NEW MEXICO Sentencing Commission

Rio Arriba ReRoute,
A Law Enforcement Assisted Diversion (LEAD) Program

Authored by Nancy Shane, PhD; Ana X Gutiérrez Sisneros, PhD, MALAS, APRN; and Grace Cairo

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Executive Summary

ReRoute is federally funded and was implemented in 2019. The program is intended especially to address needs for people with low-level offenses with substance use issues, and focuses on harm reduction through medication-assisted treatment (MAT). This evaluation includes both a quantitative and qualitative component and addresses both formative and summative evaluation questions.

We examined 131 referred individuals whose diversion took place between February, 2019 and December, 2021. People referred to ReRoute frequently have had a recent arrest—often for a warrant or a new drug or property offense. Between half and three-quarters of referred individuals visited an emergency room for a diagnosis related to drug use in the two years prior to diversion. Most have been recently involved in the justice system for low-level offenses. About half of referred individuals were homeless at the time of diversion, and one in ten were employed.

Seventy-six or 58% of referred individuals did not return to ReRoute after diversion/intake procedures. This group of non-participants serve as a comparison group to the 55 participants, 42% of referred individuals, who received services from ReRoute at least once after diversion. Among the 55 participants, about 36% engaged with ReRoute to a high level; 25% engaged to a medium level, and the remaining 31% engaged with ReRoute at a low level. There seems to be a slight tendency for referred individuals to become a participant with ReRoute when their substance use problem is not overwhelming and when they are in particular need of financial assistance.

Participants themselves generally request the help they need from ReRoute. Most often, they seek assistance with medication-assisted treatment (MAT) and/or other substance use issues, housing, legal issues, and basic needs. These topics remain important over time. Most participants face the complex challenge of addressing multiple issues at once.

We find no evidence that ReRoute changed participants' likelihood of being arrested, self-perceptions of quality of life, or levels of substance use in the first few years after diversion. These lack of effects to date are unsurprising given its recent implementation. Like many newly-implemented programs, ReRoute experienced consequential changes in data collection methods and high staff turnover. The COVID-19 pandemic certainly complicated both law enforcement and social systems in various ways both known and unknown. Not least, it takes time to address the persistent and intertwined nature of the substance use, socioeconomic, and legal/ criminal issues that is at the heart of the ReRoute program.

We offer four recommendations for ReRoute leadership to consider: (1) maintain focus on a few priority areas—substance use, legal/criminal issues, housing, and basic needs, perhaps adding planned programming in addition to responding to participants in the moment, (2) develop strategies to encourage referred individuals to maintain a steady relationship with ReRoute after diversion, (3) strengthen processes around contacting referred individuals consistently, (4) adopt data collection protocols that regularly assess outputs, short-term outcomes, and long-term outcomes.

Our qualitative analysis of interviews with participants and stakeholders revealed five themes: (1) Anchors of meanings: Root causes, (2) Malias[1]– the dis-ease of addiction, (3) Biopsychosociocultural needs, especially MAT (Medication Assisted Treatment), housing, and support systems, (4) La Conciencia Elevada:[2] Ideas for community solutions, and (5) Barreras:[3] Barriers to recovery.

In addition, we used Averill's (2002) matrix analysis technique to bring meaning to interview data by examining five aspects of ReRoute in light of four domains. The five aspects of ReRoute are: police encounters, case manager encounters, program encounters, cultural preservation and resilience, and spiritual practices. The four domains are: internal, external, consequences of interactions between internal and external domains, and central, or the interface of all domains.

From these qualitative analyses, we determine the cultural competimility (Campinha-Bacote, 2019) of ReRoute has been well developed. We derive nine additional recommendations, many drawn from interviews themselves. ReRoute leadership should: (1) continue hiring employees in recovery from substance use disorder; (2) take advantage of recent housing initiatives in Española and support additional ones; (3) support the effort to build a traditional healing drop-in center; (4) add a family counseling component to ReRoute; (5) build an alliance with Northern New Mexico College Adult Basic Education GED program to address participants' educational needs; (6) broaden eligibility to ReRoute by loosening restrictions related to criminal history; (7) continue to regularly offer LEAD training to state, tribal, city, and county law enforcement officers; (8) build alliances with local employers to increase employment opportunities for ReRoute participants; and (9) ameliorate the cost barrier to drug rehabilitation services by supporting sliding scales and/or work exchange programs.

Introduction

The Law Enforcement Assisted Diversion (LEAD) Program was developed about a decade ago to address recidivism caused by substance use and other social needs by enhancing the collaboration between law enforcement, mental health and drug treatment specialists, service providers, and other criminal justice professionals. It currently operates in over 50 locales across the U.S., including three sites in New Mexico. As the LEAD National Support Bureau puts it (2022):

> *In a LEAD® program, police officers exercise discretionary authority at point of contact to divert individuals to a community-based, harm-reduction intervention for law violations driven by unmet behavioral health needs. In lieu of the normal criminal justice system cycle—booking, detention, prosecution, conviction, incarceration—individuals are instead referred into a trauma-informed intensive case-management program where the individual receives a wide range of support services, often including transitional and permanent housing and/or drug treatment.*

The goals of LEAD are as follows: (1) reorient government's response to safety, disorder, and health-related problems; (2) improve public safety and public health through research-based, health-oriented and harm reduction interventions; (3) reduce the number of people entering the criminal justice system for low-level offenses related to drug use, mental health, sex work, and extreme poverty; (4) undo racial disparities at the front-end of the criminal justice system; (5) sustain funding for alternative interventions by capturing and reinvesting criminal justice system savings; and (6) strengthen the relationship between law enforcement and the community.

Additionally, LEAD is based upon a core principle that substance use is a public health issue rather than a criminal issue, and that prosecuting and imprisoning people for minor drug offenses is not an effective way to improve public health and safety. Instead, future criminal behavior can be reduced in a more efficient and cost-effective manner by connecting individuals with resources and services to address unmet needs.

Background

To put the program in context, here we look at trends in substance use and crime in Rio Arriba County.

Substance Use in Rio Arriba County

As seen in Figure 1, drug-related overdose death rates have been rising in the United States and New Mexico. The rate in New Mexico remains consistently higher than that in the U.S. and was 26.6 deaths per 100,000 population in 2018.[4] That year, overdose deaths in New Mexico were driven primary by non-fentanyl opioids and methamphetamines, followed by heroin, alcohol, benzodiazepines, and finally fentanyl and its analogues (Edge, 2020). In Rio Arriba County, the death rate by drug overdose far exceeds these values. Figure 2 shows overdose death rates in the county from 2011 to 2020. Over the decade, rates have fluctuated from about 67 to 113 deaths per 100,000 population. A temporal pattern is hard to discern. The value of 100.9 for 2020 is among the highest death rates in the decade and represents 38 deaths in a population of 40,330 people (New Mexico Department of Health, 2022).

Figure 1. Drug Overdose Death Rates in New Mexico and the United States, 1990-2018 (Edge, 2020, p. 2 [screenshot])

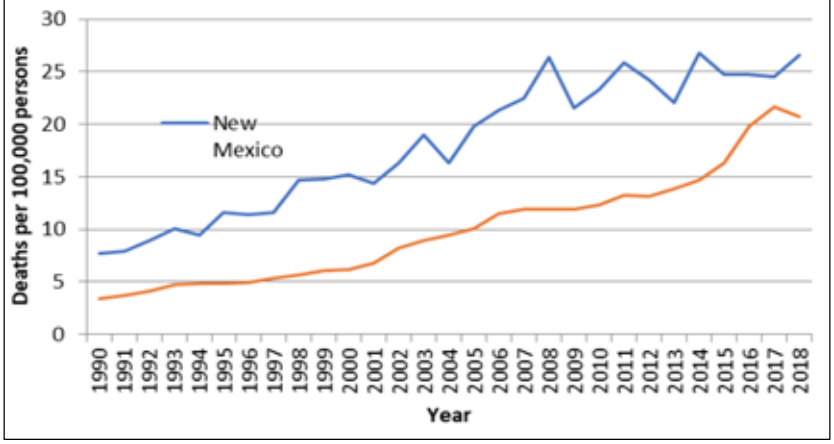
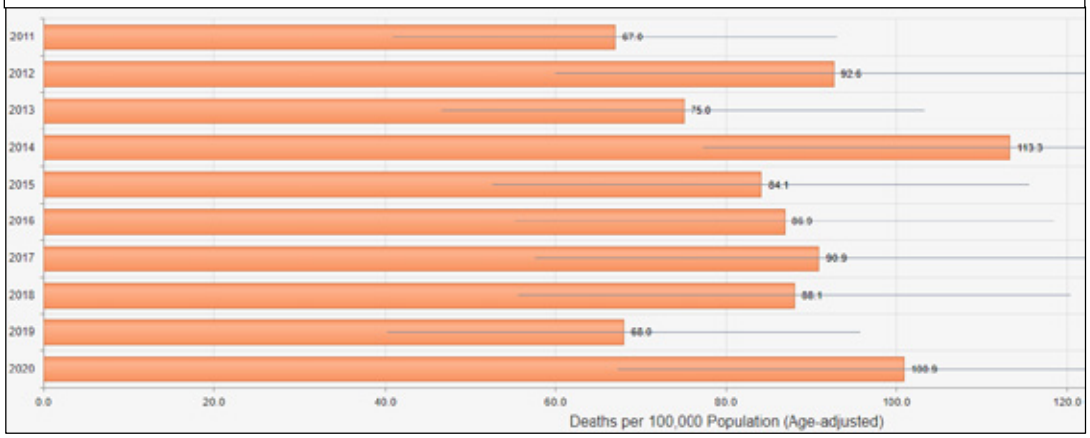


Figure 2: Drug Overdose Death Rates in Rio Arriba County, 2011-2020 (New Mexico Department of Health, 2022)



Similarly, Rio Arriba saw opioid overdose related emergency visits at the rate of 155.3 per 100,000 in the years 2013-2017 (Davis et al, 2018). In a series of epidemiological reports using hospital discharge data, the New Mexico Department of Health found Rio Arriba County had a drug-related mental disorder rate of 11.9 per 100,000 population in years 2009-2013, the highest rate in the state (Reno, 2015).

From these data of drug-related overdose deaths, emergency room visits, and diagnoses among hospitalized patients, it appears that about a hundred people a year suffer the most extreme consequences from drug use in Rio Arriba County. As LEAD is designed to catch people before such significances take place, we can calculate a better estimate for the Rio Arriba LEAD target population by using estimates of illicit drug use. The Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services, regularly provides state estimates for three pertinent populations: the number of adults using illicit drugs in the past month, the number of adults with an illicit drug use disorder, and the number of adults needing but not receiving treatment at a specialty facility for illicit drug use in the past year; the most recent estimates are from the 2018-19 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2022). Calculating Rio Arriba's proportion of the state's estimates by its share of the state population, we can assume about 747 adults in Rio Arriba County need a treatment facility; 822 adults have an illicit drug use disorder, and 4,182 adults have used an illicit drug in the past month. Given these estimates do not consider the apparent higher substance use in Rio Arriba County compared to the rest of the state—as indicated by its higher rates of drug overdose deaths for example—we might conservatively estimate a target population for Rio Arriba County ReRoute in the low 1,000s.

Crime in Rio Arriba County

Figures 3 and 4 indicate estimates of property and violent crimes as reported to the Federal Bureau of Investigation in Rio Arriba County, in New Mexico, and in the United States.[5] The data suggest that over the past decade, property crime rates in the county have been lower than the national and state averages while violent crime rates have been higher, at least through 2017, the last year for which we have sufficient information at the county level.

Figure 3. Property Crime Rate (crimes per 100,000 population) in Rio Arriba County, in New Mexico, and the United States, 2010-2020

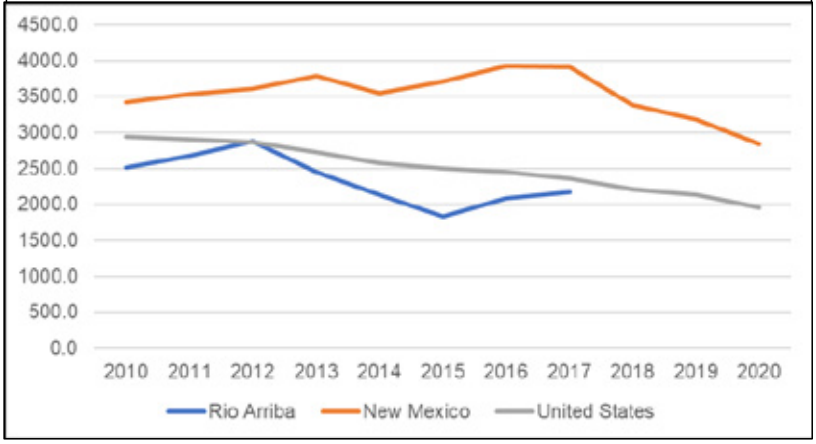
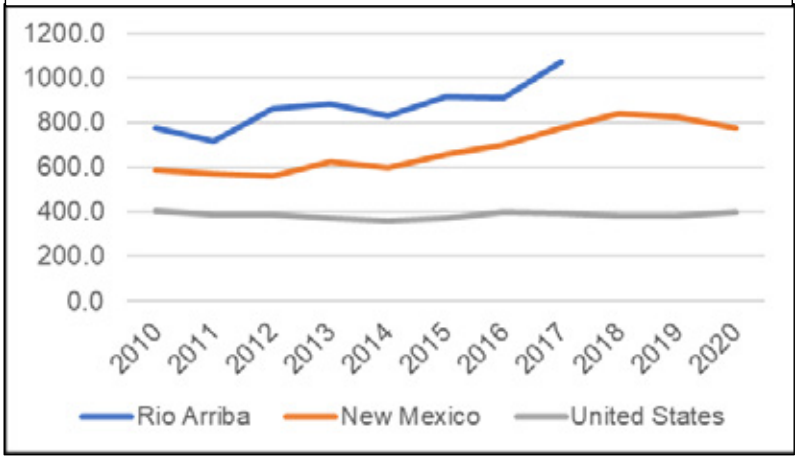


Figure 4. Violent Crime Rate (crimes per 100,000 population) in Rio Arriba County, in New Mexico, and in the Unites States, 2010-2020



Rio Arriba ReRoute

The Rio Arriba ReRoute program started in February, 2019. The program has a particular focus on substance use; one overarching goal is to reduce opioid related overdoses in Rio Arriba County. Specifically, its objectives as defined in the grant proposal are:

1. Community implements the law enforcement assisted diversion (LEAD) program with fidelity for low level drug offenders to all residents of Rio Arriba County.
2. Develop and implement strategies to identify and provide treatment and recovery support services to 'high frequency' utilizers of multiple systems who have a history of opioid abuse.
3. Encourage and support comprehensive cross-system planning and collaboration among officials who work in law enforcement, the courts, child welfare, reentry, prescription drug monitoring programs (PDMP), and emergency medical services, as well as health care providers, public health partners, and agencies that provide substance abuse treatment and recovery support services.
4. Develop and enhance public safety, behavioral health, and public health information-sharing partnerships that leverage key public health and public safety data sets and develop interventions based on this information.

The Rio Arriba ReRoute program follows the national LEAD model closely. Individuals are eligible if they have committed a low-level property crime or drug possession crime, or if they have not committed any crime but seem to have used an illegal drug. Individuals who have committed a violent offense or who have been convicted of violent offenses are ineligible. Most individuals are referred to ReRoute by police officers either through arrest diversion (also known as deferred arrest) or social referrals.[6] In an arrest diversion, police offer ReRoute as an alternative to an arrest, usually for a drug offense, property offense, or serving a warrant. When individuals accept, they must complete the intake paperwork with ReRoute. It is possible they will be arrested later if they choose not to participate in the intake process. In a social diversion, the police officer does not defer an arrest but does share information about the ReRoute program. Either way, the police officer usually notifies the ReRoute program in the moment, and ideally a ReRoute case manager meets the police officer with the individual for a 'warm hand-off.' In a small number of cases, individuals self-refer themselves; they are included with social referrals in analyses. One's treatment in ReRoute is not different based on the type of referral.

Once individuals complete the intake paperwork, they are eligible for the case management services that ReRoute offers. Case managers are field staff with 'lived experience' who help participants develop personal goals and reach them. Participants' goals usually include reducing the harm associated with substance use especially through medication-assisted treatment (MAT), but they may also include employment, housing, income, legal issues, medical care, or indeed any topic for which the participant requests assistance.

One feature of LEAD programs is that it is difficult to define the program's 'end' for any individual. Once accepted as a client, a person may start, stop, or return to services at any time. There is no minimum or maximum number of required or allowed interactions with ReRoute. This feature complicates evaluation because one cannot definitively judge when one should expect results nor when a client has ceased participating.

The ReRoute evaluation consists of two complimentary components to address these evaluation questions: a quantitative analysis of ReRoute services and participant outcomes, and a qualitative exploration of the viewpoints of both ReRoute participants and stakeholders. We begin with the quantitative analysis; the qualitative analysis begins on page 15.

Quantitative Analysis and Findings

In the quantitative analysis, we focus on seven evaluation questions, four formative in nature and three summative.

Formative

1. What are the characteristics and needs of the target population? (p. 5)
2. Who chooses to participate in ReRoute? (p. 9)
3. To what extent do participants engage with ReRoute? (p. 10)
4. What issues do participants choose to address through ReRoute? (p. 10)

Summative

5. To what extent do participants' involvement in the criminal justice system decrease? (p. 11)
6. To what extent do participants' quality of life improve? (p. 13)
7. How successfully does ReRoute address participants' substance use issues? (p. 13)

The sample for quantitative analyses includes the 131 individuals who completed ReRoute intake paperwork between February 1, 2019 (the start of the program) and December 31, 2021. We use a combination of client-based data collected from the ReRoute program as well as individual-level data from state court, arrest, and emergency room records. Fifty-five or 42% of individuals returned to ReRoute for services at least once after completing intake paperwork. We consider these individuals to be participants. The remaining 76 or 58% of individuals did not return to ReRoute after completing intake paperwork. We consider these individuals to be non-participants and use them as a comparison group to examine the effectiveness of the ReRoute program. Please see additional methodological details in Appendix A.

Formative Evaluation Questions

1. *What are the characteristics and needs of the target population?*

As indicated above, we conservatively estimate a target population for Rio Arriba County ReRoute to number in the low 1000s. We base the following characteristics and needs on the 131 individuals who have been referred to ReRoute through 2021 for whom we have sufficient information, including demographic characteristics, criminal justice history, substance use, areas of need, and quality of life.

Demographic information

Among the 131 referred individuals in our dataset, 59% are male. Ages range from 18 to 60, with a median age of 29 years. Nearly 78% of the individuals in the sample are Hispanic; 13% are White/Anglo; 8% are Native American; and 2% are Black/African-American.[7]

Criminal justice history

We examine two aspects of criminal justice history for ReRoute in the two years prior to their referral: the number and nature of (1) arrests and (2) court cases in the state.[8] Table 2 indicates the percentage of referred individuals arrested for common categories of offenses in the two years prior to diversion. Arrests were common in the target population; 65% of referred individuals had been arrested. More than half of individuals had been arrested for a new offense; and more than half had been served a warrant. The most common new offenses were violations of a public order, drug offenses, and property offenses.

Table 1: Arrests in Common Offense Categories, within Two Years Prior to Diversion	
Arrest Category	**% Referred Individuals**
n	**122**
Any arrest	65%
Any new offense	55%
Warrant	51%
Public Order	25%
Drug	20%
Property	20%

In addition, a small percentage of referred individuals were arrested for a new violent offense or an interference with justice (12% each), a DWI charge (6%), an arrest of a different type (2%), or a probation violation (3%).

Table 2 shows the number of criminal court cases resulting in a conviction, deferral, or conditional discharge for common offenses taking place in the five years prior to referred individuals' attempted diversions.[9] We include deferrals and conditional discharges in addition to convictions because the court case resulted in a guilty finding, leading to a sanction or, at least, a possible future sanction. Even given the longer timeline, criminal cases resulting in a guilty finding are less common than arrests, with 33% of referred individuals having such a case. By offense category, guilty findings for property and drug offenses are the most common at 12% each. About 4% of referred individuals had guilty findings for DWI and interference with justice cases. About 3% of referred individuals had guilty findings for violent offenses, public order violations, and traffic citations; and 2% of referred individuals had guilty findings in another category.

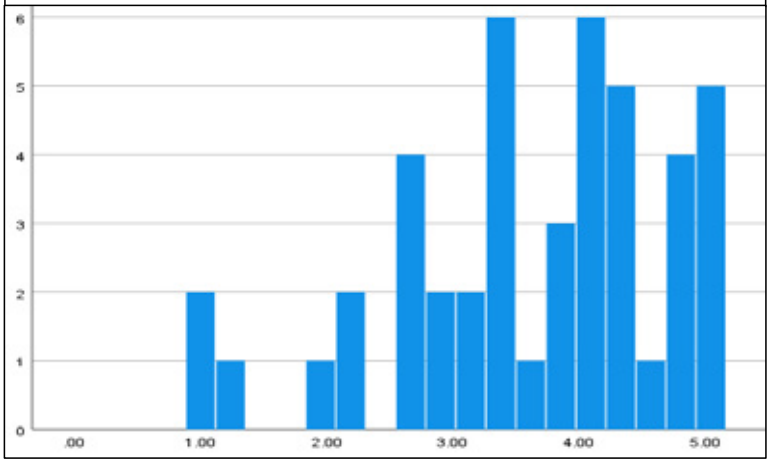
Table 2: Findings of Guilt in Common Offense Categories, within Five Years Prior to Diversion	
Cases Resulting in a Guilty Finding	**% Referred Individuals**
n	**122**
Any case	33%
Property	12%
Drug	12%

Despite the pandemic, diversions were about evenly spread across the time period from the start of the program in February, 2019 through December, 2021, with about 36% occurring in the first year, 43% occurring in the second year, and 21% occurring in the last 10 months. About 60% of referrals were social in nature, including four self-referrals; 40% were arrest diversions. Among the arrest diversions, 50% referred to property crimes; 26% were drug related; 16% were bench warrants; and the remaining 8% were other types of arrests.

Substance Use

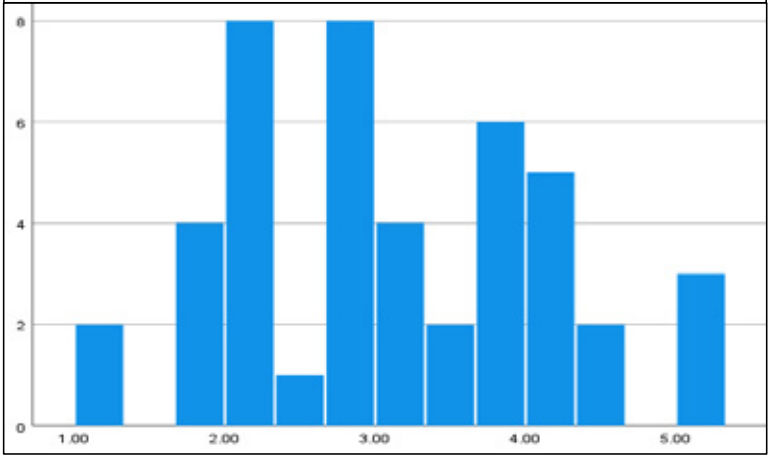
Case managers collected initial Severity of Substance Use and Quality of Life surveys from some referred individuals at their initial intake meeting or soon thereafter. Results suggest high substance severity for most referred individuals for whom we have a survey response (*n*=45), as indicated in the histogram in Figure 5.[10] More than 75% of referred individuals initially score above the mid-point of 3.0 on this scale that ranges from 1 to 5. The average value is 3.6.

Figure 5. Initial Severity of Substance Use score



It seems likely that most referred individuals had already participated in a medication-assisted treatment (MAT) program prior to ReRoute, as 45 of 52 individuals answered the question about their success with MAT.[11] Their experiences were quite mixed. On this 1-to-5 scale with 5 meaning 'successful,' 55% of referred individuals score at the midpoint or below; the mean value is 3.1. See Figure 6.

Figure 6: Initial Success with Opioid Substitution Treatment



We also use visits to a New Mexico hospital emergency room for substance use-related health problems as a measure. We collected six diagnosis categories for the two years prior to the diversion for 122 referred individuals. As seen in Table 3, some categories are directly related to substance use – alcohol-related diagnoses, drug-related diagnoses, and drug poisoning diagnoses; 46%, 10%, and 5% of referred individuals, respectively, visited an emergency room with these diagnoses. Three categories are indirectly related to substance use—injuries, mental health, and cellulitis, representing 43%, 33%, and 11% of referred individuals, respectively. In addition, the total number of visits to the emergency room can be high. Over a quarter of referred individuals, 27%, visited an emergency room four or more times in the two years before their diversion date.

Table 3: Substance-Use Related Visits to an Emergency Room within Two Years Prior to Diversion	
Category of Visit	**% Referred Individuals**
n	**122**
Any visit	76%
Drug-Related	46%
Alcohol-Related	10%
Drug Poisoning	5%
Injuries	43%
Cellulitis	33%
Mental Health	11%

Areas of Need

ReRoute administered intake forms when meeting with referred individuals for the first time. The intake form asks basic identifying information, and includes two measures of need. The form indicates that 51% of referred individuals were homeless at the time they were diverted (*n*=105); and just 10% were employed (*n*=102).

Case managers sometimes collected additional information about areas of need at the same time, usually with Daily Contact Sheets or Case Management Service Plans. From these sources we can discern issues and goals of importance to 38 referred individuals. As seen in Table 4, 55% referred individuals describe medication-assisted treatment (MAT) as a priority, and 16% name another substance use issue (often alcoholism). Nearly 40% describe a legal issue as an important area to address. Over one quarter described themselves as having basic (financial) needs (including access to social services), and almost as many wanted help obtaining employment. About 16% of referred individuals described a need for stable housing. Less often, referred individuals mentioned a medical issue (8%), education (5%), family or children (3%), or mental health (3%) as particular concerns.

Table 4: Percentage of Individuals Indicating Need by Topic Area	
Help Topic	**% Referred Individuals**
n	**38**
Medication-Assisted Treatment	55%
Other Substance Use	16%
Legal Issues	37%
Basic Needs/Social Services	26%
Employment	24%
Housing	16%

Quality of Life

Among the 52 referred individuals who completed the Opioid Substitution Treatment Quality of Life (OSTQOL), the minority score in the desired direction on most measures of quality of life.[12] Only 35% are satisfied, overall, with their level of personal development (success and future prospects), and 33% are satisfied with their material wellbeing. Just under half of referred individuals, 46%, report low levels of mental distress, and 25% report low levels of discrimination against people with substance use disorders. However, 60% of referred individuals are satisfied overall with the quality of their social contacts.

Table 5: Initial Quality of Life Scores			
Aspect	***n***	**Average**	**Desired Direction**
Higher Numbers are Desired			*Above 3.0*
Personal Development	40	2.8	35%
Social Contacts	52	3.3	60%
Material Wellbeing	52	2.6	33%
Lower Numbers are Desired			*Below 3.0*
Mental Distress	39	3.0	46%
Discrimination	36	3.4	25%

In summary, referred individuals are young and middle-aged adults. About two-thirds had been recently justice-involved, usually for violations of public orders, property offenses, or drug offenses. Of the 40% of individuals with arrest diversions, half would have been charged with a property offense and one quarter would have been charged with a drug offense. Three in four referred individuals self-reported high severity of substance use. Those who had experience with opioid substitution treatment reported mixed results. Nine in ten referred individuals lacked employment at the time of diversion; and over half were homeless at intake. Referred individuals were chiefly concerned with managing substance use, addressing legal issues, and meeting basic financial needs. Many reported feelings of discrimination, mental distress, and low personal development.

2. *Who chooses to participate in ReRoute?*

To answer this question, we examine differences between participants and non-participants at the time of referral. We categorize referred individuals as 'participants' if they interacted with ReRoute at any time the initial intake process during or soon after diversion. Referred individuals who either never contacted ReRoute or only completed the initial diversion paperwork are categorized as a non-participant and are collectively used as a comparison group in this study. Among the 131 referred individuals in our dataset, 55 (42%) are participants; and 76 (58%) are non-participants.

By understanding differences between people who choose to participate in ReRoute and those who do not, ReRoute staff may be able to anticipate and address resistance as well as tailor the program to the needs of people most likely to take advantage of their services. In truth, however, in most ways ReRoute participants and non-participants are alike. The two groups are similar demographically in terms of gender, age, ethnicity/race, homelessness, and employment status. In terms of criminal history, there are no statistically significant differences in the number of arrests in any offense category nor in the total number of arrests. There are no differences in the number of most categories of court cases in which referred individuals were found guilty. The percentages of individuals referred for an arrest diversion, rather than a social diversion, are similar. There are no statistically significant differences in most emergency room diagnoses. Participants report similar perceptions of quality of life in most respects.

However, a few enlightening differences exist. First, some evidence suggests that ReRoute participants are more stable in terms of substance use than people who chose not to participate. People who did not participate were more likely to have been sanctioned by the court for a drug offense in the five years prior to their diversion, 18% compared to 5% of participants (n=122, t=2.3, p<.05). Non-participants rated their success with medication-assisted treatment (MAT) statistically significantly lower than participants (n=30, 2.4 vs. 3.4, t=2.8, p<.01).[13] No ReRoute participants visited a hospital emergency room for a drug poisoning in the two years prior to their diversion, compared to 9% of the non-participants (n=122, t=2.4, p<.01). Fewer ReRoute participants (5%) were admitted for an alcohol-related diagnosis than non-participants, 15% (n=122, t=2.2, p<.05). Second, ReRoute participants report a higher quality of life on average at intake in two respects. Participants report a better sense of personal development than the non-participants (n=27, 3.1 vs. 2.4, t=2.1, p<.05), and higher satisfaction with their social life (n=34, 3.6 vs 2.8, t=2.0, p=.05). Even these higher averages for ReRoute participants show substantial room for improvement, however. Finally, although the two groups report similar levels of need in most respects, just 8% of the non-participants rated basic financial need as a priority compared to 35% of participants (n=38, t=2.1, p<.05).

Thus, individuals may be most likely to engage ReRoute services when their substance use problem is not overwhelming and when they are in particular need of financial assistance. Any differences—observed and unobserved—between participants and non-participants in a voluntary program are problematic when attempting to determine the impact of a program because any effects may be due to motivation or something else intrinsic to

participants, rather than the program itself. It will be important, then, to keep these differences in mind.

3. *To what extent do participants engage with ReRoute?*

The LEAD National Support Bureau emphasizes building long-term relationships with participants and recognizing that change takes time and patience (2020). One way to understand the relationships is to measure the consistency of participants' interactions with ReRoute. We count the number of interactions each participant had with ReRoute after their diversion in 6-month intervals.[14] If a participant interacted with ReRoute (once or more) in at least 50% of the intervals since their diversion, we consider the participant to be highly consistent. Of the 55 participants in our sample, 34 or 62% were highly consistent in their ReRoute interactions.[15] We also measured the frequency of interactions for each participant in each six-month interval, considering an average of two or more interactions per six-month interval to be 'high.' Among the 55 participants, 20 or 36% met with ReRoute with high frequency.

Looking at both measures together, we derived a measure of engagement for participants—low, medium, and high. We categorize twenty people (36% of participants, 15% of referred individuals) as having high engagement—that is, interacting with ReRoute both frequently and consistently. We categorize fourteen people (25% of participants, 11% of referred individuals) as having medium engagement—interacting with ReRoute consistently, but with low frequency. We categorize 21 people (38% of participants, 16% of referred individuals) as having low engagement—interacting with ReRoute both infrequently and inconsistently.[16] See Figure 7.

Figure 7: Engagement—Frequency and Consistency of ReRoute Participation

Consistency		Frequency	
		Low	High
	Low	21	0
	High	14	20

Engagement is important because ReRoute is entirely voluntary; if participants do not interact with ReRoute in a sufficiently sustained way, there is little chance the program could be effective or contribute to referred individuals' success given the overall high needs of the target population. It may give one pause that just 15% of the sample overall are highly engaged with ReRoute.[17] On the other hand, it seems clear than anyone who engages in the ReRoute program consistently and frequently would be highly intrinsically motivated.

Even among some participants we deem to have been highly engaged, patterns can change from one period to the next. For example, one client visited ReRoute once in one 6-month period, three times in the next 6-month period, and 15 times in the next. Another did not visit ReRoute at all in the first year after diversion, then began visiting about once a month. Yet another participant visited ReRoute once in the first three 6-month periods, seven times in the next, and then returned to infrequent visits. There are no set patterns, which may indicate participants seek help especially when in crisis.

Although it makes sense that participants would visit most when a situation becomes acute, if true this fact could make program implementation very challenging. ReRoute does attempt to check in with absent participants periodically, but most often these 'cold calls' are unanswered. It is likely that case managers cannot depend on regular visits from most participants, cannot anticipate participants' needs well, and are typically having to respond to participants' emergencies of the moment rather than working consistently on participants' goals.

4. *What issues do participants choose to address through ReRoute?*

Table 6 indicates the percentage of clients addressing twelve common topics or goals in each six-month time period according to Daily Contact Sheets, Case Management Service Plans, case managers' notes, and various other artifacts.[18] Participants choose their own goals; ReRoute allows participants to direct their own treatment (although courts may require or compel particular requirements). Some issues are addressed by a sizable minority of participants and seem to remain important over time: medication-assisted treatment (MAT) and/or other substance use issues, housing,

legal issues, and basic needs. Two issues seem consistently important for a lower percentage of participants, employment and family issues. Less commonly, participants address their mental health, mind/body/spirit (wellness), medical needs, domestic violence, and education goals.[19]

Table 6: Goals addressed in meetings with ReRoute over time

Issue	Intake	1st 6 months	2nd 6 months	3rd 6 months	4th 6 months	5th 6 months	6th 6 months
n (Participants)	55	53	36	27	23	15	14
MAT	27%	51%	36%	37%	13%	40%	36%
Substance Use	16%	17%	22%	4%	17%	20%	14%
Housing	45%	23%	31%	33%	13%	33%	21%
Legal	19%	32%	22%	22%	17%	20%	14%
Basic Needs	16%	42%	33%	33%	22%	40%	7%
Employment	10%	26%	19%	22%	9%	20%	14%
Family/Kids	0%	11%	17%	15%	4%	13%	14%
Mental Health	0%	13%	17%	7%	9%	0%	7%
Wellness	2%	6%	6%	7%	0%	13%	7%
Medical	0%	8%	8%	4%	4%	0%	7%
Domestic Violence	0%	6%	0%	0%	0%	7%	0%
Education	4%	2%	3%	0%	0%	0%	0%

These data support one of the principles that underlies the LEAD approach: many participants seem to grapple simultaneously with substance use, legal, income, and housing issues. LEAD assumes these issues must be treated in conjunction through the collaboration of law enforcement, mental health and drug treatment providers, service providers, and other criminal justice professionals (LEAD National Support Bureau, 2020). Each of these issues are difficult to solve, and the inability to improve one issue may threaten the likelihood of improving another. Among participants, 26% of participants worked on all four of these issues with ReRoute; 34% worked on three of the issues; 20% worked on two of them; 12% worked on one issue; and 9% worked on none. Thus, the great majority of participants face interrelated and complex challenges.[20]

These analyses of formative evaluation questions suggest high needs among referred individuals in terms of their involvement in the criminal justice system, homelessness, and need for social services especially related to income. These are the most common priority goals ReRoute participants discuss with staff. Some issues are rarely a priority, including wellness, medical concerns, domestic violence, and education.

Summative Evaluation Questions

5. ***To what extent do participants' involvement in the criminal justice system decrease?***

Table 7 is a statistical comparison of arrests for non-participants and participants for the two years before and two years following diversion. Among non-participants, the number of arrests dropped in most categories. The drops are statistically significant for public order arrests, drug arrests, warrant service, and any arrest. Among participants, we see no statistically significant difference in any category of new arrest, including property and drug offenses where we might expect ReRoute participation to have helped. One change is statistically significant: the percentage of participants served a warrant, similar to before and after diversion percentages for non-participants. Overall, it does not appear that ReRoute participation lessened criminal justice involvement in the two years following diversion. It is unclear why non-participants' arrests dropped in several categories. It may have to do with law enforcement activity during the pandemic, alternative programming, or mere chance.

Table 7: Paired t-tests, Arrests Two Years Before and Two Years After Diversion, Non-participants and Participants						
	Non-Participants *n*=44			Participants *n*=39		
Arrest Categories	**2 years before diversion**	**2 years after diversion**	**Paired t-test *t***	**2 years before diversion**	**2 years after diversion**	**Paired t-test *t***
Property	25%	32%	0.72	15%	15%	0.00
Public Order	30%	7%	3.17**	21%	21%	0.00
Violent	7%	9%	0.57	5%	13%	1.14
Drug	30%	9%	2.45*	15%	15%	0.00
Interference	16%	11%	0.70	8%	15%	1.14
DWI	5%	5%	0.00	8%	3%	1.00
Other New Offense	2%	5%	0.57	3%	0%	1.00
Any New Offense	**59%**	**50%**	**0.89**	**46%**	**46%**	**0.00**
Warrant	59%	34%	2.70*	54%	36%	2.21*
Probation Violation	7%	2%	1.43	0%	0%	--
Any Arrest	**68%**	**50%**	**2.07***	**59%**	**46%**	**1.4**

Because the analysis in Table 7 requires two years of information following diversion, n's are low with only 44 non-participants and 39 participants represented. In addition, by combining data for two years and omitting the 3rd year of information, we might miss change over time. Table 8 provides descriptive information for the 1st, 2nd, and 3rd years following diversion, without statistical comparison. The number of referred individuals who can be included in the analyses decrease. The table suggests that arrests for both property and drug arrests remained stable for both non-participants and participants across the three years. Similarly, arrests for interference with the administration of justice, DWI, other new offenses, warrants, and probation violations all remain steady over time for both participants and non-participants. Only for public order violations do we detect a notable drop across time, but because the drops for participants and non-participants is similar, we hypothesize that ReRoute participation did not contribute to this outcome.

Table 8: Arrests for Non-participants and Participants Across Time						
	Non-Participants After Attempted Diversion			Participants After Diversion		
Arrest Categories	**1st Year**	**2nd Year**	**3rdYear**	**1st Year**	**2nd Year**	**3rd Year**
n	67	44	14	55	39	27
Property	16%	16%	14%	13%	13%	0.15%
Public Order	7%	2%	0%	16%	6%	0.04%
Violent	6%	7%	21%	11%	5%	4%
Drug	6%	5%	7%	9%	10%	0.07%
Interference	6%	5%	8%	9%	8%	4%
DWI	2%	2%	0%	0%	3%	4%
Other New Offense	1%	5%	0%	2%	0%	0%
Any New Offense	**33%**	**30%**	**29%**	**36%**	**26%**	**22%**
Warrant	21%	20%	21%	25%	18%	25%
Probation Violation	0%	2%	0%	2%	0%	0%
Any Arrest	**45%**	**36%**	**36%**	**44%**	**31%**	**33%**

6. *To what extent do participants' quality of life improve?*

ReRoute planned to administer the Quality of Life Assessment to participants regularly, but this seems to have been impractical with sometimes extended lengths of time between visits and participants sometimes dealing with emergencies. We interpret Table 9, therefore, with caution.[21] The table compares average scores on the five measures of quality of life across time. There is little movement in average scores for personal development or social contacts. Average scores for material wellbeing unexpectedly drop over time, though not to a statistically significant level.[22] Mental distress drops over time, while feelings of discrimination drop and rise again. We compared participants' earliest and last iterations of the assessment using paired t-tests and found no statistically significant differences. Overall, it is hard to conclude that ReRoute participation affects participants' quality of life, at least within the first 18 months after diversion.

Table 9: Quality of Life Averages for Participants Across Time

Aspect	Diversion	1st 6 months	2nd 6 months	3rd 6 months
n	*14-21*	*15-21*	*15-16*	*5-8*
Higher Numbers are Desired				
Personal Development	3.1	3.0	3.1	2.9
Social Contacts	3.6	3.5	3.6	3.8
Material Wellbeing	2.9	2.8	2.7	2.6
Lower Numbers are Desired				
Mental Distress	3.3	2.9	2.9	2.9
Discrimination	3.6	3.1	2.7	3.2

7. *How successfully does ReRoute address participants' substance use issues?*

We examine change in participants' substance use in a number of ways. First, as seen in Table 7 above, while there is a statistically significant drop in the number of drug-related arrests before and after diversion among non-participants, there is no drop among ReRoute participants.

In Table 10, we examine the average ratings for two Quality of Life measures related to substance use, success with medication-assisted treatment—as we know, a common focus among ReRoute participants—and severity of substance use. Neither measure moves in a consistent direction.[23]

Table 10: Severity of Substance Use and MAT Success Across Time

Aspect	Diversion	1st 6 months	2nd 6 months	3rd 6 months
n	*19-20*	*15-21*	*14-16*	*7*
Higher Numbers are Desired				
Success with MAT	3.4	3.3	3.0	3.4
Lower Numbers are Desired				
Severity of Substance Use	3.4	3.5	3.4	3.2

Finally, we examine whether there are changes in emergency room visits for substance use-related diagnoses for ReRoute non-participants and participants in Table 11. About three in four non-participants and participants visited the emergency room for any drug-related diagnosis both before and after diversion. Among non-participants, changes in visitation patterns are usually small and never statistically significant, although the percentage of non-participants visiting the E.R. for drug-related diagnoses dropped by ten percentage points. Among participants, the percentage visiting the E.R. for drug-related diagnoses and alcohol-related diagnoses each increased by ten percentage points or more after diversion, a statistically significant difference for alcohol-related visits. On the other hand, injuries dropped by ten percentage points. These inconsistent data are difficult to interpret and probably suggest ReRoute had no impact on substance use-related visits to emergency rooms in the two years following diversion.

Table 11: Paired t-tests, Emergency Room Visits Two Years Before and Two Years After Diversion, Non-Participants and Participants						
	Non-Participants *n*=49			Participants *n*=40		
Visit Type	2 years before diversion	2 years after diversion	Paired t-test *t*	2 years before diversion	2 years after diversion	Paired t-test *t*
All visits (Avg.)	2.9	3.4	0.88	2.2	2.9	1.11
Any visit	80%	73%	0.90	75%	75%	0.00
Drug-Related	53%	43%	1.53	45%	58%	1.30
Alcohol-Related	10%	14%	1.00	2%	12%	2.08*
Drug Poisoning	12%	10%	0.38	0%	8%	1.78
Injuries	45%	43%	0.20	38%	28%	107%
Cellulitis	31%	39%	1.00	35%	28%	0.32
Mental Health	12%	16%	0.63	10%	12%	0.44

By examining percentages of visits in each of the two years following division in Table 12, this conclusion is supported. There are no statistically significant differences between non-participants or participants for either year. We note there are substantively more participants than non-participants who visited the E.R. for both drug-related diagnoses and injuries in the first year following diversion, differences that disappeared in the second year.

Table 12: Emergency Room Visits for Non-Participants and Participants Across Time				
	1st Year after Diversion		2nd Year After Diversion	
Visit Type	Non-Participants	Participants	Non-Participants	Participants
n	67	55	49	40
All visits (Avg.)	**1.6**	**1.6**	**1.7**	**1.5**
Any visit	**58%**	**56%**	**45%**	**40%**
Drug-Related	27%	38%	33%	30%
Alcohol-Related	7%	7%	8%	8%
Drug Poisoning	6%	4%	4%	2%
Injuries	12%	24%	7%	8%
Cellulitis	21%	16%	18%	20%
Mental Health	7%	5%	6%	5%

In summary, these analyses of summative outcomes reveal little impact from ReRoute participation so far. We find no effect in terms of criminal justice involvement, perceived quality of life, or substance use and associated health conditions. These lack of effects to date are unsurprising given ReRoute's recent implementation. Programs often require time to build content, frequency, duration of delivery, and coverage—elements of program fidelity (Dharni, 2019). ReRoute experienced frequent staff turnover and multiple changes in its data collection techniques that may have compromised its effectiveness. Moreover, its start was nearly synchronous with the apex of the COVID-19 pandemic, which has affected social service provision and law enforcement activities in multiple ways, although it is beyond the scope of this research to examine them. Finally, participants face persistent and intertwined issues of substance use, socioeconomic, and legal/ criminal issues. These conditions are serious and interrelated, taking longer perhaps than the time the program has been in existence.

Due to data limitations, this study does not examine shorter-term outcomes such as employment, financial stability, housing, or consistency in health care or MAT. These measures are likely to occur before and strongly affect the longer-term outcomes we are able to measure, such as arrests and emergency room use. ReRoute may already have positively affected such outcomes for some participants; unfortunately we cannot know at the present time.

Recommendations Based on the Quantitative Analysis

Based on the findings to formative and summative evaluation questions, we make the following recommendations for ReRoute leadership to consider:

1. Maintain the strong focus on medication-assisted treatment and substance use. Ensure sufficient staff awareness and tools for other common needs among the target population, including homelessness/ housing, legal/ criminal issues, and basic financial needs/ access to social services, as well as guidelines regarding how best to approach such challenges when they are concurrent. This could mean adding programming to address these issues intentionally and regularly, rather than strictly individually-based, as-needed approaches that may lead to addressing issues primarily when a participant is near crisis. ReRoute may be able to lessen its focus on other issues that are less likely to be priorities for most people, even though participants likely will need help with them from time to time.
2. Create strategies and incentives to encourage diverted individuals to return to ReRoute after intake and participate in ReRoute routinely, rather than as a 'drop in' service. ReRoute might create milestones or a 'graduation' to which participants can aspire.
3. Create a consistent schedule for contacting all referred individuals, perhaps quarterly or more often. These outreach efforts could be tied to collecting Quality of Life surveys or other forms to track progress. Consider sharing attendance information with law enforcement and/or courts as a matter of course if they might help increase engagement.
4. Modify data collection processes to incorporate short-term outcomes such as employment, financial security, access to medical treatment, and use of medication-assisted treatment on a regular basis.

We turn our attention now to qualitative findings gathered through interviews with ReRoute participants and stakeholders.

Qualitative Analysis and Findings

Phenomenology

Exploring the lived experiences of both recovering opiate addicts, and the stakeholders of the ReRoute Program, may be viewed as phenomena ("a remarkable thing, or event" per Oxford Languages Dictionary, 2022, p. E-1), which can initially be viewed/ defined as the study of structures of experience, or consciousness. Literally, phenomenology is the study of 'phenomena:' the appearances of things, or things as they appear in our experience, or the ways we experience things, thus, *the meanings things have in our experience*. Phenomenology studies conscious experience as experienced from the subjective, or first-person point of view (Woodruff Smith,2013).

We triangulate our data using three qualitative methods:

1. Interviews were all coded by hand by Co-PI Gutierrez Sisneros, for families of meanings, codes, themes, patterns, categories, and excerpts, within the 30 transcribed interviews.
2. DeDoose – computer software used to examine codings, derived from Co-PI input.
3. Matrix Analysis – Averill (2002, p. 856) defined a matrix as "a set of numbers or terms arranged in rows and columns, that within which, or within and from which, something originates, takes from, or develops, where a crossing of two or three main dimensions occurs." She defines these four important dimensions as:
    - I – internal domains of intrinsic, emic patterns.
    - E - external domains that arose from the community and society.
    - O – consequences of interactions between I and E.
    - C – central domain, which is the interface of I:E:O—actual health experiences of participants
    - (ibid, p. 858).

In the qualitative analysis sample, we included 30 individuals who were interviewed. Twelve were offered diversion from arrest into the ReRoute Program and consented to a one-time interview, and the other four were social referrals, with one being a "volunteer," as well (because interviews were only done once, there is no attrition value in the qualitative portion of this evaluation). Thus, there are 17 primary participants and 13 primary stakeholders in the sample. Please see characteristics of interviewees and additional methodological details in Appendix B.

We divide our findings into two main sections, Themes and Matrix Analyses.

Themes

First, we excerpted 29 codes from primary participants and 43 codes from primary stakeholders. These data yielded five main themes. They are detailed in Table 13, followed by an analysis of each, including its pattern and categories using evidence from interviews.

Table 13: Five Main Themes Identified from Transcripts / Research Notes, Summations

I. Anchors of Meanings: Root Causes	II. Malias - The Disease of Addiction	III. Biopsychosociocultural Needs by Importance			IV. La Conciencia Elevada: Ideas for community solutions	V. Barreras: Barriers to Recovery
		a. MAT is foremost important issue (for all but one client)	*b. Housing is second most important issue (for all but one client)*	*c. Support system is third most important*		

I. Anchors of Meanings: Root Causes[24]

Pattern: Importance of Identity and cultural preservation to imbue resilience / meaning to life

Categories: Causes of Addiction – personalized.

- Theories/ comments on: multigenerations/familia[25]
    - "My parents were both addicts. I saw drugs my whole life…I knew about heroin when I was six, I knew the full details…"
    - "I am raising my sister's kids and one of them has started to use drugs"
- Genetics mentioned
    - "My mom she actually is an addict. So, I kind of more or less took that on from her."
- Poverty identified: inactivity, no job or completed education, making a living selling heroin
- Love of community, importance of a homeland to the soul, honoring ancestors - effects of historical trauma

II. Malias - The Dis-ease of Addiction (body-mind-spirit)

Pattern: Transitions in Life, personal health choices, physical / psychological dependence can develop

Categories:

- Physical - Effect of addiction on physical health
    - Hepatitis, cirrhosis, HIV; overdoses; suffering and pain, abscesses, growing older
    - Reluctance to seek healthcare; apply for Medicaid
- Psychological Treatment
    - Motivational Interviewing, CBT, intense case management, art; self-esteem work
- Spiritual – Use of remedios[26] for abscesses[27]
    - Traditional healers; Penitente Brotherhood; Narcotics Anonymous.
    - Use of (unhealthy) ritual – buying, cooking, injecting heroin becomes a "ceremony" (form of spirituality?)

Etic statement by a stakeholder: *"I've realized that pretty close to 90% of the people that are users – even maybe higher than that – don't wanna be using, but they don't wanna be sick either because the sickness is sometimes worse than the addiction itself. So, they don't understand what it is, what are they covering up."*

III. Biopsychosocialcultural Needs by Importance

Pattern: Consequences of addiction will lead to unmet needs, neglect, struggle, loss

Categories: Improvements through:

- M.A.T. – Medication Assisted Therapy (ASAM, 2022; Koehl, Zimmerman, & Bridgeman, 2019) was obtained within a short time period, decreasing high risk behaviors and harm reduction immediate: needle exchange and Narcan offered
- Housing – every client mentioned this, except one who was currently married
- Social Support – this is a reference to staff who work with clients, and lead / help prioritize them to resources for food, transportation, counseling, legal assistance (warrants, drivers licenses, birth certificates, INS applications), and it was noted that they become a sort of surrogate family to client, e.g. *"ReRoute has honesty been there for us and they treat us more like family in a sense, in a way. So, honestly, I hope ReRoute, I hope it continues to succeed, and I hope that they reach their goal because, yeah, I believe it's a good Program and I'm, all with it."*

IV. La Conciencia Elevada: Ideas for community solutions[28]

Pattern: Perpetuation of Life – community members dying prematurely, for example.

Categories:

- *Respeto*[29] is lacking, for example: *"I still get judged a lot because of my visible tattoos. They – I do notice a change in attitude from when they talk to me on the phone to in-person. Because as soon as they see me, they treat me worse."*
- Spirituality
- Increase life span
- End drug trafficking, end overdoses (importance of Narcan distribution)
- Improve/delete stigma experienced by clients

V. Barreras – Barriers to Recovery

Pattern: Interdependence - importance of forming community support groups to remove barriers together

Categories:

- Forgiveness of self (for some)
- Covid-19
- Medicaid model incompatible with ReRoute technology used
- Unemployment
- Mourning the loss of something – heroin's chemical name: [*(5a,6a)-7,8-didehydro-4,5-epoxy-17-methylmorphinan-3,6-diol diacetate*] , or other opiate drugs of choice

Instead, need to *celebrate the presence* of "wellbriety," which means achieving sobriety and abstinence from substance abuse without stopping there - it means going beyond "clean and sober" by entering a journey of healing and balance - mentally, physically, emotionally, and spiritually. (Coyhis, 2011, Wellbriety Movement, n.d). This would be a way of promoting open hearts to personal sobriety, unblocking *barreras internas*.[30]

Matrix Analyses

The Matrices in Tables 14 and 15 are based on two axes. Axis A creates breadth to our analysis and represents Averill's (2002) four dimensions—(I)nternal domains, (E)xternal domains, C(O)nsequences of interactions between internal and external domains, and (C)entral domain, the interface of I, E, and O, the actual health experience of participants, as described above. Axis B represented five categories of evaluative questions that were asked in ReRoute interviews:

1. Police encounters re: diversion from incarceration
2. Case Manager encounters
3. Program encounters
4. On culture preservation/ethnicity and resilience
5. Spiritual Practices (clients only)

Table 14: Client Matrix Analysis of the 5 Research Question Categories with the 4 Matrix Analyses Categories

		Axis B: Five Categories of Research Questions About ReRoute Asked				
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**	**5: (Qualitative): Spiritual practices**
Axis A: Four Evaluative Categories (Averill, 2002)	**I**: Intrinsic emic patterns	*I came here to ReRoute a huevo.*[31] *It's kind of like rerouting your brain, I think. So, you know, to change old habits and make new ones, something like that.* *…[the officer] asked me if that was the life I wanted to live. And I told him that I was looking for ways to quit, and I had been looking for – to get into programs like the Methadone program or the Suboxone stuff, and I was checking to see which one accepted my Medicaid. So, I was already in the process, but he told me he had an easier way of skipping that and getting me on the program right away.* *Officers need more training on humanity.*	*My case manager knows I am an old school tecato*[32] *– 3 ½ decades of heroin use.* *I want to get some beneficial advice and some kind of guidance from caseworker.* *A couple years ago, it was a different clientele than what it is now, en serio,*[33] *and I don't like to talk to somebody who gets changed all the time, they don't even know my business, you, know, this program, when I started it – and since now yeah, there has been workers that have come and gone, but my case manager, and counselor, they're still here so, you know.* *Emergency housing: There is 7 million in the budget, doesn't that include an 'emergency fund,' to help pay for housing – where is the feria?*[34]	*I know that I think that what they are doing is a good thing, and I think that what they have so far and what they're offering and the benefits and all, is very supportive.* *This Program changed my life, actually.* *[It is]….a blessing in disguise…* *…But, like I said, they think, I guess, that we forget everything and a lot of people tend to - when this program got started, this program has gone through a lot, but anyway, empty promises. They used our name as tecatos/tecatas to get their funds. And I'm not stupid, you know what I mean?*	*Culture and ethnicity applies to making you want to be positive. Do you know what I mean? To better yourself and continue to do good, yeah, and I guess you could say that. I mean stereotypes would basically say, 'Oh, all these Hispanics are addicted to drugs' or whatever. So, I guess it's kind of like a stereotype in a sense, but I guess it kind of could. But I don't think that it's specifically due to one race because I think it can happen to anyone.*	*A couple noted: just pray to God, he just – I think he just puts paths for me. You know, I have my guardian angels up there, and he's just putting a – we were in a dark place… he pulled us out of that and put a path of light with opportunities and blessings along the way, because we've had lots of blessings, just for being sober for such a short amount of time.*

n=17. Participants were admitted to ReRoute for arrest diversion (12), social (4) or volunteer (1).

Table 14: Client Matrix Analysis of the 5 Research Question Categories with the 4 Matrix Analyses Categories

		Axis B: Five Categories of Research Questions About ReRoute Asked				
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**	**5: (Qualitative): Spiritual practices**
Axis A: Four Evaluative Categories (Averill, 2002)	**I**: Intrinsic emic patterns		*I got support…this program has changed my life for the better… [and] The interactions with the case managers as positive role models… are a way to interact with my own struggles…by talking to someone who understands.* *So, this program offers those type of people, the ones that want to try and keep on trying, and it's just hard to get out of whatever situation they're in and all that, a second chance… Yeah, that's what it gives you, a second chance to head in a different direction, a better direction, and they're not doing all the work for you. They're not the ones that are – like my case manager tells me, she's all, "It's all you," I mean, she tells me, "You're the one making the extra steps and the effort."* But, there was also this comment from one client: *I think the program would be able to help more people if more people knew about the program, or if they enter the program.*			

Table 14: Client Matrix Analysis of the 5 Research Question Categories with the 4 Matrix Analyses Categories						
Axis B: Five Categories of Research Questions About ReRoute Asked						
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**	**5: (Qualitative): Spiritual practices**
Axis A: Four Evaluative Categories (Averill, 2002)	**E**: Arise from Community (Etic)	*I think Rio Arriba County is unique because we're such a small community. We have officers who are here and from here that engage with the community. So, I think that gives us a unique aspect to – they have a more interest in making sure that our youth or our kids are helped and to make sure that, whereas in other communities, I don't necessarily think that that's accurate. They're just there to do a job. They don't have an interest in the community because they're not from there. A lot of them come in from other cities or other states.*	*Case managers have big, open hearts* *I think the program would be able to help more people if more people knew about the program, or if they enter the program.*	*I want us to be somebodys, not nobodys, you know what I mean? And we're going to get there, I know we are.*	*But Espanola has a lot of good things that come out of it and I have spent a few years away from Espanola and I've heard just nothing but, "Oh, you're from Espanola?" You know, people they think bad just because you're from there but I'm like, "There's a lot of good things about it." The food, you know, from Hispanics to the Native culture everything. It's not a bad place, it's just that there's lack of, you know, there's not that much help for people that need that help, so they end up falling and into doing drugs and criminal activity and stuff like that.*	*The only spiritual practice I have is reading the Bible and going to church on Sundays and/ or Wednesdays and talking to God myself. I just I pray but that's the only thing I've – that's the only spiritual practice I guess I have. Because I don't go see curanderos.*[35] *I don't believe in all that.*

Table 14: Client Matrix Analysis of the 5 Research Question Categories with the 4 Matrix Analyses Categories

Axis B: Five Categories of Research Questions About ReRoute Asked						
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**	**5: (Qualitative): Spiritual practices**
Axis A: Four Evaluative Categories (Averill, 2002)	**O**: Consequences of interactions between I & E	*Wrong place at the wrong time **VS. right place at the right time (ReRouted)*** *Honestly, I'd probably be back in jail if it wasn't for ReRoute because when I got out of jail, the judge had put me on probation, she gave me all these classes, as well as all these court fees, these fines, all that, and if it wasn't for ReRoute going to every one of my court hearings – and speaking for me, I don't think the judge would have even thought that I was trying to do better or trying to head in a different direction and a positive direction. And, I mean, it kind of happened for me like not by coincidence but, honestly, it was like a blessing.*	*All of the CMs understand what we're going through because they have gone through it themself, so it's easy to relate.*	*I want to get off of Methadone, too. I am still young, and there's more to this world than just drugs.* *… I would say it's definitely a positive outlook just on everything. My attitude I mean the way I look at drugs and just everything. it's been a positive thing all around. The Program has been really good overall.*	*I do know that I took the wrong road what I did and I meant if I could take it back, of course, I would. But now, all I got to do is fight through it…I brought it upon myself, so now it's a fight that I have to do to get back to where I was and I know I can do it. I know I can do it.*	*I want to be clean and live a happy, good life, get a job, live a normal life.*

Table 14: Client Matrix Analysis of the 5 Research Question Categories with the 4 Matrix Analyses Categories

Axis B: Five Categories of Research Questions About ReRoute Asked						
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**	**5: (Qualitative): Spiritual practices**
Axis A: Four Evaluative Categories (Averill, 2002)	**O**: Consequences of interactions between I & E	*God answered my prayers and God got me you guys… the officer was really, really good about it. I'm very glad that I didn't go to jail - if you go to jail, it changes you, you know, and you either are gonna go more downhill or you'll succeed. But 9 times out of 10, you're gonna just go downhill, I think, when you go to jail. Thank goodness for that officer.*				
	C: Interface of I:E:O – What are actual health experiences? *For example, at the hospital as well, I do tell them that I was an ex-user, and as soon as they hear that they treat me worse. Their attitude changes, because they were just friendly a second ago, and as soon as I tell them I was an ex-drug addict, they started to treat me like a drug user. They don't wanna help me, they don't want me there. And that's how it is a lot here in Española. Nobody wants drug addicts around, because the people that do bad stuff to good people mess it up for the ones that don't.* *….and I also got a job shortly after. I got saved, we'll say, with you guys' Program. It really changed me in good ways, you know? [The Program is] supportive mentally, physically, everything. So, I'm really, really glad that you guys have this program for people like me because some people – I'm lucky enough that I have [family], but some people don't have that support. So, do you know what I mean? I received mental health therapy…case manager was just great with me. I mean she helped me a lot with my problems. You know I talked to her about a lot of things and she was really – a real big asset to this.*				

We turn now to evidence from primary stakeholder interviews.

Table 15: Stakeholder_Matrix Analysis of the 4 Research Question Categories with the 4 Matrix Analyses Categories

		Axis B: Five Categories of Research Questions About ReRoute Asked			
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**
Axis A: Four Evaluative Categories (Averill, 2002)	**I**: Intrinsic emic patterns	Police officer commented that clients were told, after having been ReRouted: *I told you. Now, because I haven't lied to you, time to stop lying to yourself. Look at everything that you can see yourself in, which is a glass, a window, a mirror, and tell yourself, 'I am somebody. I will make it.' No matter how somebody puts you down, no matter what they tell you, you always look in that mirror and say, 'I can make it, I can do it,' and they love that.* *So, when we heard about the LEAD program, ReRoute, and its data-based – its data-driven basis showing that there is enough information out there that when you have – I'm gonna give you figurative numbers – when you have 20 clients in the program, and five of them go into recovery, that's huge. That's huge. Our hopes...are that as we continue the program, and more and more people understand it, and get involved in it.*	*Because I'm in recovery myself, and I completely understand and can empathize with what happens, what goes on, the struggles, and be able to understand and relate.* *…good case management that they do have, as caseworkers are really passionate about their jobs.* *…and the most important needs to their welfare or their wellbeing is what I look at, and I try to address that as priority. And then we work down the steps, and according to the Stages of Changes in which a client is at kinda gives me a heads up of where that person can be placed or where that person's needs are. If they're in maintenance, well, obviously, they're gonna need homes.* *We're walking the walk.*	*I get more independence for myself, meeting more people, interacting with the community, and being able to see where I can fit in and help and use the addictions in my past life and my recovery, now, to help the community and others. That's what I'm able to get from the ReRoute Program. oh, and more friendships.* *Recovery! Which is a way of learning how to live, coping skills, life skills, things that, in addiction, we tend to lose or forget. And also, for clients to feel good about themselves, and be independent. Yeah* *I've taken an initiative in the ReRoute program because I want to be able to reach individuals who are young enough that we can still turn their life around.*	*…And, it's like I tell everybody: Don't give up, because once you give up on them, they don't have nobody to really do it. Will they steal from you? Will they lie to you? Will they do whatever it takes to get to you? Yes, but you gotta remember one thing: They're our family, they're our children, and no matter whose it is, like I tell them, all this valley is my kids, and I will take care of them. So, that's what it's all about.* *Oh, being Hispanic and learning from my grandmother and seeing her resilience in taking care of the many kids that she had had – and beautiful, my aunts and uncles – yes. Seeing her strive to do better and be the best mother and grandmother, I believe it's very important. Yeah, it has helped my identity and my recovery, absolutely.*

Table 15: Stakeholder_Matrix Analysis of the 4 Research Question Categories with the 4 Matrix Analyses Categories

		Axis B: Five Categories of Research Questions About ReRoute Asked			
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**
Axis A: Four Evaluative Categories (Averill, 2002)	**E**: Arise from Community (Etic)	*…I've heard, out there on the streets, with some of the clients that say they are treated with more respect because they know they're in a program, and the officers actually do the same and treat the client with respect, as well as the client treating the officer with respect, because there's no stigma behind all that.* ***It's starting to change up a lot.*** *…but I know officers to have that compassion that they want to see the clients get help rather than go to jail.*	*I've gotta say that every ReRoute person or client has always had the support of their case manager… they've got their case manager always with them, which is awesome* ***because that support doesn't end at 5:00.*** *You may need it throughout the day, through the evening, a phone call. And from what I've seen, their case manager has been really, really a part of the process. And that's important.* *So, they (Case Managers) spend probably 85% of their time out in the community with the client, as opposed to in the office.*	*What I hope to see is a stronger, healthier comunidad.*[36] *I think I would hope that we could reach out to the community and say, 'Hey, give these people an opportunity'…once you have established a criminal history, it's hard to gain employment after that. So, after some time I think we as a community, as well, local merchants, local businesses – everybody's saying support your local business – well,* ***support the community****, so that the community can support the local businesses. (Recommendation is in this report.)*	*One thing does stand for certain, is in this valley, generations have been introduced to addiction, have grown up with addiction, and have accepted addiction as a norm, and it's gonna take us a little bit longer than a year to make a significant impact into generations of culture.* *I think that it's a generational thing. It's a culture thing because – my grandparents didn't do it. But my parents got into it. And I see that children my age, people that I went to school with all followed in the same footsteps of their parents. And so, I do think that it is a cultural, generational issue. Everybody badmouths Española. We're 'the heroin capital of the world.' But if you look outside of the state of New Mexico, there's so many other areas that could be the heroin capital of the world or whatever it may be. But I just think that here, it's a generational thing where grandparents are now raising their grandchildren because Mom and Dad are not functional.*

Table 15: Stakeholder_Matrix Analysis of the 4 Research Question Categories with the 4 Matrix Analyses Categories

Axis B: Five Categories of Research Questions About ReRoute Asked					
		1: Police Encounters	**2: Case Manager Encounters**	**3: Program Encounters**	**4 (Qualitative): Cultural Preservation/ Resilience**
Axis A: Four Evaluative Categories (Averill, 2002)	**O**: Consequences of interactions between I & E	*What has definitely changed is the police attitude about it, and the public attitude has changed. People don't think of it as much as a crime anymore as they do think of it as a chronic disease, and that means we've been able to get a shelter up and running, which we never were able to do before. And we were able to get a treatment center here in Española through planning and zoning (Darrin's Place).* *That's a shame that we – and, I say "we" because it takes a community to solve a problem, not the police department. It's a whole community getting together and doing it together as a team. If it's not done that way, it's not gonna work.*	*CMs / CPSWs formalized peer support and practical assistance to people who have or are receiving services to help regain control over their lives in their own unique recovery process. Through a collaborative peer process, information sharing promotes choice, self-determination and opportunities for the fulfillment of socially valued roles and connection to their communities (NMHSD/OPRE, 2022).*	*The main thing that helped me was my Lord and Savior, Jesus Christ, because I found him and he was the one that pulled me out of my addiction and I rely on him every day, but I also needed that support system, and I needed other people to help me and show me different techniques and ways that jail can't teach you. So, I think that's where this ReRoute program takes that precedence over the jail is that they're actually helping and getting to the root of the problem.*	*Well, we are shaped by every interaction we have from the moment that we start developing in utero, and it decreases exponentially after birth, so these imprints have these effects that go through all these different threads in your life, so it's impossible to separate these things out from your experiences and how you interact with the world, so that's for sure, but how it affects criminality is, unfortunately, that we have a very gendered and raced system that we live in – our society at large that we all have to function in – and so, if we were to just have those things factor in, affect us in our interactions without judgment or value to it, that'd be one thing, but then, the society at large we live in places value on those things and determines that this skin color is better than this one or whatever it is, or this is how things should be structured and function – hierarchy, whatever it is in your family – so we can't separate those things out. We're experiencing it all the time.*
	C: Interface of I:E:O – What are actual health experiences? *…me personally, this is a sickness. This is an illness. And I look at somebody walking through those doors and I say, "Well, if they had cancer would I turn them away? Would I put them inside jail?" They're not – believe me -they're not seeking heroin or seeking crime as a way of life, but it's the way of life that it is right now, because they're ill.* *Rehab stakeholders, comments from two clients: "I had tried getting in the Santa Fe Recovery and there was no room and my mom knew Officer Danny Pacheco and talked to him and he then referred me to the ReRoute Program and that's how I was able to get in, voluntarily," and, issue re: "… paying for rehab - how can I possibly save $150.00 to pay for rehab, with no job, no steady income source, nothing. I have to ask my mom for help, and she is not financially stable."*				

A Note about Cultural Competimility (Campinha Bacote, 2019) and Addiction

Culture is related to one's ethnicity, or race, naturally, but many other cultures are definable, for example, and for the purpose of this report, we are referring to the culture of recovering heroin addicts. There are also the cultures of veterans; women, men, or transgendered peoples' culture(s); nursing culture; the culture of shamans; the culture of researchers; and the culture of peer counselors, to name a few. It is noted that the 2022 Oxford Dictionary defines an addict as: "An enthusiastic devotee of a specific thing or activity" and "Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits (reward, motivation, memory), genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue, despite harmful consequences" (American Society of Addiction Medicine, 2022).

The competemility of the Rio Arriba County ReRoute program has been well developed, where the hermeneutics (interpretation, including non-verbal, verbal, and written communications) of life lived, which the program case managers and CPSWs, themselves in recovery, are able to share is owed to their understanding of the nuances and subtleties of addiction, rendering a deep compathy (empathy from having had same co-experience) within this culture of those *prójimos* (proximates / community members/ friends) recovering from opiate use disorder (OUD). The fact that, as noted therapist Paolo Giudici from Ayudantes, Inc. (personal communication, August 13, 1997) at a Methadone training with the Española City Police that I attended, "Addicts are sensitive, traumatized, delicate people, in need of understanding and empathy," broadens the *vista*[37] we have of the clients which ReRoute, and the law enforcement in Rio Arriba work with (see, also, Deleuze, Rochat, Romo, et al., 2015).

Recommendations from the Qualitative Analysis

1. The continued hiring of employees in recovery from SUDs (Substance Use Disorders) is an important part of the ReRoute Program's success and contributes to its cultural competimility. Huerto (2020) discussed how a doctor who looks like, sounds like, and comes from the same culture as the patient she/he is treating, is an important way of decreasing health disparities. We could extend that to say that case managers / CPSWs who look like the ReRoute clients are, through their own lived experience, an inspiration of hope and belief - that recovery is possible - through their role modeling, maturity, wisdom, and self-empowerment (NMHSD/OPRE, 2022).
2. Housing – an investment in transitional and recovery housing is a paramount need of this population, and has been recognized over time (RAHHS, 2001; COSSAP, 2022). It can be noted that during the time of this evaluation, the Española Pathways Shelter was opened, and the Eagle Village (a hotel was purchased and remodeled) transition housing was opened, too. More needs to be done with building housing, for example, the Lifelink La Luz housing model in Santa Fe, NM (http://www.thelifelink.org/housing-support).
3. Support the creation and funding of a Traditional Healing Drop-in Center at Barros Unidos in Chimayo, though a satellite office close to the shelter and to the ReRoute Offices, perhaps, is more geographically amenable to this much needed outreach. A one-year anniversary of the successful Remedio Outreach occurred in July, 2022, which has built the foundation for showing that this type of competimility is viable for the vulnerable population we are working with, a population that is reluctant to go to hospitals or to medical doctors. With the expansion of Medicaid by Governor Susana Martinez, this has improved somewhat, but stigma is still common. Working against stigma and social ostracism (Gutierrez Sisneros, 2002) is an important endeavor, which could involve all of the local agencies listed by COSSAP (2022) in regard to rural response(s) to OUD in Rio Arriba.
4. *"I think that we need to get a little bit more maybe family counseling added to the program. And the reason I say that is speaking, again, from my personal issues that I've dealt with as far as family and addiction. I think that it starts at home. …I think that we need to engage the family a little bit more in this whole process and so they can understand what it is that we're doing and help them before it gets out of control (re: juveniles, e.g.)."*
5. *"I wish that there was some educational services, an educational aspect because, for example, you can't get an ID without a Social Security card and a birth certificate. Thus, you can't get our new minimum wage, $9.00 an hour, job without a GED. And an educational component is basically one of the little things we're lacking in the program itself. And if we did have a little extra funding for that, it would kinda be the cherry on top, I'd say, because we do have some for housing and other things. A lot of the other stuff that we can provide, like IDs and birth certificates – all that – is a matter of a memorandum of understanding between that entity. So, it can be done. But education, I'd like to*

see." Create an MOU with Northern New Mexico College Adult Basic Education GED Program.

6. One stakeholder recommends, *"The one thing I would like to see is raising the bar when it comes to the criminal charges because, for every 10 that get into the program, we lose 20 because of certain charges, because of certain barriers. Let's call them barriers that do with their background or what they're presently charged with, if it's a diversion, or whether – even a social can present itself with barriers because of the background. So, to be a little bit more open, that would be great because we could help so much more."*
7. Offer trainings for law enforcement, so that arrest diversions continue. Involve state police and tribal police, with city and county police being vested in this process. Note, from a stakeholder, *"Brendan Cox is with the National Bureau (a national support for compliant LEAD models throughout the country), and we brought him in from Albany to train our law enforcement here, and we had law enforcement from Rio Rancho, Las Vegas, Española, Rio Arriba, and tribal and state. We trained, I think, 40 officers and deputies altogether over two days (in ~2018)."*
8. Offer community support for employment of those in recovery: *"…so that the community can support the local businesses. So, hopefully we could help them (clients in ReRoute Program) with employment at some point, as well. I don't know if that's the goal for ReRoute at this time."*
9. "Cost of rehab" is an issue with clients – can drug rehabs have a sliding scale, or allow an exchange work for the admission cost(s). Poverty was mentioned by several participants – clients and stakeholders alike.

Endnotes

1. *Malias*: Southwest Spanish vernacular – literally, 'feeling bad,' to be in withdrawal (from opiates, usually).
2. *La Conciencia Elevada*: Elevated Consciousness – improvement/changed thinking, mindfulness about one's life situation(s)
3. *Barreras*: Barriers – perceived external blockages to successful recovery, such as abuse, stigma, history
4. All rates described in the Substance Use in Rio Arriba County section of this report are age-adjusted to the US 2000 standard population, as are the rates graphed in Figures 1 and 2.
5. Crime data in Figures 3 and 4 should be interpreted with caution, as we collected data from different sources and imputed some values. Rates were derived from crime data collected from the Federal Bureau of Investigation (FBI) and population data collected from the U.S. Census Bureau. Most crime data were collected from Crime Data Explorer (https://crime-data-explorer.app.cloud.gov/ pages/home). This website provides reported crime counts for the nation and by state as well as from each individual law enforcement agency. For Rio Arriba, we collected information for the Rio Arriba Sheriff's Department as well as for the Jicarrillo, Ohkay Owingeh, and Santa Clara Tribal Police Departments. Data were unavailable from the Jicarrillo Tribal Police for years 2013 and 2014; we averaged the counts from 2012 and 2015 to impute values for 2013 and 2014. Crimes reported to the Jicarrillo Tribal Police account for a low percentage of total crime in the county in this time period, usually 6% or less of violent crime and less than 1% of property crime. As data from the Española Police Department was not available from this source, we used the FBI Criminal Justice Information Services Division's Crime in the United States, Offenses Known to Law Enforcement by State by City annual reports (https://ucr.fbi.gov/crime-in-the-u.s). This data was unavailable for the city of Española in years 2013, 2018 and 2019; and the 2020 Crime in the United States was not available at the time of print. We averaged the counts from 2012 and 2014 to impute values for 2013. Crimes reported to the Española Police Department account for a high percentage of total crime in the county in this time period, usually more than 70% of both violent and property crimes. Given the high percentage of crimes in the county that are reported to the Española Police Department, we cannot provide estimates after 2017 for Rio Arriba County as a whole.
6. We use the terms 'referral' and 'diversion' interchangeably in this report.
7. The median age in Rio Arriba County 41.3 (United States Census Bureau, 2022a). The county is 49% male and 51% female (United States Census Bureau, 2022b), and the county is 67% Hispanic (of any race), 16% Native American, 15% White, 1% Black, 1% Asian, and 1% some other race (United States Census Bureau, 2022c).
8. We include 122 of the 131 individuals in analyses of arrests, court cases, and (in later sections) emergency room visits. Since we only receive information for individuals who have any arrest, court case, or emergency room visit,

we assume no arrests, court cases, or emergency room visits as appropriate for individuals missing from our datasets. We omit from all outcome analyses the nine individuals who did not participate in ReRoute and who had no confirmed arrests, court cases, or emergency room visits because we cannot be confident we have correct identifying information.

9. We pulled court cases using dates of diversion within three years of each individual's referral, but include offenses that took place up to five years prior in order to retain enough cases for a meaningful analysis. We categorize cases according to the most serious offense for which they were found guilty in the following order: violent, property, DWI, drug, interference, public order, traffic citation, other. We are unable to include cases that have not closed, an important limitation given the time it takes for many cases to close. The date of the offense separates cases counted as occurring before and after diversion. Some offenses may have been committed before an individual's diversion data but were disposed afterward.
10. To boost *n*, we include as initial any individual for whom a Severity of Substance Use or Quality of Life Survey is available within the first six month of diversion (*n*=52). Some but not all individuals completed the survey during the initial intake meeting with ReRoute. For participants who completed multiple surveys within the first six months, we use the earliest survey.
11. Although 45 people answered the question about the severity of substance use and 45 answered the question about medication-assisted treatment, these individuals are not the same. Forty individuals answered both questions.
12. Many referred individuals did not answer every question, hence the variation in *n*.
13. Non-participants reported a higher severity of substance use compared to participants (3.4 vs. 3.9 on a 5-point scale) but this difference does not reach statistical significance.
14. The number of 6-month intervals after diversion ranges from 1 to 6 depending on the referred individual's diversion date. If an interval extends beyond January 26, 2022, the last day we collected interaction data, and there are no interactions in the interval, we do not include the interval in our data, but we do include the interval if there was one or more interactions with ReRoute.
15. The percentage of highly consistent clients may be artificially high given the number of clients who have been hired in the past year, since even one interaction reaches the bar for 'high' consistency. If these recent ReRoute clients follow the pattern of prior clients, many will cease or lessen their interactions with ReRoute in the future.
16. Had any clients interacted with ReRoute frequently but with low consistency, we would have categorized them as having Medium engagement; none did. It may be useful in future evaluation work to analyze outcomes based on the level participants' engagement or 'dosage.' We deem these analyses premature given the low number of individuals in each category and the short amount of time ReRoute services have been available.
17. The percentage of participants who engage highly with ReRoute may increase or decrease with time. Most participants categorized as having medium engagement have relatively recent diversion dates and may ultimately settle into either a more or less active pattern.
18. For the most part, these topics are listed with checkboxes at the top of the Daily Contact Sheet form case managers complete with each encounter. Although we took note of checkmarks, we applied our own coding, noting the checkboxes were at times incomplete or used inconsistently. We substitute the topic 'Family/Kids' for 'Pregnancy/Postpartum,' and distinguish Medication-Assisted Treatment from other substance use issues. ReRoute began using Daily Contact Sheets in May, 2021. We similarly applied this coding to all other artifacts.
19. Given the fact that participants have a wide range of diversion dates ranging from February 2019 to September, 2021, we rely on relatively few participants for information in later time periods; thus, our conclusions are tentative.
20. For this analysis, we include a topic if it is addressed at any time. Although the intake form includes checkmarks for homelessness and employment, we exclude this information since it does not identify a priority from the participant's perspective. We also do not assume a participant is addressing a legal issue merely due to participating in ReRoute due to an arrest diversion.
21. We retrieved Quality of Life surveys for more than two (6-month) intervals from only six referred individuals, and we collected no more than 15 surveys from any interval after diversion.

22. The drop in material wellbeing could be evidence that referred individuals choose to participate when financial needs are high.
23. In Table 10, the higher n always refers to the 'Severity of Substance Use' measure. We compared participants' earliest and last iterations of the assessment using paired t-tests and found no statistically significant differences, although both measures moved in the desired direction.
24. There was one specific qualitative question on history, ethnicity, resilience to addiction that was asked. See interview questions, Appendix C.
25. *familia*: family
26. *remedios*: home remedies, such as herbs, salves, patches, etc.
27. There was one specific qualitative question on spiritual practices that was asked of clients, but not stakeholders. See Appendix C.
28. We make nine recommendations in this report, including these five from clients' and stakeholders' input.
29. *respeto*: respect
30. *barreras internas*: internal barriers – perceived internal blockages to success, such as fear, trauma, and impass(es)
31. *A huevo*: phrase translates from the Caló language to 'by one's balls, by force' (Polkinhorn, Velasco, & Lambert, 1986).
32. *tecato*: A male heroin addict, with the word *tecata* used for a female addict (ibid).
33. *en serio*: seriously
34. *feria*: money
35. *curanderos*: community healers
36. *comunidad*: community
37. *vista*: view
38. *Soberviviendo 'la segunda jornada del muerto'*: Surviving 'the second journey of the dead'
39. Intake paperwork may have taken more than one visit.

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APPENDIX A: Methodology for Quantitative Analysis

Sample. In these analyses we include 131 individuals who were offered diversion from the program's inception in late February, 2019 through December, 2021 and for whom we have ReRoute treatment information and criminal justice outcomes (incarcerations and arrests, although some data may be missing). We omitted individuals for whom we could not verify the date of diversion. We categorize fifty-five of the individuals (42%) as clients, since they returned to ReRoute at least once after completing intake.[39] Of these, ReRoute considered 24 to be active clients in December, 2021. We categorize 76 individuals (58%) as non-participants. Of these, 67 met with ReRoute at the time of diversion to complete the Release of Information form and, occasionally, surveys and/or an initial case management plan. However, by definition, they had not returned to ReRoute after intake as of December, 2021. The remaining 9 non-participants members had been offered diversion by a police officer but did not apparently ever contact ReRoute personnel.

Client Screening Form. We collected information of potential ReRoute clients from Client Screening Forms, which were completed by or with assistance from the arresting officer at the 'handoff.' From these forms we collected the diversion date, demographic information about the potential client, the reason for referral (Social or Arrest, including type of offense), employment status, and housing status. We also gathered the identifying information we needed to track emergency room and criminal history information: individuals' first and last names, birthdays, and the last four digits of their social security numbers.

Severity of Substance Use and the Opioid Substitution Treatment Quality of Life (OSTQOL) Surveys. These two surveys were administered to prospective clients at the time of intake, usually, and to clients at irregular intervals thereafter. ReRoute collected surveys from twelve individuals who did not participate in ReRoute (non-participants) at intake. ReRoute collected 82 surveys and from 45 program clients: 23 at intake, 26 within 6 months of starting ReRoute, 20 between 6 months and 1 year, 9 between 1 and 1.5 years, 2 between 1.5 and 2 years, and 2 between 2 and 2.5 years. ReRoute collected only one survey from 27 or 60% of clients, two surveys from 12 clients, three surveys from 4 clients, four surveys from one client, and five surveys from one client.

The Severity of Substance Use survey consists of seven Likert-type questions gauging respondents' perceptions of the severity of illicit drug use in the past 30 days. Questions include the amount or frequency their drug use was, for example, 'out of control,' 'overpowering,' and 'caused problems.' Higher values indicate more severe illicit drug use problems.

The Opioid Substitution Treatment Quality of Life Survey consists of 38 Likert-type questions averaged into six aspects of quality of life: personal development, mental distress, social contacts, material wellbeing, success of opioid substitution treatment (if applicable), and discrimination. The scales range from 1 to 5. Higher values indicate higher quality of life for personal development, social contacts, material wellbeing, and success of opioid substitution treatment. Higher values indicate *lower* quality of life for mental distress and discrimination.

Encounter information. We collected encounter information for each individual from ReRoute paper records, including initial diversion paperwork (completed by a police officer), case management service plans, daily contact sheets, expense sheets, roster notes, attempts to contact clients, and various other artifacts that suggest an encounter such as housing and substance use treatment applications, informal case manager notes, and letters or memos sent to judges or other persons. We noted the date of the encounter as well as area(s) addressed during the encounter. (While we attempted a measure of client self-sufficiency, we found this measure to be unreliable and therefore omitted it.)

Arrests. We collected criminal arrest information in New Mexico for participants and non-participants from the Department of Public Safety from 2017 forward.

Emergency Room Data. We collected emergency room visit information from the Department of Health for substance-use related diagnoses from 2017 forward.

Court cases. We collected completed criminal court case information in New Mexico for participants and non-participants from the New Mexico Administrative Office of the courts from 2014 forward, including only those cases resulting in a conviction or deferred sentence.

APPENDIX B: Methodology for Qualitative Analysis

Prepared interview questions were used, as protocol, keeping all questions the same and informed consent was obtained, and will be kept for three years in the office of the Co-PI, in a locked cabinet. All participants were over age 18. All Covid-19 precautions were maintained (vaccination is not a requirement of the Program), until UNM and the Internal Review Board stopped all in-person interviewing for approximately one year, but allowed telephone interviews. None of the 30 completed interviews were done by phone. Co-PI Gutierrez Sisneros gave clients an incentive of a $20 gift certificate to the Pojoaque Market for their one-time participation, supported by the NM Sentencing Commission. The interviews with clients took place at the ReRoute offices on Industrial Park Road, and interviews with stakeholders took place at the business office where the interviewee worked. All interviews were recorded, as consented to by participants, and were sent electronically for transcription, with no identifying names, just the first two letters of first and last names, the month and day of birth, as 4 digits.

The NM Sentencing Commission supported this important transcription step in this research. Co-PI Linda Freeman was instrumental in creating the success of this qualitative data collection, beginning in August, 2020.

Table B.1: Client Primary Participants (including three couples)

Number (codes deleted)	Date of interview	Ethnicity	Gender
1.	8/8/2019	Hispanic / Chicano	2 = male
2. (social)		Hispanic	1= female
3.	8/9/2019	Hispanic	2
4. ("volunteered")	8/14/2019	Hispanic	1
5.	8/27/2019	Hispanic	1
6. (+ addendum)	9/26/2019	Mexican / Hispanic	2
7.	10/2/2019	Hispanic	1
8. (social)	12/4/2019	Hispanic	2
9.		Hispanic	1
Covid-19 pandemic (live interviews were stopped ~ 1 year)			
10.	4/16/2021	Hispanic	2
11.	4/23/2021	Hispanic	2
12.	4/30/2021	Hispanic	2
13. (social)		Hispanic	1
14.	5/13/2021	Hispanic	1
15.	5/13/2021	Hispanic	2
16. (social, MH)	5/21/2021	Native American	1
17.	5/21/2021	Hispanic	2
n = 17 12/17 arrests = 70.6% 4/17 social = 24% 1/17 "volunteered" = 5.9%	(15 documents transcribed/reviewed)	16/17 = 94% Hispanic 1/17 = 5.9% NA	Males = 9 (53%) Females = 8 (47%)

Table B.2: Stakeholders/ Business Participants			
Number (codes deleted)	**Date of interview**	**Ethnicity**	**Gender**
1.	11/27/2019	Hispanic / Chicano	1
2.	12/6/2019	White	2
3.	1/6/2020	Hispanic	1
4.	1/6/2020	Hispanic	1
5.		Hispanic	2
6.		Hispanic	2
7.	2/18/2020	Hispanic	2
8. (3 sections, total)	2/21/2020	Hispanic	2
9.	3/18/2020	Native American	1
Covid-19 pandemic (no live interviews conducted for one year)			
10.	4/16/2021	Hispanic	1
11.	4/16/2021	Hispanic	2
12.	4/23/2021	White	1
13.	6/8/2021	White	1
n=13	(13 documents transcribed/reviewed)	9/13 = 69% Hispanic 3/13 = 23 % White 1/13 = 7.7 % NA	Males = 6 (46%) Females = 7 (54%)

APPENDIX C: Interview Protocol for Primary Participants

1. How did you find out about the program?
2. Please tell me about your experience with the program and services you received. Can you describe the intake process, the counseling component, and the case management component?
3. How long did it take before you received benefits like housing, counseling, needle exchange, legal aid, transportation, anything like that?
4. What did you expect to get from the program when you decided to participate, what did you expect?
5. What are you actually getting from the program?
6. Are there any services you wished you were getting but aren't getting?
7. What elements or elements of the program are working or have worked for you?
8. What are the case managers like? Do you trust them? Have they helped you work towards your goals?
9. Is there anything, that you would change about the program or recommendations you would make to improve it?
10. Do you think that the birthplace, you know, where you were born, your ethnicity, your history, and your culture play a part in the development of health situations such as addiction?
11. Is there any of those that give you resilience?
12. Tell me about any spiritual practices that have helped you remain sober during the time in the program.
13. Do you have anything else to add?