of communication with the case management team.	Some stakeholders noted that systemic factors such as delayed prosecutions, low prosecution rates for low-level drug offenses, the constraints the APD consent decree imposed on field officers at APD, and low perceptions of buy-in erode officer morale and perceptions of procedural accountability.

[10] When we identify "consensual agreement", this means that all relevant stakeholders who answered the question agreed with the sentiment. When we identify "general agreement", this means that 50+% of relevant stakeholders who answered the question agreed. When we identify "some agreement" or otherwise note that "some stakeholders" reported, this means that at least two interviewed stakeholders reported that specific facilitator or barrier.

There was general agreement across stakeholders that interorganizational coordination and collaboration were satisfactory ($\bar{X}$ = 6.0 on 7-point scale where 1 = "Very Unsatisfactory" and 7 = "Very Satisfactory").	--
There was general workplace satisfaction across stakeholders ($\bar{X}$ = 5.67 on 7-point scale where 1 = "Very Unsatisfied" and 7 = "Very Satisfied".)	--
Among stakeholders tasked with data entry, there was general agreement that tracking the data was easy with the only minor difficulties reported concerning the generation of reports.	--

Interviewees also evaluated the success of LEAD to date on a seven-point scale where a value of 1 = "Very Unsuccessful" and where a value of 7 = "Very Successful." Participants were then asked to elaborate on why they ranked LEAD implementation success in this manner. On balance, PCG interviewees perceived LEAD to be moderately successful ($\bar{X}$ = 4.5 on 7-point scale; *s.d.* = 0.58). One reason for perceived program success related to hiring of a program manager in March 2021 and increases in referrals and training over time. As three interviewees noted:

> *I am going to put it at about a 4 but I think it is on a great upward trajectory. Previously, the program had had a hard time attracting participants and that has changed a lot especially since [Program Manager] has come on board so we are seeing more referrals, and I only think the program can work if more people are participating.* – DBHS Staff

> *I think right now, because we are so new, I'd say we are about a 5 or 6. Now we are averaging about 20 [referrals] a month and with that being said, we were strictly focused on the PRT teams which is just a very select subset of officers within each area command, and now we are expanding out to the regular rank and file so, um, all the officers once we get all of our briefings done and the FTOs trained up we are going to start seeing a lot more referrals and of course with the social and community referrals coming in. So hopefully within a short period of time, the success of LEAD will bump up to a 7, um, but these programs take time.* – DBHS Staff

> *I am rating it a 5 because I feel like it has a lot of room for improvement. We have a lot of programmatic details that need to be ironed out, we have some collaboration details that need to be ironed out with our program partners but in general, when we are actually providing services to active clients, I feel like those clients are actually succeeding in the program*. – DBHS Staff

Other program successes interviewees identified related to the perceived increased use of the warm handoff procedure over time, the perceived increase in officer buy-in over time, and the perception that the referral and eligibility-screening processes for assessing criminal background were efficient, typically occurring within a few hours to a day within the request being made. Perceptions of the quality of coordination across stakeholder groups of the PCG were, on balance, positive ($\bar{X}$ = 6.2 on 7-point scale where 1 = "Very Unsatisfactory" and 7 = "Very Satisfactory"). Stakeholders noted that frequency of

communication across PCG members was generally high, that the biweekly nature of PCG meetings was appropriate, and that the perceived availability of other actors within the PCG was high. Case management staff reported having caseloads consistent with ICM recommendations (i.e., having 8-12 active clients at any given time), positive relationships with the clients they served ($\bar{X}$ = 6.33 on 7-point scale where 1 = "Very Unsatisfied" and 7 = "Very Satisfied"), and high levels of perceived similarity (i.e., peerness perceptions) with the clients they served ($\bar{X}$ = 6 on 7-point scale where 1 = "Very Dissimilar" and 7 = "Very Similar"), consistent with LEAD National Support Bureau Recommendations.

Interviewees also identified a series of impediments to program implementation to date. A majority of stakeholders noted that the novelty of the program, paired with the onset of Covid-19 in March 2020, were initial constraints on program operations with stakeholders specifically flagging how the closure of social services offices as a result of initial lockdown measures during the early stages of the Covid-19 pandemic and the implementation of social distancing measures prevented case managers from actively engaging in streets-based case management for the middle year of program implementation. Issues with low referral counts in the program's early stages were commonly cited across stakeholders as an early weakness to the program with the longitudinal increase in referral counts being a commonly reported cause of optimism about the program's trajectory. In general, while interviewees expressed positive attitudes about collaboration across and between relevant PCG stakeholder groups, one expressed concern related to the competing time demands on stakeholders. To this end, one interviewee noted:

> *I feel like, um, everyone who is part of the working group are probably short on time and so they don't have a lot of extra time to plan and strategize how to make the LEAD program more successful and efficient, um, so I feel like all the staff involved are kind of committed to other duties in their job so there is not enough time to really allocate toward the LEAD program.* – DBHS Staff

In terms of external barriers to program implementation, some stakeholders identified concerns with the availability of housing and other behavioral health services in the community. To this end, when asked about the availability of housing and housing support for services for their clients, case managers noted:

> *There was none really. They were put on a list and you had to wait. There is more need for housing than what we have…Most of my clients didn't have the income needed for certain apartments or, um, where they wanted to live because most of my clients were on Social Security. Other barriers were criminal history and past evictions and trying to find someone to work with them.* – Case Manager

> *The availability of housing is horrible. That's the hardest part of the job is being able to find housing if they don't have income coming in or if it's not just a person by themselves, if they are only enrolled in LEAD but they have a spouse, a lot of places want people to first go into a substance abuse center first and some people don't want to leave their spouse, so it's really difficult sometimes to find housing and then the waiting list can take a year to a year and a half to two years, and that's a really long time to wait.* – Case Manager

There were also some perceived impediments to program implementation unique to specific partnering agencies. In what follows, we specifically focus on perceived impediments identified within

DBHS and APD. One concern expressed by staff – both at the case management and program management level – at the DBHS centered on the hierarchical structure of bureaucratic decision-making and a concern that the process for acquiring approval for particular case management requests impeded the operational efficiency of case managers. To this end, three interviewees noted:

> *There have been instances where operational decisions, um, were suggested and not implemented by the management team and that was a bit of a hindrance. So, for example, we had requested that the case managers receive two monitors because they are using more than two systems at a time when they are entering client information, so they are using a database and also using other systems to check a client's background and to communicate with external agencies to determine the eligibility of the client and so they would need to go back and forth between monitors. We requested for the case managers to receive two monitors and that request was denied. We also requested for case managers to have access to laptops while they are in the field in order for them to conduct intakes while they were in the field, and it was determined that they would be able to use tablets rather than laptops which is a little bit less convenient for them…And I feel like being able to support the case managers in a way which makes their job more effective and efficient has not been something that I have had the authority to do, so that's been a bit of a hindrance.* – DBHS Staff

> *"We get offered training a lot but if the supervisor does not approve trainings, we cannot go."* - Case Manager

> *"Sometimes when you – when we discuss certain things – sometimes we are belittled or told how to do our job so the supervision is there, it's just how it is being handed back is not always professional or how you're being watched or talked to sometimes…It is hard to do your stuff when you have to send a daily log on what you've done or when I came in there wasn't any training at all…There wasn't actually any actual trainings. We have been offered meetings but only one person is allowed to go to meetings and not everyone is getting the same trainings as anyone else."* - Case Manager

Another concern expressed by both program management and case management stakeholders at the DBHS related to case management staffing levels. Two linked concerns were identified: (1) low levels of case management staffing at various points over program history and (2) a reallocation of LEAD case management staff time to non-LEAD DBHS operations. To this end, two interviewees noted:

> *I thought my role would be more case management but now we are only doing three days out of a five day work week or, uh, one of us works 8:00 AM – 4:30 PM and the other one works from 11:30 AM to 8:00 PM and on weekends and as a case manager, there is a lot of stuff you cannot do on weekends or after business hours because everything is closed so that cuts down our time again to do more work.* – Case Manager

> *They have us working the floor right now as floor staff and if we can squeeze in our case management while we are working the floor, we will take our work with us and try to squeeze in what we can, but sometimes it is just impossible when you have almost 30 clients on the floor here*

> *you have to work with uh so it takes away from us doing our job as LEAD case managers….There is the detox unit and those are people who are detoxing so we will – we are there doing vitals, we're taking them to breakfast, lunch, and dinner. Taking them to smoke breaks; we are just doing the ins and outs of what the facilities techs would be doing while we're back in SAC, that's the inpatient that we have and it's just monitoring all the clients there, making sure they are getting to their groups…Once in a while we will have LEAD client come into the detox floor, but when we are working the floor, we don't have time.* - Case Manager

Among LEO stakeholders at APD, concerns centered around the usability of existing data systems and the lack of broader levels of support for LEAD, specifically among agency leadership. To this end, LEO interviewees noted the following difficulties:

> *Having a set process to make it more user friendly and not as time consuming when it comes to working out charges would be helpful…We know the easy ones are the social referrals but the more difficult ones are the ones where we have to do our own cases and that's the way it is kind of set up where officers have to prosecute their own cases…paperwork and charging documents and all the stuff that goes with court*. – Officer

> *For APD, it is a little bit difficult – so we're obviously under the consent decree – so we have a lot of oversight and policies and procedures that govern how things progress especially with new programs and so that has been one of the challenging things within our organization is really just trying to get those best sorted out and approved by our various stakeholders with the consent decree so I think for us this is hard part, introducing new programs. It is difficult to get buy-in with programs because a lot of times we have done this in the past and the programs just disappear*. – Officer

> *Modifying forms and occasionally having differences in opinions over what should be a good criteria, and I would say this is very minor too, I might have a different perception as to whether someone is a good LEAD candidate. It is still an additional form for officers to fill out when officers are extremely busy and understaffed.* – Officer

> *I have just heard things like "It should be a mandatory program" or I think expectations are a lot higher that they want more referrals or data from people not involved.* – Officer

Interview participants were given the opportunity to identify specific recommendations they would make to improve the implementation of LEAD going forward. Three of these recommendations centered on the extension of outreach to additional groups in the community at both the participant and stakeholder-levels. Specifically, multiple stakeholders identified new outreach hotspots within the catchment area (i.e., Coronado Park) as part of the broader COSSAP Expansion Plan objective to both expand the volume of LEAD social referrals through targeted streets-based outreach strategies and to engage and raise awareness among community partners such as churches, community groups, and other service providers to similarly increase the volume of LEAD referrals as well as potential harm reduction and community service referral partners. Two interview participants noted the need to raise awareness of, and support for LEAD among executive-level agency and county leadership (i.e., mayor; police chiefs; county commissioners). There

were not any specific strategies recommended to achieve this particular end. Similarly, another stakeholder identified the need to increase the level of leadership engagement within PCG stakeholder group meetings. Another recommendation among officers was to introduce a mechanism to streamline LEAD data collection and entry processes for officers, specifically for arrest diversions, to avoid the perceived burdensome time-consumption of the referral process. Finally, another recommendation was to improve the safety of case managers doing streets-based outreach either through the establishment of a buddy system or through the inclusion of officers alongside LEAD-trained case managers during outreach events.

Discussion and Conclusion

In what follows, we review the limitations to the present report, provide evidence-based recommendations to address data-quality concerns and some of the concerns stakeholders identified in the interviewing process, and summarize key study findings. As with any study, the present process evaluation has several limitations which limit the ability to draw inferences from the presented data. We address the limitations of each data type in brief here and provide some recommendations on how to remedy some of these limitations in the subsequent *Recommendations* subsection.

Participant-Level Data

The participant-level data allowed us to develop a profile of the typical LEAD participant, to better understand the scope of referral sources and program in-flows over time, the specific needs of LEAD participants at the point of program intake, the recent geographic distribution of LEAD referrals, the form and intensity of case management services provided to participants, and the predictors of case management dosage. However, there were limitations to the participant-level data. First, the sampling frame of the participant-level data from NetSmart CareManager was time-restricted to a period of 16.7% of the program's life due to an EHR transition at DBHS and an adjunct ransomware attack on Bernalillo County in January 2022 which precluded analysis of the correlates of case management dosage among a more representative sample of program participants. The sample excluded approximately 30% of referred participants from subsequent analysis (n = 93). Similarly, due to data limitations, we were unable to investigate the effect of LEAD participation on proximate intervention outcomes identified in the Expansion Plan as performance metrics (i.e., reductions in overdoses; reduction in substance use) as these variables were only assessed at the point of program intake and not at regular, repeated intervals throughout program enrollment. We were unable to assess the types of specific services participants were linked to and participant-level predictors of service referral type and number. Due to the form the data was stored in (i.e., written case notes in .pdfs), we were unable to systematically explore what goals participants most frequently identified in their IIPs, their progress toward those goals, or assess predictors of goal progress and achievement. Additionally, we requested CFS data from APD and BCSO detailing the location of LEAD-eligible offense calls from July 1, 2019, through December 2021 in January 2021. We did not receive this data by the time this report was completed and cannot statistically assess the degree of spatial overlap between LEAD referral sites and LEAD-eligible offense hotspots.

The data from the COSSAP RedCap database is limited as well. Specifically, at the time of our initial data quality audit in early February 2022, only 78% of participants (n = 39) had information logged on both the Baseline and Enrollment form and Monthly Client Services Form. 14% of referred participants had complete information logged on the Monthly Client Services Forms and yet did not have completed Baseline and Enrollment forms despite the collection of the latter preceding the former in time (n = 7). Per our initial data receipt, 0% of the 39 logged participants were offered harm reduction services (n = 0). Only 34.1% (n = 14) of clients were referred to conventional case management services (i.e., housing; therapy).

Moreover, some of the services coded as Other Case Management Services on the Monthly Client Services Form could be more accurately coded: for instance, assistance helping participants secure a Social Security card was often coded as an "Other Service" when this could more accurately be coded as Identification Card. A second data quality audit of the COSSAP RedCap data in March 2022 reviewing data entered through February 2022 indicated that these inconsistencies were still present. Specifically, less than 7% of participants received harm reduction referrals (n = 6). 75.6% of clients were not referred to other services, and there were additional “Other" codes reported for case management services received which could be reclassified (i.e., shelter could be reclassified to “Housing” as a referral service provided).

The limitations of the initial COSSAP data audited – specifically, the mismatch between the Baseline and Monthly Data forms – limited our ability to conduct multivariate analyses of the predictors of case management dosage due to the small sample size. In a March 2022 meeting with the Bernalillo County DBHS team, DBHS partners speculated that data discrepancies in the COSSAP data likely understate the extent of case management services provided. For example, the DBHS team indicated that the count of harm reduction services should be higher than what the data reveals given the frequency with which hygiene supplies, food, and water are provided to program participants. We are unable to evaluate the scope of this data entry problem or assess the accuracy of these claims (i.e., how much of the missingness is a function of the failure to track and enter this information into the EHR versus how much is a function of the true lack of provision of harm reduction services).

Officer Survey Data

We conducted surveys of 68 sworn field officers at APD and BCSO in December 2021. These surveys allowed us to assess officer familiarity with LEAD, participation in LEAD trainings, perceptions of the ease of making a LEAD referral, the likelihood of officers making a LEAD referral, and responding officers’ demographic profiles. The response rate for officer surveys was 16.5%. Compared against the review of officer survey research conducted by Nix et al., (2019), the present survey’s response rate is toward the lower end of response rates reported in peer-reviewed studies of officers, the average of which was 64%. Nix et al. (2019) identify best practices to maximize response rates to officer surveys. Specifically, the researchers highlight survey administration mode (i.e., in-person administration versus online administration) as one of the primary survey design features which predicts higher response rates. However, the authors note that the choice to conduct surveys in-person should be balanced against potential costs associated with in-person survey administration (i.e., reduced perception of survey anonymity among officers taking the survey heightening the risk of socially-desirable responding; increased researcher cost and time). Due to agency-access issues and Covid-19 social distancing protocols, we were unable to conduct the officer survey in-person. Having noted this potential limitation to the survey, we want to underscore a critical point made by Nix et al. (2019) to preempt assertions that the 16.5% response rate alone invalidates the survey’s conclusions:

> *Yet, it bears repeating that research has demonstrated that low response rates are typically only weakly related to non-response bias. As such, a low response rate on its own is no reason to dismiss the findings of a survey. Given the weight of the evidence (Groves and Peytcheva 2008), the burden should be on manuscript referees to state why they believe a low response rate is suggestive of non-response bias. That is, referees should be required to identify explicitly patterns of over- or under-representation on some variable that is known to be related to the outcome. At the same time, it is incumbent upon researchers to be completely transparent about their survey methodology so that referees and readers can have a better idea why a response rate may be low – or high.* (p. 26)

There are two additional limitations to the survey data. First, survey data came from a nonprobability sample and not a random sample of officers. Because of this, it is possible that self-selection biases skew observed responses. Stated differently, perhaps officers who felt particularly strongly about the LEAD program, whether positively or negatively, had a higher propensity to complete the survey. Secondly, we observed high rates of missingness for a few explanatory variables: specifically, officer ethnicity and perceptions of cooperation with the Second Judicial District Court had moderate levels of missingness. To address this, we employed the MICE imputation procedure to simulate the missing data. However, despite the advantages of the MICE approach over alternative methods for dealing with missing data (i.e., case wise deletion; single imputation), some methodologists argue that the MICE approach can still be sensitive to the presence of higher levels of item-level missingness (i.e., rates of item-level missingness greater than 40%) (Jackobsen et al., 2017). Having noted this, there is some disagreement on this point. For instance, a recent study by Madley-Dowd et al. (2019) suggests the proportion of missing data provides limited information about the bias and efficiency gains that can be made from multiple imputation procedures.

Interview Data

We conducted 10 interviews of members of different stakeholder groups of the LEAD - Bernalillo County PCG. These interviews provide a window into implementing agents' perceptions of the strengths and deficits of program implementation. However, not all stakeholder groups participated at equivalent rates in the interviews (Response Rate: 45%): for instance, there was underrepresentation of stakeholders from the Second Judicial District Court and no representation from officers at BCSO. Thus, it is unclear whether or how the attitudes of stakeholders within these respective partner groups differ from the broader PCG, if at all. Additionally, interviews were completed in September and October 2021 during the first 60 days following the formal start date of the COSSAP-funded Expansion Plan. Thus, it is not obvious to what extent the results of the interview hold across time through the end of the data reporting period considered for this report. Finally, while we intended to conduct interviews with LEAD participants to assess their attitudes toward and experiences within the LEAD program, due to time and resource limitations, we were unable to conduct interviews with program participants within the evaluation window.

Recommendations for LEAD

The data from the present report suggest several ways to strengthen the implementation of LEAD. We provide recommendations to improve components of program implementation and data collection going forward. Specifically, we focus on (1) how to improve the dosage of case management service delivery, (2) how to increase agency-level support for LEAD within police agencies, and (3) strategies to improve participant access to housing.

The Intensity of Case Management Services

One of the concerns mentioned by PCG interviewees was the slow pace of referrals within the initial phase of program implementation and through early stages of the Covid-19 pandemic in March 2020. LEAD - Bernalillo County averaged 4.4 referrals per month through February 2021. However, per Worden and McClean's (2018) evaluation of LEAD - Albany, low referral rates within the first year of LEAD program implementation are not unusual. Referral volume has increased since March 2021 to 19.2 referrals per month. Despite longitudinal increases in referral volume, however, the enrollment rate of LEAD - Bernalillo County of 46% is lower than enrollment rates at other sites, and interviewees expressed concerns that the dosage of case management services to program participants was variable.

The average number of case management contacts per participant in LEAD - Bernalillo County (i.e., 7 attempted contacts; 3 successful contacts) was considerably lower than rates of case management contact per participant reported in process and outcome evaluations of LEAD - Seattle and LEAD - Santa Fe (Beckett et al., 2014; NMSC 2018). Relatedly, the median duration of time between attempted contacts was approximately 12 days. In LEAD - Seattle, 84% of referred individuals had at least one meeting with their case manager (Collins et al., 2017). In LEAD - Honolulu, 78% of clients were actively engaged in case management 15 months following intake (Gralapp et al., 2019). Given that data on case management contacts was only logged in NetSmart CareManager from September 2021 through January 2022, it is worth highlighting that the number of attempted and successful contacts occurred following the hiring of a program manager, the onset of the COSSAP Expansion Plan, and the hiring of a case management supervisor, albeit also during a period with some case manager turnover: one case manager resigned during this period.

The explanation for cross-site disparities in attempted and successful contacts and duration between contact is something we cannot evaluate with the present data beyond speculation informed by remarks made in the context of PCG interviews. Specifically, some DBHS interviewees asserted that the comparatively lower rate of case management contact was a function of turnover in case management staffing over program history, with some program intervals punctuated by a complete lack of LEAD case management staff at DBHS, a finding similarly highlighted in the June 2021 gap analysis (Ericson et al., 2021). Since inception, the program has undergone churn in case management staffing with low rates of case manager retention: at least four LEAD case managers have exited their roles, either due to resignation or promotion, since program inception. Compounding the potential effects of limited staffing on case management dosage, case management staff indicated that their staffing time is distributed across LEAD and non-LEAD tasks at the discretion of higher-level DBHS administrative staff. Moreover, case managers noted that most social service offices are closed on weekends, limiting case managers' ability to connect participants to appropriate services. Case management staff further speculated that due to institutional distrust and stigma, LEAD referrals often provided inaccurate phone numbers, email addresses, and home addresses during program intake which reduced prospects for future receipt of case management services. While speculative, an additional explanator might be that the lower volume of total contacts is related to the program's definition of a participant's active-status (i.e., defining the threshold of client inactivity at 30 days following enrollment and then stopping outreach activities).

Case management engagement with the LEAD target-population following intake can be difficult due a combination of participant personal characteristics (i.e., low levels of motivation and desire to change; high rates of substance use; high levels of system distrust), incentive structures (i.e., the risk of legal punishment for noncompliance for arrest diversions), and environmental conditions in the community (i.e., the supply and accessibility of housing and harm reduction resources). SAMHSA TIP 27, "Comprehensive Case Management for Substance Abuse Treatment" (2015), in detailing some of the intersecting barriers to early-stage participant engagement, notes:

> *Engagement activities are intended to identify and fulfill the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor. This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services. Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail*

> *or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment.* (p. 19)

These complications, considered against a backdrop of trending increases in referral and enrollment numbers and the limited number and time of case management staff, suggest caution against continuing the current level of community outreach. Assuming concerns expressed by case management staff regarding the divided distribution of their working time are accurate, that these concerns have persisted since the conclusion of our interviews in October 2021, and that case management staffing levels remain constant going forward, increasing referral and enrollment rates threatens to violate recommended ICM and National Support Bureau recommendations for caseloads.

Referrals to LEAD - Bernalillo County have gradually increased since January 1, 2021. To date, the ratio of referred to enrolled individuals is approximately 1:1 (i.e., 46% of referrals subsequently enroll in LEAD as of February 2022). If we assume that 46% of newly referred individuals enroll in LEAD, that case managers lose contact with 50% of their clients during a given month rendering them inactive per current program definitions, and we assume linearity in the relationship between referrals and program duration, this suggests that – absent the hiring of an additional case manager – by September 2022, each of LEAD - Bernalillo County's two case managers will have an average active caseload of 43.7 active cases. Even if we assume the lower bound of the referral estimates based on linear projections (i.e., the referral of an additional 16 new prospective participants per month) and we assume that 46% of these individuals enroll and that 50% of enrolled individuals disengage after a month, for a conservative net increase of two active cases per case manager per month, then current projected caseloads by September 1, 2022, will be approximately 32 active participants per case manager. We note that these estimates are potentially underestimates as they assume no case manager turnover, that the use of warm handoffs will not increase over time which theoretically would increase the enrollment rate, and no direct engagement with participants after the 30-day active status window expires. We visualize projected trends in referrals and active caseloads in Figures 6 and 7.

We stress that the peer-reviewed literature on ICM specifies that for case management to be considered intensive case management, the case manager-to-client ratio should be between 1:10-20 in the context of patients with SMIs and that ratios above this amount constitute standard case management practice. The LEAD National Support Bureau, while not officially defining an ideal case manager-to-participant ratio in existing documentation, informally advised the Bernalillo County team in February 2022 that a ratio up to 1:25 which includes harder to reach active clients is permissible, though it is not obvious that this recommendation is consistent with the existing ICM literature. Additionally, the LEAD - Santa Fe evaluation team noted that as part of the COSSAP grant requirements, other LEAD sites within New Mexico have been advised that case managers can have caseloads up to 30 clients. We note that while standardizing the ratio across sites may make cross-site comparisons cleaner due to a reduction in potential confounding variables, an argument premised on standardization would be strengthened by more clearly articulating why the departure from ICM recommendations in the peer-reviewed literature is justified as case managers in the context of SMI ICM studies did not engage in similar levels of outreach to disengaged clients.

Figure 6.

Projected Increase in LEAD Bernalillo-County Referrals Through September 2022

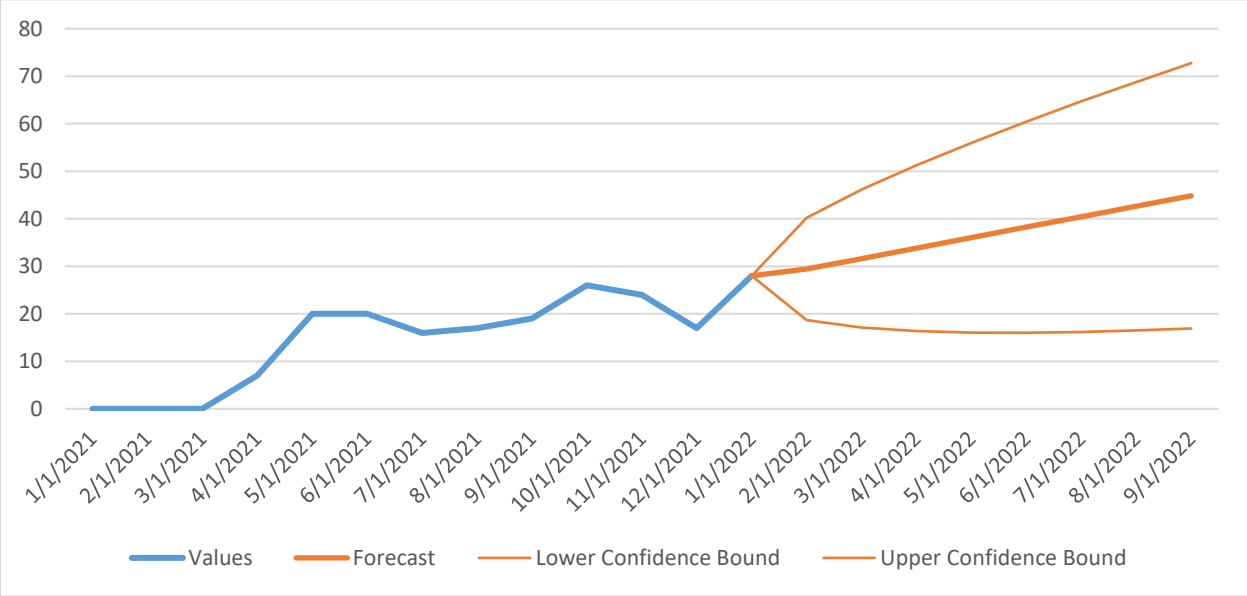
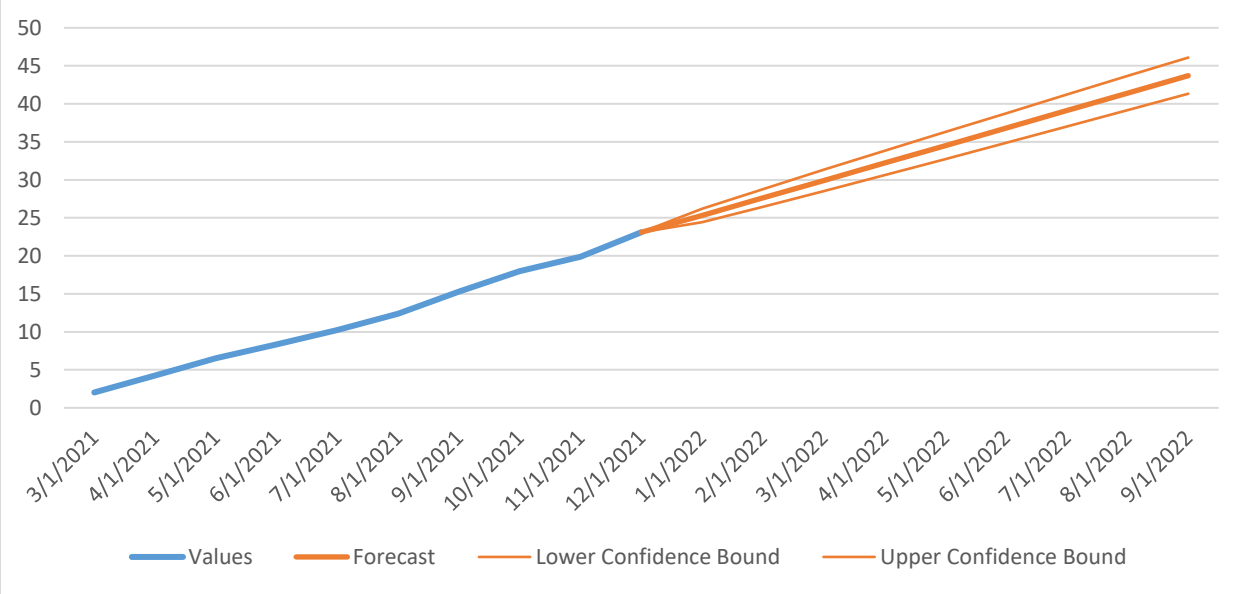


Figure 7.

Projected Increase in LEAD-Bernalillo County Active Caseloads with Current Staffing Levels Through September 2022



While LEAD - Bernalillo County is currently in the process of hiring a new case manager which would bring the current count of case managers to three, we note that, given the present two case managers and case management supervisor, the ratio of active clients to case manager is projected to outpace ICM and LEAD National Support Bureau recommendations by May 2022. We thus advise either hiring remaining COSSAP-funded case managers in the short-term and/or shifting macro-level program focus

away from increasing training volume of new officers and community partners, though continual harm-reduction training of previously-trained LEAD officers is a program best practice, and more toward a concentration on firming up the delivery of case management services to the existing client base.

The LEAD - Santa Fe evaluation team advised LEAD - Bernalillo County in February 2022 to expand the window of participants' active status from 30 days to 90 days minimum to align implementation in Bernalillo County with the Medicaid peer case management definition of participant enrollment status and the LEAD - Santa Fe and LEAD - Seattle models. To this point, a 2020 University of Cincinnati Guide on LEAD Best Practices notes:

> *Often there is no set length for LEAD participation. Length of participation in the program is dictated by the needs and maintained eligibility of the client. Additionally, LEAD clients may transition between "active" and "inactive" participation over time."* (2020, p. 2).

Similarly, SAMHSA TIP 27 (2015), notes:

> *While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a "come-on" to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits, case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency created distinctions such as "pretreatment" and "primary treatment*. (p. 20)

However, a cursory review of Medicaid case management documents on national and New Mexico continuity of care provisions did not provide any clarity on statutorily required disenrollment timeframes. Additionally, the LEAD National Support Bureau does not provide specific documentation on precise timelines to disenrollment. The staff at the DBHS expressed concern in February 2022 that expanding the timeframe to classify a program participant as inactive from 30 days to 90 days would result in the overextension of case managers given limited staffing and could result in pushback from the broader public and other stakeholders (i.e., a concern that labelling a client as active when they have not had contact with a case manager for 89 days would be perceived negatively by others as an artificial inflation of client counts).

It is important to be objective about the costs and the benefits associated with modifying the window of participant active status. In defense of extending the window from 30 days to 90 days, one notes that the unique characteristics of the target population served by LEAD (i.e., the unpredictability of participant living arrangements and access to cell phones; the nature of substance use) do not lend themselves to consistent, linear patterns of engagement in case management over time. Thus, extending the active window beyond 30 days increases the likelihood of participant engagement, and participants may be more likely to engage in services as they develop a rapport with case managers, a process which can take time.

However, while there may be difficulties establishing repeated contact with the target population and while substance use can generate swings in participant motivation which may not lend themselves neatly to falling within a 30-day time frame, expanding the active window – and thus levels of active outreach – raises a question about how case managers should optimize their time. If there are statistically low rates of participant re-engagement after the 30-day window (i.e., < 30% of participants would re-engage with case managers after a month of no contact), it is worth considering whether limited case management time is better spent engaging in low probability outreach efforts or in providing more intensive care to participants who have already demonstrated a higher likelihood of program engagement within the first 30

days following program enrollment. Similarly, it is worth considering whether some types of outreach strategies are more effective at different points of a participant's enrollment in the program, how much time different case management strategies take on average (i.e., active streets-based case management versus passive texting), and whether attempted contact frequency or form should be universally as intensive despite variability in prior contact success rates (i.e., whether some types of strategies should be used for a client who enrolled a week ago and has already attended one case management appointment in person and a client who enrolled three weeks ago and has only responded to one text). The LEAD - Santa Fe evaluation team advised DBHS staff to pursue an equally active streets-based engagement strategy for participants beyond Bernalillo County's one-month window given the unique challenges associated with establishing contact with, and building rapport with, the existing participant base. The definition used in the COSSAP grant of ICM-consistent encounters states that case managers must have five or more successful contacts with each client per month with most attempted contacts being streets-based.

To increase case management dosage, we recommend modifying existing eligibility criteria and procurement rules in an effort to increase utilization of the Urban Institute grant for cell phone distribution. Through March 2022, only five cell phones have been distributed to LEAD participants. Participants can receive a phone if they attend an additional meeting with their case manager after the initial intake appointment and if they do not already have a phone. We recommend distributing phones at the point of program intake and to not make phone distribution conditional on whether a participant already reports having a phone.

We also note that the use of streets-based case management should increase. Only 44.4% of attempted case management contacts reviewed involved this form of outreach. Articulating the benefits of streets-based outreach, SAMHSA TIP 27 states:

> *Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they take buses or wait in lines to register for entitlements. This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals—and helps the client trust and respect the case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts.* (Center for Substance Abuse Treatment, p., 14)

We summarize additional recommendations for increasing case management dosage below.

1. Per NetSmart CareManager data, the median time between case management contacts with participants was approximately 13 days. To be consistent with ICM recommendations, contact attempts should be more frequent.

2. DBHS staff need to formalize expectations for, and measure at monthly or quarterly intervals, desired program benchmarks beyond the four objectives identified in the COSSAP Expansion Plan (e.g., What is a desired no-show rate at case management appointments? What is a desired target for the program's enrollment rate?), establish clear time periods to better understand progress toward goals which explicitly involve change over time (i.e., What is the relevant start period when goals such as "Increase connections to recovery support and consumer services by 50% from the

beginning of the grant period to the end of the grant period" are stated? What month(s) are used as the beginning of the grant period?), ensure that measurements toward goal progress are being tracked, and append goals to existing performance measures and activities identified in the COSSAP Expansion Plan documentation accordingly. A 2011 meta-analysis suggests that setting specific, difficult group-centric goals (e.g., 95% of biweekly PCG meetings will be attended by all stakeholder groups from September 1, 2021 through September 1, 2022) instead of non-specific goals (e.g., High attendance of biweekly PCG meetings by stakeholder groups from September 1, 2021 through September 1, 2022) or individual-level goals (e.g., Case Manager X will successfully contact 10 active clients each month) promotes positive group performance (Kleingeld et al., 2011).

3. While case managers indicated that they used Motivational Interviewing (MI) approaches in interactions with participants and had received training in MI, DBHS case managers need to continue to deploy MI strategies and structured interviews at the point of program intake. A 2018 study which explored how MI techniques influenced attendance at Intimate Partner Violence (IPV) treatment sessions found that random assignment to MI-centric case management caused subsequent increases in session attendance rates and program compliance (Soleymani et al., 2018). Even if initial conversations with LEAD participants are more organic and less structured than intake conversations with those in IPV treatment, efforts should be taken to continually use MI methods throughout participant interactions as a strategy for simultaneously building participant trust and optimizing prospective engagement.

4. Case managers should be in frequent contact with the agencies participants are referred to in order to assess client attendance and progress receiving recovery support services in accordance with COSSAP Expansion Plan Objective #4. Lapses in attendance can precede program disengagement, in which case, SAMHSA TIP #27 advises holding a case conference. Additionally, information on referral services offered and referred to should be routinely logged in EHR systems by case managers and include, at minimum, information on (a) the date participants were referred to and/or received services, (b) the name of the service provider referred to or contacted, and (c) the type of services the service provider offered. Barring HIPPA confidentiality protections limiting access, additional information on the length of service provided and attendance rates should be gathered to better understand how specific harm reduction and support recovery services received condition program outcomes and whether some types of external programming optimize likelihood of program success.

5. It is important to track the offering and provision of harm reduction services to participants, however seemingly trivial (i.e., provision of water bottles). This data is not currently logged in a data-usable fashion in the NetSmart Care Manager system and is underreported in the RedCap database where, per data from March 2022, only 7% of active cases have received harm reduction services.

6. DBHS staff need to hire state-certified peer case managers with similar lived experiences of substance use, homelessness, and prior criminal justice system involvement per recommendations from the LEAD National Support Bureau. While case managers reported high levels of similarity

to the participants on caseloads in PCG interviews, it is not clear whether DBHS has a specific protocol in place in the hiring process to verify peerness systematically prior to hiring.

7. DBHS staff need to use additional COSSAP funds to onboard case management staff to keep pace with increasing referral streams and to increase the use of active street outreach. As of March 1, 2022, there were two currently active case managers. COSSAP funding is sufficient to cover the hiring of up to five case managers.

8. DBHS staff need to ensure that LEAD-hired case managers are not being reassigned to non-LEAD case management tasks as project reassignment reduces the amount of time case managers can allocate to locating and providing services to LEAD participants and increases the risk of case manager turnover. Task reassignment increases perceptions of role ambiguity (Jong, 2016) which, in turn, correlates with reductions in job satisfaction (Abramis, 1994) which, in turn, predicts higher rates of employee turnover. Strategies – such as providing employees with regular performance feedback and providing employees with as much information as possible about strategic program changes – are factors previous research has identified as predicting higher retention rates (Kottwitz et al., 2017). Some case management staff reported in interviews that they were unaware of program changes occurring or were not asked for input. Similarly, a recent process evaluation presents evidence that providing peers with clear role expectations and meaningful engagement opportunities increased the quality and success of case manager client engagement specifically in the context of harm reduction interventions (Greer et al., 2016). Greer et al., (2021) state:

   > *While peer workers found a high degree of purpose and meaning in their day-to-day work, their roles lacked definition within organizations, which produced feelings of ineffectiveness and being undervalued. A lack of organizational understanding and recognition of their roles was evident from unclear "peer" role titles, a lack of role communication and expectations, the representation of experiential knowledge, and a lack of role support and training.* (Greer et al., 2021; p. 1)

9. DBHS needs to ensure equal access to training opportunities in harm-reduction across all case managers and ensure case managers have appropriate training in EHR systems and data entry tasks.

10. Several studies identify evidence-based strategies to increase attendance at healthcare appointments specifically among vulnerable populations. A 2021 meta-analysis and systematic review by Crable et al., (2021) presents evidence across 34 studies that facilitated appointment scheduling (i.e., offering same-day access, pre-scheduled follow-up appointments, and simpler referral pathways), and the use of financial incentives are promising strategies which may promote increased appointment adherence. However, this recommendation assumes that these findings generalize to behavioral health appointment environments which have different client populations. We are agnostic on whether the use of these strategies may promote increased attendance given variable access to telephones, internet, and private or safe spaces among the LEAD target population which may limit the usefulness of these strategies specifically for the unhoused segment of the target population (Bakken, 2020).

11. DBHS training materials should explicitly mention in training slides for both police agencies and community providers information about the mechanics and process for conducting a warm handoff. Those who have been LEAD-trained should be periodically reminded of the process flow and expectations. Information about the procedures for warm handoffs should be regularly and consistently communicated to these audiences.

12. If there is a mechanism to validate contact information of participants at the point of program intake (i.e., dialing participant-provided phone numbers to see if the call redirects to a business or is disconnected), use of these mechanisms may reduce attrition rates after the warm handoff. It may also be worthwhile considering collecting other types of contact information of participants (i.e., social media handles or usernames). A 2019 article in *The Journal of Bioethics*, "Ethical and Regulatory Considerations for Using Social Media Platforms to Locate and Track Research Participants", highlights the usefulness of using social media platforms to contact homeless populations with SUDs and outlines informed consent guidelines which may be helpful to consider going forward. The study notes:

> *Participants lost to follow-up are often those with higher rates of cell-phone instability, homelessness, incarceration, and social and financial impairments (Soderstrom et al. 2007; Sommers et al. 2006). Attrition of these participants from research skews findings toward economically and socially stable participants, violating the principle of justice underlying all human subjects research. Fortunately, for vulnerable populations at risk of loss to follow-up, such as racial minorities, older adults, rural residents, and those with lower levels of income or education, rates of social media use are between 60% and 70% (Pew Research Center 2017b). Populations who may be less likely to have broadband Internet service are often able to access the Internet and use social media through smartphones.* (Bhatia-Lin et al., 2019, p. 49)

13. A recent study by Heaslip et al., (2021) found that time spent on the street influences the types of services homeless clients seek out. Specifically, the study found that individuals who have been recently homeless clients tend to seek out housing and employment support whereas longer-term homeless clients tend to seek out services related to basic acute needs and are less prone to seeking housing and employment services due to feelings of hopelessness and resignation. Thus, data should be collected in NetSmart CareManager on the amount of time a participant has been homeless, as this can information can potentially inform IIP goal prioritization among case managers.

14. Given that we found lower rates of attempted and successful contacts among male participants, unmarried participants, and homeless participants, subsequent outreach and engagement efforts might consider innovative ways of engaging these populations.

Low Perceptions of Agency-Wide Support for LEAD

The results of our officer survey suggest that despite widespread agency participation in LEAD trainings by responding officers, there are moderate levels of support for the LEAD program among responding officers and mixed perceptions of agency-level support for LEAD. This is important to consider

given both (a) the broader cultural milieu in which LEAD exists (i.e., mixed messaging from the department chief on diversionary programs; reductions in public trust in officers since George Floyd protests) and (b) the fragility of the referral stream (i.e., the fact that 35% of total program referrals originate with four distinct officers). While the success of LEAD - Seattle suggests that widespread participation in LEAD by officers is not necessary for positive program outcomes to be achieved, the extent of skewness in the referral distribution in Bernalillo County suggests a need to focus on expanding the scope of officer buy-in, if possible, to re-engage officers who have already made one LEAD referral, and to survey officers who have made LEAD referrals previously on their experience making a referral.

Recent studies examine factors which influence levels of officer-buy in for police reform proposals. Rosenbaum and McCarty (2017) analyzed survey data of over 15,000 officers at 88 police agencies across the United States. The authors present evidence that perceptions of organizational justice, defined as "an employee's perception of their organization's behaviors, decisions and actions and how these influence the employees' own attitudes and behaviors at work" (p. 80), increase officer buy-in to policing reforms and that this effect is mediated through increased officer commitment to their agency, job satisfaction, and compliance with agency rules. The authors suggest that officer buy-in is higher in departmental contexts where officers perceive agency leadership as fair, where officers are able to provide regular feedback on specific reforms, where officers perceive that growth opportunities exist, and in agencies where officers' welfare is prioritized. While not directly analogous, a 2019 study of 1,062 prison officers in Ghana presents evidence that support for rehabilitation correlated with key components of organizational justice – being treated fairly by supervisors and having good relationships with colleagues (Boateng & Hsieh, 2019).

While we did not assess perceptions of organizational justice directly in our survey and PCG interviews, officers' responses to open-ended survey questions implied that some officers at both agencies might score low on measures of organizational justice. Specifically, some officers noted that the perceived degree of oversight by the Department of Justices' Independent Monitor was overly restrictive and reduced time officers could engage in protective policing. Some studies suggest that negative public perceptions of officers and of policing work (i.e., low levels of community trust and antagonism toward officers) correlates with officers feeling higher levels of social isolation, lower levels of work-group solidarity, greater cynicism toward the public, and a higher likelihood of adopting coercive attitudes (Marier & Moule, 2019). It is worth considering how feedback loops between negative public attitudes toward officers, ambiguity in agency and county-level leadership support, and individual-level perceptions of organizational justice might dynamically interact to influence officer perceptions of LEAD's effectiveness.

Finally, a 2019 training presentation by COSSAP on how to obtain officer buy-in for a first responder diversion program implemented in Tucson, Arizona highlighted the following recommendations for increasing officer buy-in (Bureau of Justice Assistance, 2019). While it is not obvious that each of these recommendations is evidence-based given a lack of studies on these topics, they may be worth considering:

1. Emphasize the power of individual officer discretion
2. Strongly suggest not making deflection mandatory
3. Incentivize deflection by officers (i.e., commendations)
4. De-emphasize the value of arrest as a measure of officer productivity
5. Ask for ongoing process improvement suggestions
6. Executive leadership in agencies should have unified front
7. Have higher-level executive agent heads attend trainings

8. Highlight success stories, however small

Some of these practices have been clearly incorporated into LEAD - Bernalillo County training materials (i.e., Points 1, 2, 8). However, it is not clear the extent to which other practices for increasing buy-in are currently implemented. Exploring these factors, alongside fielding officer surveys which include objective scales of organizational justice and requesting agency-data on time to process LEAD referrals versus standard bookings, could be an important component of future LEAD evaluations. We also note that officers who have made LEAD referrals do not typically attend PCG meetings despite LEAD National Support Bureau Recommendations encouraging rotation of referring officers into OWG meetings. We advise LEAD partners at APD and BCSO to encourage referring officers and leadership, where possible, to attend these meetings.

The Complication of the Housing First Model

One of the largest structural challenges to implementation fidelity for LEAD – Bernalillo County is limited housing availability. The LEAD model is premised on a Housing First model which the National Alliance to End Homelessness defines as a "homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life" (*Housing First*, 2020). The Housing First model asserts that by achieving housing stability, participants will be more likely to achieve other goals (i.e., achievement of basic food and necessities; attending to substance use issues) as housing reduces a key element of uncertainty in participants' lives.

A 2021 annual Point-In-Time (PIT) count by the Housing and Urban Development (HUD) Department and the New Mexico Coalition to End Homelessness suggests that there were 1,567 sheltered and unsheltered homeless people living in Albuquerque, that 42% of Albuquerque's unsheltered were chronically homeless, 30.2 % of the homeless self-reported having an SMI, and 25.5% self-reported using substances (New Mexico Coalition to End Homelessness, 2021). While Albuquerque has increased funding for supportive housing vouchers by 73% since 2018 (City of Albuquerque, 2021), a 2020 Urban Institute needs assessment of homelessness in Albuquerque suggested that only 37% of Albuquerque's assisted housing units are affordable to those with extremely low incomes (Leopold et al., 2020). Several PCG interviewees reported that long housing voucher waitlists and restrictive requirements on prospective tenants (i.e., no pets; number of tenants), some of which were in direct contradiction to harm-reduction principles (e.g., sobriety or abstinence requirements), were a primary barrier to participants' ability to access needed housing services and maintain housing long-term. The problem of growing housing unaffordability and housing instability among LEAD's target population is not unique to Bernalillo County. Articulating the scope of the housing waitlist problem at the national level, a 2021 report by the Center on Budget and Policy Priorities stated:

> *Due to limited program funding, families struggling to afford housing that manage to get off the waiting list for a Housing Choice Voucher must typically wait for years before receiving a voucher, CBPP analysis of Department of Housing and Urban Development (HUD) data shows. Among the 50 largest housing agencies, only two have average wait times of under a year for families that have made it off of the waiting list; the longest have average wait times of up to eight years. On average nationally, families that received vouchers had spent close to two and a half years on waitlists first, exposing many to homelessness, overcrowding, eviction, and other hardship while they wait.* (Acosta & Gartland 2021, p 1)

Insofar as the success of LEAD is predicated on early-stage receipt of housing services, we are concerned that the effectiveness of LEAD in Bernalillo County will be constrained by limited housing supply, limited voucher access, and long voucher waitlists barring any substantive changes to present housing market conditions or rapid increases in the distribution of housing vouchers. One of the primary fidelity breaks identified in the process evaluation of LEAD - San Francisco and one of the cited factors which contributed to the termination of the LEAD program in San Francisco was the deviation from the Housing First model (Magaña et al., 2022). However, a 2015 study by Gabrielian et al. (2015) suggests that poor adherence to outpatient care, substance use disorder, hepatitis-C, chronic pain, justice involvement, and frequent emergency department utilization, among other factors, predicted premature exit from supportive housing programs. Inasmuch as these risk factors for premature housing exit exist within the Bernalillo County target population, harm-reduction approaches, complemented with appropriate case management services, stand to increase the prospects of a participant achieving housing, though these variables may be slow to change.

Some recent bipartisan reports on the topic of housing affordability identify potential policy solutions to increase housing availability, though proposals vary in political feasibility in Bernalillo County. A 2021 report from HUD suggest strategies such as zoning reform, legislation defining a target goal of below-market rate units dedicated to multifamily development projects for low- to moderate-income renters, low income housing tax credits, land value taxes, split property taxes, the use of incentives, and increased housing subsidies as policy options which stand to increase housing availability and affordability. We encourage readers to explore the HUD report in more detail, as well as recent bipartisan reports on the topic from the Center for Budget and Policy Priorities and The Urban Institute.

Summary of Key Findings

313 individuals were referred to LEAD - Bernalillo County from July 2019 through January 2022. 45.6% of referred individuals subsequently enrolled. 63% of total referrals have been arrest diversions, and 36% have been social contact referrals. 70% of referrals originated from APD, 16% from BCSO, and 14% from other community partners. 70% of referrals have occurred since March 2021, and 40% have occurred since the beginning of the COSSAP expansion plan in September 2021. Four officers were singularly responsible for 111 referrals which represents 35.4% of LEAD referrals from all sources and 44.4% of overall referrals from officers. There were some differences in the profiles of individuals referred through arrest diversion or social contact pathways: specifically, arrest diversion referrals were significantly more likely to be users of methamphetamine, fentanyl, and opioids and were statistically more likely to be men than those referred through social contact pathways.

In the five-month span between September 2021 and January 2022, 48% of referrals enrolled in LEAD. Only 25% of referrals in this time period made use of the warm handoff. Case managers had 1,034 attempted contacts with participants in this timeframe. Contact with participants was successfully achieved in 42% of attempted contact cases. The average number of attempted contacts with active program participants was 7, the average number of successful contacts with active program participants was 3.1, and the median number of days between contacts was 12. Contact rates were lower than other LEAD sites which have reported data on contact figures, specifically LEAD - Seattle ($\bar{X}$ = 18 successful contacts per participant) and LEAD - Santa Fe ($\bar{X}$ = 45 = successful contacts per participant). Male participants, unmarried participants, and homeless participants had significantly lower volumes of attempted and successful case management contacts. Age and heroin use predicted longer case management duration.

In our officer surveys, we found that familiarity with LEAD among responding officers was high, training participation was high, and officers had a moderate willingness to make LEAD referrals. We also found evidence of mixed perceptions of agency-wide support for LEAD, and some responding officers expressed concerns that the Second Judicial District Court often avoided prosecuting LEAD non-compliance, that officers perceived that the LEAD referral process took too much time, and that increases in officer resignations reduced officers' capacity to engage in proactive policing work, though we are unable to falsify these perceptions. In multivariate regression analysis, we found evidence that perceived levels of agency support for LEAD, perceived cooperation with the Second Judicial District Court, and lower officer education levels significantly increased officers' likelihood of referring an eligible participant to LEAD, all else equal.

In our PCG interviews, we found evidence that there was general satisfaction among PCG stakeholders on the degree of collaboration that occurs within the PCG and moderate agreement on the success of LEAD implementation to date. Specifically, most PCG interviewees noted that the hiring of a program manager in March 2021 was a crucial contributing factor to increased referral counts and training, that the use of warm handoffs has increased over time, and that the turnaround time on background checks for program referrals by appropriate judicial actors was quick. However, PCG interviewees noted that the onset of the Covid-19 pandemic, and attendant social distancing regulations, limited program reach, the ability to link participants to appropriate social and behavioral health services given their closure, and the degree of streets-based outreach for the middle year of program implementation (i.e., March 2020 – March 2021). Stakeholders expressed concern that the limited availability of community housing resources, specific bureaucratic impediments to case management (i.e., uneven case manager participation in harm-reduction trainings; denial of specific technological requests to facilitate intakes), reductions in agency-level staffing levels at APD, BCSO, and DBHS, reassignment of job responsibilities among case managers to non-LEAD tasks coupled with consequent role ambiguity, and a lack of satisfaction with the perceived strictures of the consent decree specifically among APD officers, limited program implementation quality to date.

Our prior audits of participant-level data recorded through DBHS' internal NetSmart CareManager EHR, SmartSheet, and RedCap suggest areas of improvement in data collection going forward. We have highlighted these limitations to data quality in previous meetings and email exchanges with the DBHS from January 2022 through March 2022 and thus, we cannot comment on whether or when these recommendations have been or will be implemented. In terms of the data tracked in NetSmart Care Manager, we have advised DBHS to start tracking data on referrals beyond case notes, to quantitatively track outcome data for participants where possible (i.e., housing status, employment outcomes, income/benefits; recidivism; ER system utilization), to reduce the reliance on text-fields if possible (i.e., detailed information on IIP goals or participant goal progress currently logged in case notes), and to reassess specific social determinant of health and outcome data (i.e., substance use data; ODs) at regular program intervals where possible, analogous to COSSAP data reporting periods (i.e., at monthly or quarterly intervals). While we are aware of existing pulls on case manager time and of expressed concerns surrounding the redundancy in data entry across multiple EHR systems, we encourage the DBHS to retrospectively enter data from participants from the fifteen months of program implementation into NetSmart CareManager, if feasible. Staff of the DBHS noted during interviews that the introduction of COSSAP funding has positively influenced the breadth and depth of non-COSSAP data tracking and has increased staff awareness of which specific variables need to be recorded in local data systems going forward. Per data tracked as part of the COSSAP grant through RedCap and SmartSheet platforms, we have advised the DBHS to clarify specific process points about data entry and to remedy inconsistencies in this

data including mismatches between the number of case management encounter days and encounter count, incongruencies in the collection of Baseline and Enrollment Form data and Monthly Services Form data, and the current reported levels of harm reduction services provided to participants.

Finally, we want to reiterate the deficits of our own data analysis to guard against drawing unwarranted inferences from the present report. One of the weaknesses of the data from our document review is that despite rules and procedures being codified on paper, this does not necessarily mean that rules and procedure changes are appropriately communicated to relevant parties or instantaneously adopted (e.g., warm handoff procedures). Despite requesting a number of documents at various time periods through the evaluation window, it is possible we have not reviewed all relevant program documentation. Our document review does not allow us to assess more recent procedural modifications to program practice initiated since December 2021 (e.g., recent modifications to expanding the window of client searches). Some of the deficits of the participant-level data are the incomplete coverage of participant characteristics for the first fifteen months of program implementation, data on important measures (i.e., substance use) only being recorded at program intake and not at regular reporting periods, a lack of documentation of, or incomplete collection of, important moderating process variables over the duration of program implementation (e.g., program referral sources; harm reduction services offered or provided), and a lack of access to raw CFS data on LEAD-eligible call codes from BCSO and APD to inform targeted outreach strategies. As most of the data on case management dosage only covers the period from September 2021 through January 2022, we are unable to assess what case management dosage looked like prior to this window.

In terms of the limitations to our officer surveys, we note that the overall response rate of 16.5% is lower than the 64% response rate identified across officer surveys in Nix et al., (2019). However, we cannot assess whether the comparatively lower response rate correlates with nonresponse bias and are thus agnostic on the question of whether our officer survey results generalize to nonresponding officers at existing agencies. We also note that the use of the MICE procedure to impute responses for variables with high-levels of data missingness (i.e., officer ethnicity and officer perceptions of judicial cooperation), while superior to other methodological choices such as case-wise deletion or single imputation, still relies on specific assumptions about the nature of missingness (i.e., whether this missingness is at random or not) which we are unable to assess directly. In terms of the limitations to our PCG interviews, we note that there were low or zero levels of participation from staff attorneys at the Second Judicial District Court and officers at BCSO respectively; thus, it is unclear how perceptions of LEAD program success might generalize to these partners. Additionally, due to time constraints, we were unable to assess the attitudes toward the program of those referred to the program and those who enrolled.

Future Research

The data limitations suggest a number of profitable avenues for future research of process and outcome related variables. However, before discussing these avenues, we want to note that there are some challenges to conducting an outcome evaluation of LEAD going forward. One primary challenge relates to existing incompleteness in the participant-level data in the NetSmart CareManager system, specifically the lack of data recorded at multiple time points as participants progress through the program (i.e., how participant substance use evolves; high missingness for data on overdoses; low volumes of reported harm reduction services offered). This missingness limits our ability to assess potential non-linear and gradual changes in participant drug use and service utilization over time, which is important to record given the gradualness of a behavior-change intervention like LEAD. A second challenge relates to the

multidimensional nature of the intervention itself: as the LEAD program is composed of overlapping interventions which have each individually been shown to induce positive changes on specific desired program outcomes (i.e., ICM; MI; harm reduction; Housing First), it is potentially difficult to assess which specific component of the LEAD program intervention package is most necessary for inducing these outcomes. Relatedly, it is not obvious whether interactions between competing intervention strategies increase or decrease the likelihood of participants achieving specific program outcomes (see, for instance, Moore et al., 2015).

Having noted this, in what follows, we present a sampling of research questions which could help us better understand the dynamics of program implementation and assess program effectiveness downstream, assuming we are able to access the appropriate data sources given time and budget constraints (i.e., health exchange data; agency CFS data).

1. We could use causal inference matching techniques (e.g., genetic matching; propensity score matching), supplemented with pre-post testing, to assess how LEAD enrollment causally influences recidivism rates, housing security, substance use patterns over time, overdoses, quality of life perceptions, and hospitalization use rates. We could also explore whether and how key implementation variables (i.e., number of case management contacts; duration of case management contacts; number of referred services received; duration in program) predict these outcome variables.
2. We could use CFS data from BCSO and APD, supplemented with New Mexico and Bernalillo County Metropolitan Court data to validate criminal backgrounds, to assess the proportion of LEAD-eligible calls for service which are referred to LEAD.
3. We could survey LEAD clients to assess their experiences with the program. We have already developed IRB-approved interview guides which could be adapted to this end.

Conclusion

After two and a half years of program development, the implementation fidelity of LEAD - Bernalillo County is mixed. On the one hand, LEAD - Bernalillo County has considerably expanded referral streams and training opportunities for officers, community partners, and case managers over the past year of program implementation, 61 distinct officers at APD and BCSO have made at least one LEAD referral, perceptions of interagency collaboration among PCG members are high and organizational siloing low, and most interviewed PCG members perceive the program as trending in the correct direction. Additionally, the socio-demographic profiles of LEAD referrals suggest that the appropriate target population is being served by the program. On the other hand, limited community housing resources and delays in receipt of housing vouchers threaten the intervention's Housing-First theoretical pathway, the amount of case management contact with participants, and the time between attempted contacts, is lower in LEAD - Bernalillo County than at other comparison sites, the true level of harm reduction services provided is unknown, referrals by officers are heavily concentrated among a subset of four referring officers, the pace of increased referrals and the expansion of the participant active status window threaten to violate ICM caseload recommendations barring the hiring of more case managers, warm handoffs are inconsistently used, and there appears to be equivocal support for diversion programs among executive-level staff and officers at APD and BCSO. Additionally, we were unable to assess a number of interesting process questions due to time and resource constraints and data access issues (i.e., surveys of clients enrolled in the program; statistical analysis of LEAD-eligible offense hotspots from CFS data). The present report offers a series of

evidence-based recommendations to address existing fidelity breaks. However, some of the environmental conditions which negatively interact with program implementation (i.e., housing availability and affordability) may be beyond the scope of implementing agents' power to address within the timeframe for evaluation and may constrain program effectiveness in the long-term.

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Appendix A – LEAD Inclusionary and Exclusionary Criteria

The following describes the LEAD exclusionary criteria for LEAD – Seattle derived from Beckett (2014).

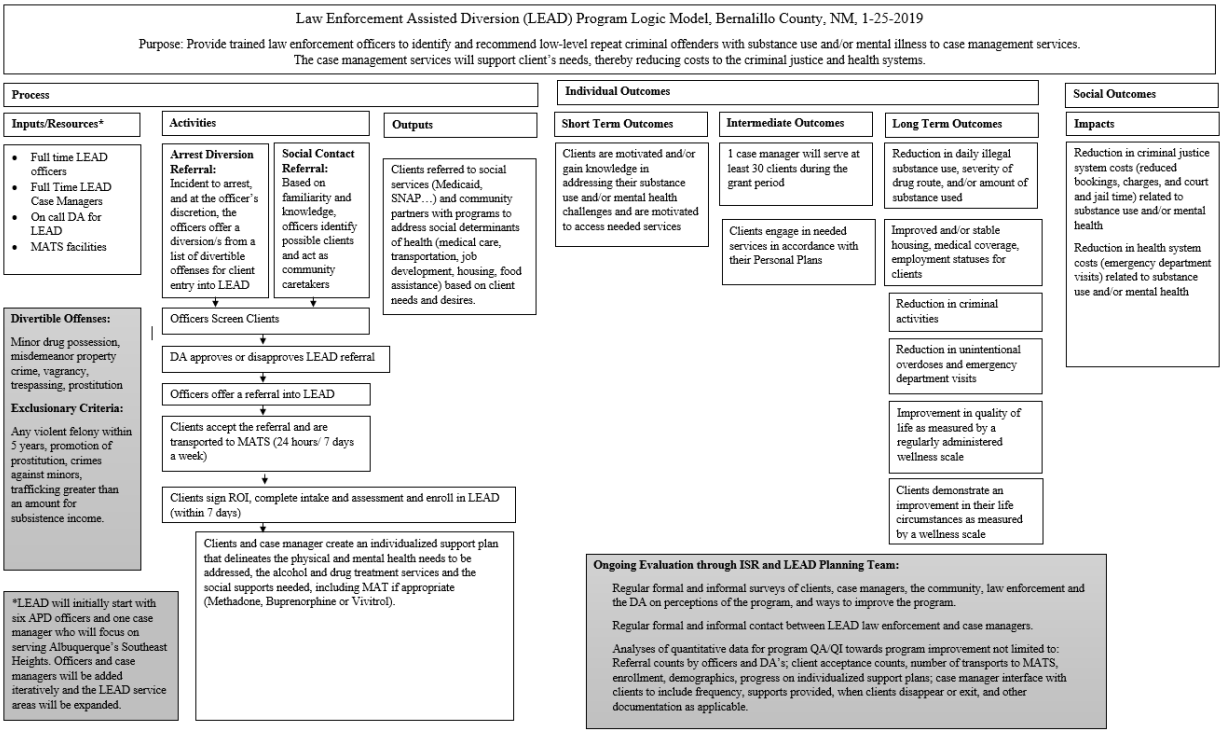
- The amount of drugs involved exceeds 3 grams (except where an individual has been arrested for delivery of or possession with intent to deliver marijuana, or possession, delivery or possession with intent to deliver prescription controlled substances (pills); in such cases, officers will consider the other criteria listed here without reference to the amount limitation)
- The individual does not appear amenable to diversion and social service intervention
- The suspected drug activity involves delivery or possession with intent to deliver (PWI), and there is reason to believe the suspect is dealing for profit above a subsistence income
- The individual appears to exploit minors or others in a drug dealing enterprise
- The individual is suspected of promoting prostitution; and/or
- The individual has disqualifying criminal history, including any conviction for Murder I or II, Arson I or II, Robbery I, Assault I, kidnapping, VUFA I, or any sex offense (or attempt of any of these crimes) at any time; or any conviction for a domestic violence offense, Robbery II, Assault II or III, Burglary I or II, or VUFA II within the past ten years.

The following describes the LEAD exclusionary criteria for LEAD – Santa Fe derived from NMSC (2018).

- The amount of drugs involved exceeds 6 grams
- The individual does not appear amenable to the program
- The suspected drug activity involves delivery or possession with intent to deliver, and there is reason to believe the suspect is selling illicit substances for profit above a subsistence income
- The individual is under the age of 18
- The individual appears to exploit minors
- The individual is suspected of promoting prostitution
- The individual has a conviction in the last 10 years for homicide, vehicular homicide, aggravated arson, aggravated burglary, all robbery, all kidnapping, all sex offenses, and any conviction involving firearms or deadly weapons (or attempt of any crime listed here).

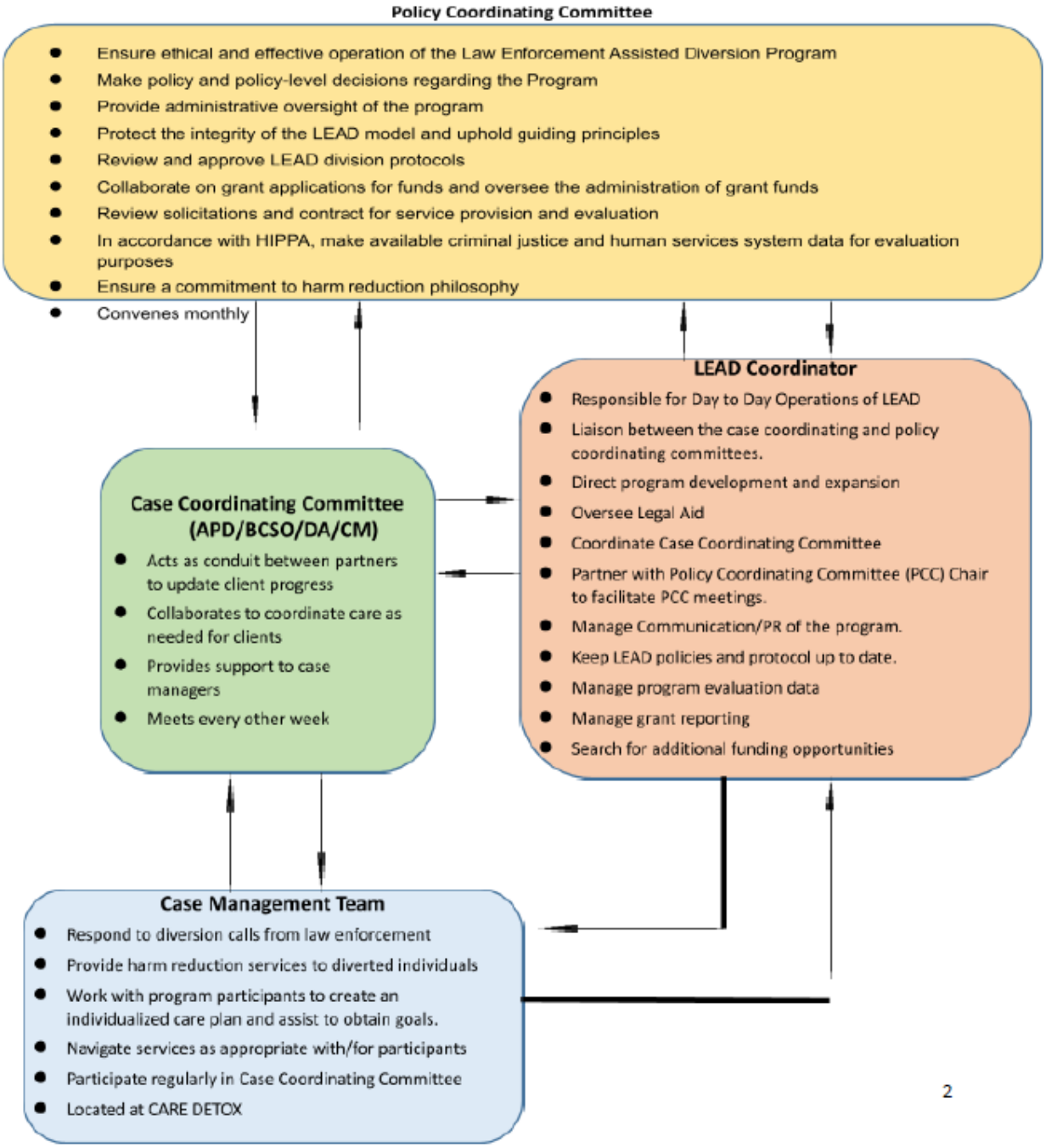
Appendix B – LEAD – Bernalillo County Logic Model and Flow Chart

DBHS published an initial LEAD logic model in February 2019 replicated below in Figure 1.



The logic model has not been updated since February 2019. However, DBHS published a flowchart in March 2021:

Bernalillo County Lead Flow Chart



Appendix C – LEAD Intervention Protocol for Arrest Diversions

A. Intervention Protocol

Arrest Referrals:

1. Upon arrest, arresting officer determines whether the individual is eligible for LEAD.
    - The arresting officer will access electronically through the Albuquerque Police Department Records Management System or Bernalillo County Sherriff's Office Record Management System information about the individual's criminal history and prior LEAD referrals. A prior referral does not preclude a second referral, but is a factor the officer can consider with respect to the individual's amenability to the intervention model.
    - The arresting officer shall determine, based upon the stated eligibility criteria, including his/her own assessment of the individual's amenability to the intervention model, whether an individual under arrest will be referred to LEAD.
2. Arresting officer reads LEAD participant criteria to individual.
3. Individual either accepts or declines the offer to participate in the LEAD program. If the individual declines, they are formally booked and the process ends here. If the individual accepts, move onto #4.
4. LEAD officer fills out "LEAD Participant Screening Form" with the individual and (again) determines whether or not the individual is eligible for LEAD. If the LEAD officer determines the individual is eligible, he/she will call the LEAD case manager to inform him/her of the new participant.
    - Arresting officer must draft the incident narrative and forward it to their identified commanding LEAD officer and to the case manager within 24 hours of the arrest. The incident narrative must clearly state that the individual has been diverted to LEAD.
5. Case Manager sends name, date of birth, social security number and incident narrative and the LEAD Participant Screening of LEAD client referral to the identified Second Judicial District Attorney's Office Liaison by email ASAP for background check.
    - The Second Judicial District Attorney Liaison will receive copies of the incident narrative and the LEAD Participant Screening Form for review.
6. Arresting officer contacts the on-call LEAD case manager during hours that the case manager is on duty and arranges for the case manager to come and meet the officer and the individual, or determines to transport the individual to the case manager at the CARE campus. If it is after hours and no case manager is on duty, the officer will transport the individual to the CARE campus where the individual will be provided food, a shower and a bed until the case manager is on duty and can conduct an intake and assessment.

7. Upon arrival, the LEAD officer releases the LEAD participant to the case manager staff if there is not a case manager on duty), and provides the case manager (or CARE intake staff) with a copy of the Participant Screening Form. Participant is released from custody.

8. LEAD officer documents the time at which he/she passed off the participant to the case manager (or CARE intake staff), and the name of the case manager, on the "LEAD Participant Screening Form."
9. The LEAD officer will then leave the case manager (or CARE intake staff) to engage with the LEAD participant and may return to the streets.
10. Case manager completes LEAD Intake Assessment within 3 working days of referral date for a felony and 30 days for a misdemeanor.
    - LEAD case manager will explain to LEAD referral that they are not officially a client until they are cleared by the DA; however, basic needs for the potential client can be addressed using LEAD program funds as needed (i.e. food and clothing).
    - If the individual is delivered to the CARE campus and leaves before the LEAD case manager can complete the LEAD Intake Assessment, the case manager will contact the arresting officer who then may refer the case to the prosecutor. If the client leaves during after hours, the Tech Lead will send an email to the LEAD Case Manager notifying them they have left.
    - The case manager may also determine at the point of referral or intake that the individual is unlikely to make good use of the program's resources, and can refer the case back to the APD or BCSO for a filing decision.
11. Case manager addresses immediate acute needs.
    - Based on the intake assessment, the case manager will first work to meet any immediate needs that must be addressed, such as shelter for the night, medication assisted treatment, detox, food, etc. (even if the person has not yet cleared a background check by the DA - See #5 above). She/he will also thoroughly explain the LEAD process and the assistance that might be available through the LEAD program.
12. Over the next few meetings, the case manager, with the help of the LEAD participant, will develop an Individual Intervention Plan (IIP).
    - Once any acute needs have been addressed, the case manager will work with each participant in one or more meetings to design an IIP, which will form the action plan for the individual. The IIP discussed in greater detail below, under "Case Management and Individual Intervention Plans."
13. LEAD participant works with the case manager on goals set out in the IIP.
14. Participant cases are monitored through regular staffing sessions with LEAD partners (members of the Case Coordinating Group). Discussed in greater detail below, under "Program Oversight".

*If the participant is intoxicated or incapacitated and unable to engage effectively in the intake process, the participant will be admitted into the Detox program at the CARE campus until s/he is able to engage in the intake process. If, in the officer's and/or case manager's judgment, a participant is unable to provide informed consent and/or poses a risk to self or others due to severe mental illness, the participant will not be referred to LEAD.