

Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders

History and Impact of the Sequential Intercept Model

The Sequential Intercept Model (SIM) was developed over several years in the early 2000s by Mark Munetz, MD, and Patricia A. Griffin, PhD, along with Henry J. Steadman, PhD, of Policy Research Associates, Inc. (PRA). The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.

After years of refinement and testing, several versions of the model emerged. The “linear” depiction of the model found in this publication was first conceptualized by Dr. Steadman of PRA in 2004¹ through his leadership of a National Institute of Mental Health-funded Small Business Innovative Research grant awarded to PRA. The linear SIM model was first published by PRA in 2005² through its contract to operate the GAINS Center on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA). The “filter” and “revolving door” versions of the model were formally introduced in a 2006 article in the peer-reviewed journal *Psychiatric Services* authored by Drs. Munetz and Griffin.³ A full history of the development of the SIM can be found in the book *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*.⁴

With funding from the National Institute of Mental Health, PRA developed the linear version of the SIM as an applied strategic planning tool to improve cross-system collaborations to reduce involvement in the justice system by people with mental and substance use disorders. Through this grant, PRA, working with Dr. Griffin and others, produced an interactive, facilitated workshop based on the linear version of the SIM to assist cities and counties in determining how people with mental and substance use disorders flow from the community into the criminal justice system and eventually return to the community. During the mapping process, the community stakeholders are introduced to evidence-based practices and emerging best practices from around the country. The culmination of the mapping process is the creation of a local strategic plan based on the gaps, resources, and priorities identified by community stakeholders.

Since its development, the use of the SIM as a strategic planning tool has grown tremendously. In the 21st Century Cures Act,⁵ the 114th Congress of the United States of America identified the SIM, specifically the mapping workshop, as a means for promoting community-based strategies to reduce the justice system involvement of people with mental and substance use disorders. SAMHSA has supported community-based strategies to improve public health and public safety outcomes for justice-involved people with mental and substance use disorders through SIM mapping workshop national solicitations and by providing SIM mapping workshops as technical assistance to its criminal justice and behavioral health grant programs. In addition, the Bureau of Justice Assistance has supported the SIM mapping workshop by including it as a priority for the Justice and Mental Health Collaboration Program grants.

With the advent of Intercept 0, the SIM continues to increase its utility as a strategic planning tool for communities who want to address the justice involvement of people with mental and substance use disorders.⁶

1 Steadman, H. J. (2007). *NIMH SBIR Adult Cross-Training Curriculum (AXT) Project – Phase II final report*. Delmar, NY: Policy Research Associates. (Technical report submitted to NIMH on 3/27/07.)

2 National GAINS Center. (2005). *Developing a comprehensive state plan for mental health and criminal justice collaboration*. Delmar, NY: Author.

3 Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57, 544-549. DOI: [10.1176/ps.2006.57.4.544](https://doi.org/10.1176/ps.2006.57.4.544)

4 Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.). (2015). *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness*. New York: Oxford University Press. DOI: [10.1093/med:psych/9780199826759.001.0001](https://doi.org/10.1093/med:psych/9780199826759.001.0001)

5 21st Century Cures Act, Pub. L. 114-255, Title XIV, Subtitle B, Section 14021, codified as amended at 41 U.S.C. 3797aa, Title I, Section 2991

6 Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law*, 35, 380-395. DOI: [10.1002/bsl.2300](https://doi.org/10.1002/bsl.2300)

Sequential Intercept Model as a Strategic Planning Tool

The **Sequential Intercept Model** is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others. Employed as a strategic planning tool, communities can use the **Sequential Intercept Model** to:

- Develop a comprehensive picture of how people with mental and substance use disorders flow through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections
- Identify gaps, resources, and opportunities at each intercept for adults with mental and substance use disorders
- Develop priorities for action designed to improve system and service-level responses for adults with mental and substance use disorders

SAMHSA’s GAINS Center

SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation serves as a resource and technical assistance center for policy, planning, and coordination among the mental health, substance use, and criminal justice systems. The GAINS Center’s initiatives focus on the transformation of local and state systems, jail diversion policy, and the documentation and promotion of evidence-based and promising practices in program development. The GAINS Center is funded by the Substance Abuse and Mental Health Services Administration. It is operated under Task Order Number HHSS2832012000581/HHSS28342003T for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Nancy Kelly serves as the Contracting Officer’s Representative.

INTERCEPT 0

Expanding the Sequential Intercept Model to prevent criminal justice involvement

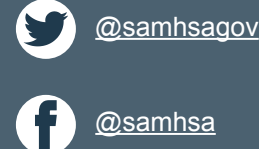
 Crisis Response Crisis response models provide short-term help to individuals who are experiencing mental or substance use crisis and can divert individuals from the criminal justice system. Crisis response models include: <ul style="list-style-type: none"> • Certified Community Behavioral Health Clinics • Crisis Care Teams • Crisis Response Centers • Mobile Crisis Teams 	 Police Strategies Proactive police responses with disadvantaged and vulnerable populations are a unique method of diverting individuals from the criminal justice system. Proactive police response models include: <ul style="list-style-type: none"> • Crisis Intervention Teams • Homeless Outreach Teams • Serial Inebriate Programs • Systemwide Mental Assessment Response Teams 	 Tips for Success Strong support from local officials Community partnerships Law enforcement training Behavioral health staff training
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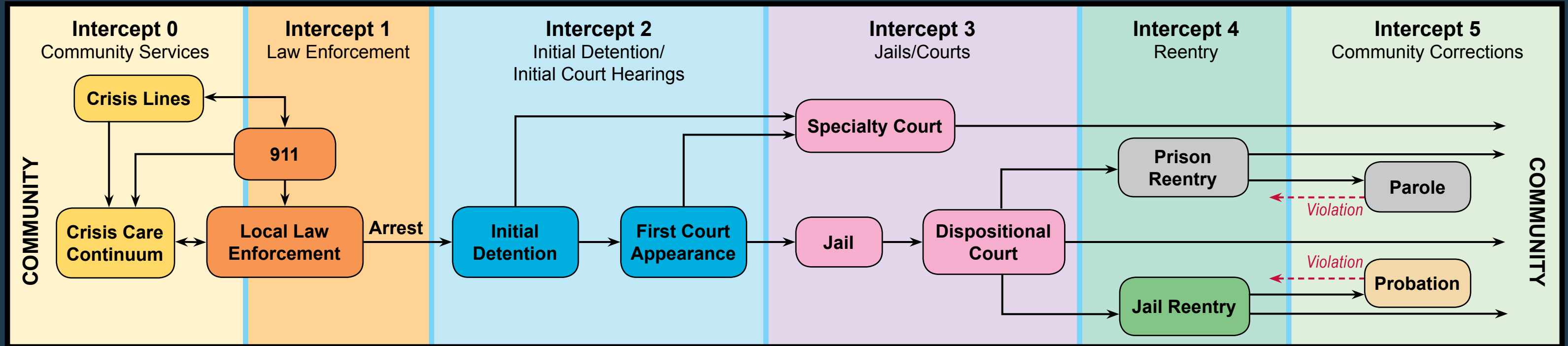
THE SEQUENTIAL INTERCEPT MODEL

Advancing Community-based Solutions for Justice-involved People With Mental and Substance Use Disorders

SAMHSA’s GAINS Center
<https://www.samhsa.gov/gains-center>
 PEP19-SIM-BROCHURE



The Sequential Intercept Model








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Key Issues at Each Intercept

Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
<p>Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a mental or substance use crisis or co-respond to a police encounter.</p> <p>Emergency department diversion. Emergency departments (EDs) can provide triage with behavioral health providers, embedded mobile crisis staff, and/or peer specialist staff to provide support to people in crisis.</p> <p>Police-behavioral health collaborations. Police officers can build partnerships with behavioral health agencies along with the community and learn how to interact with individuals experiencing a crisis.</p>	<p>Dispatcher training. Dispatchers can identify mental or substance use crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.</p> <p>Specialized police responses. Police officers can learn how to interact with individuals experiencing a crisis in ways that promote engagement in treatment and build partnerships between law enforcement and the community.</p> <p>Intervening with frequent utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce frequent utilizers of 911 and ED services through specialized responses.</p>	<p>Screening for mental and substance use disorders. Brief screens can be administered universally by non-clinical staff at jail booking, police holding cells, court lock ups, and prior to the first court appearance.</p> <p>Data-matching initiatives between the jail and community-based behavioral health providers.</p> <p>Pretrial supervision and diversion services to reduce episodes of incarceration. Risk-based pre-trial services can reduce incarceration of defendants with low risk of criminal behavior or failure to appear in court.</p>	<p>Treatment courts for high-risk/high-need individuals. Treatment courts or specialized dockets can be developed, examples of which include adult drug courts, mental health courts, and Veterans treatment courts.</p> <p>Jail-based programming and health care services. Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment, including providing access to medication-assisted treatment (MAT) for individuals with substance use disorders.</p> <p>Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.</p>	<p>Transition planning by the jail or in-reach providers. Transition planning improves reentry outcomes by organizing services around an individual's needs in advance of release.</p> <p>Medication and prescription access upon release from jail or prison. Inmates should be provided with a minimum of 30 days' medication at release and have prescriptions in hand upon release, including MAT medications prescribed for substance use disorders.</p> <p>Warm hand-offs from corrections to providers increase engagement in services. Case managers that pick an individual up and transport them directly to services will increase positive outcomes.</p>	<p>Specialized community supervision caseloads of people with mental disorders.</p> <p>MAT for substance use disorders. MAT approaches can reduce relapse episodes and overdoses among individuals returning from detention.</p> <p>Access to recovery supports, benefits, housing, and competitive employment. Housing and employment are as important to justice-involved individuals as access to mental and substance use treatment services. Removing criminal justice-specific barriers to access is critical.</p>

Best Practices Across the Intercepts

 <p>Cross-systems collaboration and coordination of initiatives. Coordinating bodies serve as an accountability mechanism and improve outcomes by fostering community buy-in, developing priorities, and identifying funding streams.</p>	 <p>Routine identification of people with mental and substance use disorders. Individuals with mental and substance use disorders should be identified through routine administration of validated, brief screening assessments and follow-up assessment as warranted.</p>	 <p>Access to treatment for mental and substance use disorders. Justice-involved people with mental and substance use disorders should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.</p>	 <p>Linkage to benefits to support treatment success, including Medicaid and Social Security. People in the justice system routinely lack access to health care coverage. Practices such as jail Medicaid suspension (vs. termination) and benefits specialists can reduce treatment gaps. People with disabilities may qualify for limited income support from Social Security.</p>	 <p>Information sharing and performance measurement among behavioral health, criminal justice, and housing/homelessness service providers. Information-sharing practices can assist communities in identifying frequent utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.</p>
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Data Collection Across the Sequential Intercept Model: Essential Measures

INTRODUCTION

The Sequential Intercept Model (SIM) was introduced in the early 2000s with the goal of helping communities understand and improve the interactions between criminal justice systems and people with mental and substance use disorders. The SIM is used to identify community resources and help plan for additional resources for people with mental and substance use disorders at each phase of interaction with the justice system, beginning with Intercept 0 (crisis response) and ending with Intercept 5 (community corrections). The SIM can help leaders and staff more effectively collaborate to divert people with mental and substance use disorders away from the justice system and into treatment. The SIM is used as the basis for a workshop, conducted by both Policy Research Associates, Inc., and the Substance Abuse and Mental Health Services Administration's (SAMHSA) GAINS Center, that produces an actual map of a community's resources across the intercepts. During the many SIM mapping workshops over the years, it has become clear that tracking and understanding data across the intercepts is a critical part of developing a robust continuum of behavioral health services and reducing justice system involvement of people with mental and substance use disorders. While stakeholders may agree that local system improvements are needed, challenges may exist in identifying, gathering, analyzing, and applying data to inform those changes.

How to Use This Manual

This manual is a compilation of recommended data elements organized around each of the six intercepts represented in the SIM. Each section lists data points and measures that are essential to addressing how people with mental and substance use disorders flow through that intercept. The sections also cover common challenges with data collection and ways to overcome them, along with practical examples of how information is being used in the field. Efforts to share data often fail when stakeholders lack clarity on the most essential information to collect, integrate, and examine. This manual provides a starting place for jurisdictions in considering important data points and measures they should be gathering and analyzing at each intercept.

Information and resources to address concerns around data sharing are provided and should be considered before decisions are made against sharing or integrating data. While current regulations are intended to protect privacy, they were also developed with portability in mind. *Readers are encouraged to consider the guidance provided here, along with their state laws, as efforts are made to share information across intercepts.*

Data Collection Approaches

The recommended data elements should be gathered and analyzed with the goal of understanding how people flow through the behavioral health and criminal justice systems. This can be accomplished through two approaches.

- Aggregate data may be gathered to understand the sheer volume of people with mental and substance use disorders across the intercepts and how the availability of or gaps in services at one intercept may impact other intercepts. In most cases, data in aggregate can provide substantial insight into how many people with mental and substance use disorders are encountered at each intercept and the capacity of community, behavioral health, and criminal justice systems to route people into appropriate services at each intercept. The data can illuminate where gaps or insufficiencies in the continuum of behavioral health services may be contributing to significant impacts on the criminal justice system.
- Alternatively, identifiers may be used to track individuals as they move through the intercepts, which requires that those identifiers be linked across systems and databases. This allows jurisdictions to understand more precisely how people with mental and substance use disorders flow from intercept to intercept and may provide a more accurate count of how many people need services and the frequency of their engagement with criminal justice and behavioral health systems.

How to Use the Data

Once stakeholders have identified data to collect at each intercept, the following approaches to gathering, analyzing, and using data to support the development of services are recommended:

- **Capture baseline data.** Whenever possible, collect baseline data prior to implementing changes. These baseline data can help determine if program or policy changes influence the problems the community is trying to address. If changes have already begun, it may be possible to gather historical data—pulling data from before implementation—to analyze for emerging trends. Data can be analyzed to evaluate program impacts by comparing the baseline data with data captured at various intervals after systemic or programmatic changes have begun.
- **Analyze data in the aggregate and share findings across all agencies.** Stakeholders should work together to determine what types of data and measures are relevant at each intercept point and to identify the various sources of these data. If decision-makers aren't involved in the initial conversations, ensure that a clear request is presented to them, detailing exactly what data is needed and toward what purposes. Each data set may need to be extracted and analyzed by its own agency to maintain compliance with privacy laws. Aggregate, blinded data can then be shared about groups rather than individuals. Where identifiers are used to track individuals across systems, agreements will be essential to enabling the sharing and integration of data. The types of agreements will vary depending on the data sources, the intended use of the data, and the roles of the agencies using the data (see Information Sharing Guidance for more on this topic). Findings from these analyses should be shared in a collaborative manner, so that all agencies involved may benefit from the information shared and collectively strategize to make systemic improvements.
- **Collect data in an ongoing way.** Once stakeholders have determined which variables or measures are most valuable, develop a system for collecting these data in an ongoing, real-time way. These data may be exportable to encrypted Excel or other spreadsheet formats to allow for analysis; jurisdictions shouldn't wait until sophisticated databases or dashboards are developed to begin

sharing and integrating data as long as secure mechanisms of storing and analyzing the data are established. Memorandums of agreement should memorialize the decisions made around data collection, sharing, and integration in order to protect the integrity of the agreed-upon efforts as stakeholders and government leaders come and go.

- **Collect data for people with mental illness and people with substance use disorders.** Depending on how services are structured, jurisdictions should consider tracking data for people with mental illness, substance use disorders, and co-occurring disorders. As different treatment providers or systems may serve people with substance use disorders, it will be important to include these stakeholders in the data-collection planning process to ensure those data are gathered in addition to information regarding people with mental illness. Due to the terms established by 42 Code of Federal Regulations (CFR) 2, it may be necessary for substance use treatment agencies to analyze data internally and share only blinded, aggregate data with partners or to explore other creative data-sharing mechanisms that comply with federal regulations.

Information Sharing Guidance

The Department of Health and Human Services has issued guidance on how to understand Health Insurance Portability and Accountability Act (HIPAA) privacy regulations as they relate to information sharing between criminal justice system entities and covered entities, such as medical and behavioral health service providers. This information is very helpful for agencies when negotiating agreements that clearly delineate what can be shared and under what circumstances.

- Information sharing guidance specific to law enforcement and corrections: <https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html>
- Information sharing guidance specific to judicial and administrative proceedings: <https://www.hhs.gov/hipaa/for-professionals/faq/judicial-and-administrative-proceedings/index.html>.

The following scenarios demonstrate in practice how information may be shared in ways that are compliant with HIPAA regulations:

- A mental health center may share a client's information with a law enforcement officer if that information is needed "to prevent or lessen a serious and imminent threat to health or safety."
- Because they are a covered entity, mental health professionals acting as co-responders with law enforcement may also obtain information about a patient from other providers.
- Health providers may share information with jails about medication that a detained person has been prescribed if the information is shared to provide health care, ensure the health and safety of inmates and others, protect transporting officers, promote law enforcement on premises, or for the safety and security of the correctional facility.

State law considerations: Some state laws are more restrictive than HIPAA, so stakeholders should make efforts to distinguish what the state rules are and how they apply.

For additional information, please consider the following resource:

- *Information Sharing in Criminal Justice – Mental Health Collaborations; Working with HIPAA and Other Privacy Laws* https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf

The Substance Abuse and Mental Health Services Administration has also issued guidance around the application of 42 CFR Part 2 regarding the provision of and information sharing related to substance use disorder treatment: <https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs>. As this regulation differs from HIPAA, it is important that partners working on data collection efforts understand the regulation's requirements and develop workable pathways to gathering, analyzing, and sharing data about prevalent substance use disorders and resource gaps to inform systems change.

INTERCEPT 0: Crisis Care and First Response Continuum

Intercept 0 involves interventions for people with mental and substance use disorders prior to formal involvement with the criminal justice system. The critical components of this intercept include the local continuum of crisis care services and resources that reduce reliance on emergency response, hospitalizations, and law enforcement to serve people in crisis or with low-acuity mental health needs. In jurisdictions where very few resources exist, law enforcement may be involved in Intercept 0 diversion efforts in a *parens patriae*, or “guardian,” capacity, providing first responder services.

Crisis Lines

- **The Issue:** Jurisdictions often have multiple disconnected access points to behavioral health services through “crisis lines,” including, but not limited to, 211, crisis call centers, mobile crisis lines, and peer support lines. Stratifying calls for service by crisis, emergency, specialized (such as suicide prevention), or other categories can help clarify the demand for services, improve access to appropriate services, and reduce unnecessary utilization of public resources, resulting in a more streamlined, accessible service delivery system.
- **Sample Questions Data Can Answer:** What kinds of behavioral health services are most often requested by callers? During which days and times of the week are the most people seeking services or support? Are certain individuals calling multiple lines repeatedly within the same time frame?
- **Challenges:** Gathering data regarding calls to national call systems, such as the U.S. Department of Veterans Affairs’ Veterans Crisis Line, may not be possible due to the size of the systems; however, efforts should be made to understand the call volume and nature of calls to local call systems. Many communities have several call lines that serve different purposes. It will require coordination and collaboration to bring data from these multiple sources together to create a comprehensive understanding of the services being requested by the community through call lines.
- **Recommended Variables and Measures:**
 - # of crisis and support lines in operation (phone and text)
 - # of calls within a set time frame (e.g., last 6 months), for each line

- Across all calls:
 - Type of caller (family member, law enforcement, self, etc.)
 - Type of call or service requested (need related to mental illness, suicidality, substance use, or detoxification)
 - # of times someone from this location has called the line
 - Day of the week and time of day of call
 - Type of outcome (e.g., referral to emergency service, community provider follow-up scheduled, stabilized with no further follow-up)

Emergency Departments/Hospitals

- **The Issue:** Hospital emergency departments (EDs) are frequently used by individuals seeking care for a wide range of crisis and behavioral health needs. What is often not understood by stakeholders and the community is the impact of individuals presenting at EDs who do not meet the eligibility criteria for admission. Furthermore, many communities serve a population, often known as “high utilizers,” with a strong and costly pattern of ED services use and little to no connection to community-based services and stabilization post-discharge. Identifying and tracking these individuals across systems can enable comprehensive planning to stabilize and appropriately support those frequently accessing the community’s service systems.
- **Sample Questions Data Can Answer:** For individuals presenting at the ED for mental and substance use concerns, what proportions meet and do not meet criteria for hospital admission? What are the most common mental and substance use diagnoses among people presenting at the ED? What proportion of these individuals have health insurance coverage? How often does the hospital reach the full capacity of its psychiatric beds or unit?
- **Challenges:** While some of the recommended variables may be available in hospital electronic records systems, the data may be embedded in regional, statewide, or national databases, and its extraction may require a substantial time commitment from hospital information technology staff and data analysts. Obtaining the needed permissions to extract data for the local area can be a lengthy process, requiring multiple meetings to discuss exact data variables, understand how the data will be used, and gain buy-in from hospital administrators. Hospital electronic medical records (EMRs) may not have the capability to collect information about police involvement, such as officer wait time, or discharge planning, such as warm hand-offs to community-based services. These items may need to be tracked in supplemental reports and databases unless the hospital has the ability to add fields to its EMR system.
- **Recommended Variables and Measures:**
 - # and % of individuals presenting at ED with a primary or secondary diagnosis related to mental or substance use disorders or impairments (specific diagnosis codes may be needed)
 - Across this group:
 - # and % meeting criteria for inpatient admission

- Average and median length of stay in ED and inpatient unit, if admitted
- Insurance, by type (public, private, none, etc.)
- Discharge outcome (including to home, warm hand-off to community provider, to shelter, release prior to being seen, etc.)
- Mode of arrival (e.g., walked in alone, or brought in by car with family, by ambulance, by mobile crisis team, by co-responder team, or by police)
- Wait time for law enforcement, if applicable
- # of individuals who left prior to being evaluated or against medical advice
- # and % of days out of the year when EDs go on “diversion” (i.e., they no longer have capacity to receive patients in crisis or presenting with mental or substance use disorder symptoms)

Crisis Response Centers

- **The Issue:** As an alternative to the ED for lower-acuity crisis or mental health needs, crisis response centers often serve as voluntary, “walk-ins accepted” facilities for people with mental and substance use disorders in need of care but who do not meet the criteria for hospital admission. Crisis response centers include crisis stabilization facilities, 23-hour mental health observation units, and respite centers, which may be peer led. Stakeholders should seek to understand how the center or centers are used, what services are most requested, and ways the center or centers may lessen the demand for services from hospitals, jails, and emergency response.
- **Sample Questions Data Can Answer:** How many people are diverted from jail into community-based crisis services each year? What are the types of services most often requested by individuals presenting at the center (medication management, crisis stabilization, detoxification, etc.)?
- **Challenges:** Capturing information from law enforcement entities during drop off may be challenging as officers likely need to return to street duties promptly. The process of gathering information about the presenting problem, transportation, or wait time should be brief. Further, many crisis centers are voluntary and patients may leave without notice; information on such departures should be tracked and appropriately shared with law enforcement partners to address any problems that arise with voluntary drop-offs.
- **Recommended Variables and Measures:**
 - # of crisis centers, by type (crisis stabilization facility, 23-hour mental health observation unit, respite center, etc.)
 - # of chairs, beds, or spaces per center
 - # of individuals presenting with mental or substance use disorders or impairments; % admitted
 - Across all patients:

- Mode of arrival (e.g., walked in alone, or brought in by car with family, by ambulance, by mobile crisis team, by co-responder team, or by police)
- Wait time for law enforcement
- Average and median length of stay
- Average cost or financial charges associated
- Insurance, by type (public, private, none, etc.)
- Type of presenting issue: % mental illness, % substance use-related, % co-occurring
- Primary service provided (e.g., medication management, crisis stabilization, observation, detoxification)
- Discharge outcome (e.g., release to home, warm hand-off to community provider, referral to case manager, release to shelter, release prior to being seen)

Mobile Crisis Teams

- **The Issue:** Early, informed clinical decision-making by mobile crisis response teams or mental health professionals connected by telehealth can route people in crisis or with mental or substance use disorders to the most appropriate care setting, reduce the number of police transports, improve outcomes, and align services. Stakeholders should understand how mobile crisis or telehealth services are engaged, what primary services are provided, where services are needed, and how mobile crisis may lessen the burden of care shouldered by other community resources.
- **Sample Questions Data Can Answer:** How many people are diverted from a higher level of care or jail by mobile crisis or telehealth services? Where are people with mental and substance use disorders most often requesting services in the community?
- **Challenges:** Most of the recommended variables may be tracked in local mobile crisis team records, law enforcement records, or those of community-based service providers. Some items may need to be added to existing data collection efforts to ensure all relevant information is gathered.
- **Recommended Variables and Measures:**
 - # of individuals served annually
 - Across all individuals:
 - Primary and secondary presenting problem
 - Location of service delivery
 - Primary service provided (e.g., medication management, stabilization)
 - Type of outcome (e.g., stabilized in the community, transported to ED, diverted from jail, arrested and taken to jail)
 - % with repeat service usages in past year

Detox Services

- **The Issue:** Community-based detoxification and withdrawal management services provide a resource to people needing a safe place to sober or initiate services for a mental or substance use disorder. Gathering and integrating data regarding individuals who frequently use detoxification services may improve their stabilization, decrease returns for additional services, increase access to or facilitate warm hand-off to community-based treatment services, and decrease frequency and costs of services. This data can also provide insight into the community’s more critical substance use issues.
- **Sample Questions Data Can Answer:** Do the community’s detoxification services meet the current demand? How does providing detoxification services relieve the burden for services in other facilities, such as hospitals and the jail?
- **Challenges:** While all behavioral health agencies will need to ensure compliance with HIPAA in sharing information, detoxification centers will also need to consider 42 CFR Part 2 in planning and implementing data sharing plans.
- **Recommended Variables and Measures:**
 - # of beds and chairs available, by type of detoxification service (e.g., sobering center, social model, medical, transitional, residential, “wet beds”)
 - # of individuals presenting for detoxification services
 - Across all individuals:
 - Discharge type (e.g., general discharge, admission to hospital)
 - # of times individual was previously seen in the past year

Local Spotlight: Johnson County, Kansas

The My Resource Connection application, created in Johnson County, Kansas, combines data from multiple county-wide databases (from criminal justice and behavioral health) to identify overlapping clients of the different systems. Business associates agreements created the framework allowing partners to access combined de-identified data once staff take appropriate HIPAA training and sign confidentiality agreements. When a user queries the system regarding an individual, an alert informs the user if the individual is a “mutual client,” that is, someone who is served by another agency that sends data to the system. Further information about that person and his or her case manager is also available to facilitate communication and collaboration. The platform has built-in automation to notify people involved in the person’s treatment or case if emergency services or legal encounters occur.

For more information, see <https://icma.org/articles/my-resource-connection-collaborating-client-success>.

INTERCEPT 1: Law Enforcement Calls and Responses

At Intercept 1, law enforcement and other emergency service providers respond to people with mental and substance use disorders who are in crisis in the community. In many jurisdictions, when a person in crisis exhibits illegal behavior, law enforcement officers have the discretion to place the person under arrest or to divert them to treatment or services. Effective diversion at Intercept 1 is supported by trainings, programming, and policies that integrate behavioral health care and law enforcement to enable and promote the diversion of people with mental illness away from arrest and a subsequent jail stay and into community-based services.

Dispatch

- **The Issue:** Dispatchers should be equipped with information and skills to respond efficiently and effectively to behavioral health-related calls. This includes having the capability to identify calls related to behavioral health needs and routing those calls to the appropriate services or responders. Data collection and analysis of calls to dispatch can help stakeholders understand, on a broad level, the types of mental and substance use disorder-related needs impacting the community. This information can also clarify how people are routed from their initial request for help into services or the justice system.
- **Sample Questions Data Can Answer:** What proportion of calls to 911 are related to mental or substance use disorder concerns? What locations generate the most calls for mental health and substance use concerns, and do these locations overlap with areas requesting services from Intercept 0 resources? How often are calls involving someone with a behavioral health need routed to specialized response units (e.g., mobile crisis teams, Crisis Intervention Team [CIT] officers, co-responders)?
- **Challenges:** These data are often contained in computer-aided-dispatch (CAD) systems managed by law enforcement agencies or other regional public safety authorities. These data are not private and may be shared. However, CAD systems may not have separate codes for noting how the call came into the agency (call type) and what happened at the end of the call (disposition codes). To address this challenge, some agencies request that officers or dispatchers update the call type when they “clear the call” and close the incident. Other jurisdictions add additional fields to their CAD or records management systems to capture both pieces of information. In some places, the final disposition of calls must be extracted from the narrative of police reports or emergency medical services (EMS) records after the incident is closed.
- **Recommended Variables and Measures:**
 - # of dispatchers that are CIT trained, by agency
 - # of calls with primary concern related to mental illness or substance use
 - Of those calls:
 - # forwarded to or triaged with a crisis line representative

- # dispatched to a specialized response (e.g., CIT-trained officer, co-responder team, mobile crisis)
- # dispatched to EMS
 - # and % with primary or secondary impression related to mental or substance use disorders or impairments
 - % of each disposition, by type
- # dispatched to law enforcement
 - % of each disposition, by type (e.g., stabilized in community, transported to hospital, referred to community-based services)
- # dispatched to fire department, where applicable
 - % of each disposition, by type (e.g., stabilized in community, transported to hospital, referred to community-based services)
- Locations where calls for service originate

Law Enforcement

- **The Issue:** Law enforcement officers are often the front line responders when community concerns are raised regarding a person who is experiencing a crisis or showing symptoms of a mental or substance use disorder. Specialized responses, such as CIT officers and co-responders, are promising or proven effective, but many jurisdictions lack data to demonstrate or evaluate the impact of those programs at the local level. Further, while calls involving mental health concerns may be tracked, many agencies are less consistent in recording and analyzing data around encounters during patrol that raise mental health or substance use concerns.
- **Sample Questions Data Can Answer:** How many calls or encounters in the field involve someone with a mental health or substance use-related need each year? How much time do officers spend transporting people in crisis to behavioral health services? What are the outcomes when specialized teams versus non-specialized teams respond?
- **Challenges:** Law enforcement agencies typically track all incidents where they take someone into custody, whether transporting to jail, to the ED, or to diversion locations, such as a crisis center. Those reports are contained in records management systems, which may not link to the CAD data. When officers do not take someone into custody, the only record of what happened at the scene may be what is contained in the CAD data. Some agencies require officers to complete separate data collection forms for CIT responses, but these reports are often inconsistently completed or may not link with other agencies' data.

Local Spotlight: Lucas County, Ohio

A web-based data entry portal enables law enforcement to enter and track information about CIT encounters, which may later be analyzed and shared with stakeholders. This tool allows the jurisdiction to better understand the dispositions of CIT calls for service, the general medical conditions of people apprehended, whether or not mental health professionals were on scene, and to where people with mental illness are diverted, such as a local hospital. In the aggregate, this information provides a wealth of insight about the level of need for community-based services, as well as the impact the CIT program is having on reducing bookings of people with mental illness. The jurisdiction also launched a CIT Person Query tool, where CIT officers can quickly search for previous interactions between law enforcement and a person with mental illness.

Dashboard Image 1

Import Suspect Information Add Suspect

Suspect4 SOUP, JOHANNA Suspect3 KONGER, KING Suspect2 UNKNOWN **Suspect1 KERMIT, FROG J**

SUSP# 1 TOT SUSP 4 TYPE Individual UNKNOWN SUSPECT CATEGORY ARRESTEE Warrant Issue CIT Runaway Missing Other

NAME, Last: KERMIT Suffix: First: FROG Middle: J MARITAL STATUS: FBI#: BCI#: JUVENILE

Address Same As Incident Location No Home Address

Street Num Suffix Direction Street, Intersection(+), Place Suffix Unit Type Unit Num City State Zip

PHONE TYPE: CELL PHONE PHONE 1: HOME PHONE PHONE TYPE: HOME PHONE PHONE 2: Email Address: OLN: OLN State: POB: UNKNOWN (US)

DOB: 01/01/1980 AGE: 38 AGE RANGE: 35-39 Report Dt: SSN: 123-45-6789 RID: 55043658 RACE: Black SEX: Male HGT: 500 WGT: 150 HAIR: Bald EYES: Gray

DOMESTIC VIOLENCE: GANG AFFILIATION: ADDITIONAL DESCRIPTIVES: Scars/Marks/Tattoos:

No Injury EMPLOYER: OCCUPATION: PHONE:

Street Num Suffix Direction Street, Intersection(+), Place Suffix Unit Type Unit Num City State Zip

SUSPECTED OF USING: RESIDENT STATUS: STATEMENTS OBTAINED: CHARGES FILED:

ALCOHOL DRUGS COMPUTER NOT REPORTED

SUSP# 1 CIT Officer On Scene Disposition: Hospitalized (injuries) Charges: Diverted to Mental Health System Living Arrangements: Homeless

Mental Health Professional On Scene Transported to Hospital: Flower

Crisis Intervention

Suicidal: NO YES

Condition: Unknown Alcohol use Drug use Taking medication Currently under mental health treatment

Behaviors

Agitated Disorganized speech Belligerent Hallucinations Delusional Paranoid Depressed Anxious/Panic attack Disoriented/Confused Threatening violence

Techniques used on Subject

Verbal de-escalation Physical control Handcuffs Chemical agent Taser Other

Subject Injury

None Injured prior to police contact Injured during police contact Medical treatment for Injury

Officer Injury

NO YES Medical treatment for Injury

Dashboard Image 2

by Person
by Location
by Offense

Report #: 000162-17 **Agency:** NORIS **Occurred From:** 10/5/2017 2:52 PM **Occurred To:** 10/5/2017 2:52 PM **Report Date:** 10/5/2017 2:52 PM

Dispatch #: **Disposition Date:** **Disposition Code:** **Call Location:** E911

Offense Code: 42005 **Offense Description:** INJURED/ENDANGERED ADULT

Available Report Images:
Current Report (Internal Use Only)

CIT Information

CIT Officer On Scene: No	Mental Health Professional On Scene: No	Suicidal: YES
Disposition: Left with third party	Charges: Diverted to Mental Health System	Living Arrangements: Homeless
Subject Injury: Injured prior to police contact	Subject Treatment Sought: YES	Officer Injury: No
Condition: Currently under mental health treatment, Alcohol use	Officer Treatment Sought: YES	

Behaviors:
Agitated, Anxious/Panic attack, Delusional, Disoriented/Confused, Hallucinations

Techniques used on Subject:
Handcuffs, Taser, Verbal de-escalation

Report #	Name	Agency	Occurred	Role	RID/SSN	Age/DOB	Sex	Race
000162-17	SOHO, FRENCH	NORIS	10/05/2017	Suspect		30-34 03/03/1985	F	I
000162-17	LUCAS, LOLA	NORIS	10/05/2017	Victim		21	U	W
000162-17	WALLER, LA NIESHA	NORIS	10/05/2017	Victim		21 05/08/1996	F	B

• Recommended Variables and Measures:

- # and % of officers that are CIT trained, by agency
- # of cases (including calls to law enforcement and encounters in the field by law enforcement) where mental health or substance use is or becomes primary concern
 - Of those calls and encounters:
 - Length of time spent addressing the incident
 - # and % of incidents involving a specialized response (e.g., CIT)
 - # and % of dispositions, by type (arrest, by type of charge; transportation to services by law enforcement; referral to EMS; stabilized in community, etc.)
 - # of total custodial arrests, by type of charge
 - # of total citations and summonses, by type of charge
 - Rate of use of force

INTERCEPT 2: Intake, Booking, and Bond Setting/Review

At Intercept 2, individuals who have been arrested will go through the intake and booking process and will have an initial hearing presided over by a judicial official. Important elements of this intercept include the identification of people with mental and substance use disorders being processed and booked in the jail, placement of people with mental and substance use disorders into community-based treatment after intake or booking at the jail, and availability of specialized mental health caseloads through pretrial service agencies.

Initial Detention

- **The Issue:** Processing arrests and booking people into a jail provides an opportunity to screen them for mental and substance use disorders and assess their need for follow-up services. With the proper tools, processes, and systems in place, defendants may be screened in a timely manner, flagged for follow-up, and supported with necessary programs so that their mental or substance use conditions do not worsen as a result of being detained. Implementing a screening at the arrest processing stage can provide jurisdictions with an understanding of the extent to which people with mental and substance use disorders are interfacing with the local criminal justice system. When linked with booking data, these screening data help stakeholders understand what proportion of detainees in the jail have mental health or substance use needs, requiring evidence-based programming and a more intentional trauma-informed approach than may normally be implemented in jail settings. Finally, when shared with other systems of care, these data are instrumental in linking people with services, new treatments, and existing case managers.
- **Sample Questions Data Can Answer:** How many people in initial detention are screened (using a standardized tool) for mental and substance use disorder-related needs? What proportion of people at intake or booking are flagged as having a history of or currently experiencing mental or substance use disorders?
- **Challenges:** Processing intakes or bookings can take time, and adding screenings for mental or substance use disorders can result in long wait times, straining the capacity of the intake or booking staff and keeping arresting officers from returning to their duties. It is important that brief screenings be used to quickly capture information about an individual's mental and substance use disorder concerns; tools that may be administered by correctional staff as well as clinical staff can increase the expediency of this process. Many screening instruments exist, and it may be difficult to recognize which tools are most appropriate. SAMHSA's publication *Screening and Assessment of Co-occurring Disorders in the Justice System*, available from the [SAMHSA store](#), can provide helpful guidance. Establishing infrastructure to share data gathered through screenings at intake or booking is critical to ensuring this information is used to increase the services or support provided. This level of data integration may require agreements, information technology capacity, and time from staff to ensure information is routed appropriately and acted upon accordingly.

- **Recommended Variables and Measures:**

- Average # of intakes and bookings per day; average # of releases per day
- Type of behavioral health screening conducted (if applicable, specify name of screening tool) and at what point in the intake or booking process
- # of individuals screened for mental or substance use problems upon intake; % screening positive
- # of individuals provided more in-depth assessment for mental or substance use disorders
- # of individuals flagged for follow-up; % provided follow-up mental health- or substance use-related services
- # of persons asked about Veteran status; % by response
- % of Veterans booked into the jail with an identified mental or substance use disorder
- # of persons at intake with no fixed address or address is a shelter

Initial Court Hearing

- **The Issue:** The initial hearings, where probable cause is established and bond is set, are another opportunity to further engage individuals and assess their need for mental health or substance use services. Many court officials at this phase have the discretion to set bonds that allow warm hand-offs to community-based treatment providers, yet those diversions are often not tracked, analyzed for trends, or reported to partnering stakeholders. Thus, opportunities to divert are often not understood and are underutilized. Jurisdictions with pretrial services—conducted through regular or specialized mental health caseloads—often do not understand the impact of pretrial supervision on individuals with mental or substance use disorders.
- **Sample Questions Data Can Answer:** How many people with mental or substance use disorders are released on “time served” for low-level charges at the initial hearing? How many people with mental or substance use needs are diverted at the initial hearings to community-based services?
- **Challenges:** In many jurisdictions, court processes are funded by the state, rather than by local entities that are more familiar with local needs for mental and substance use services. It may be challenging to obtain or integrate data housed in state databases due to the permissions needed, as well as difficulties in extracting and exporting local-level information. Furthermore, not all state court systems collect the data that is needed, which may require local jurisdictions to create their own data collection processes and systems. Diversions may depend on a number of decisions, including choosing to refer the individual to services, to accept referred individuals onto pretrial services caseloads, or to accept referred individuals into community-based services. Stakeholders should gather and integrate data from magistrates or other initial hearing court officials, pretrial services, and community-based organizations to understand the need for and level of diversion at this intercept.

- **Recommended Variables and Measures:**

- # of initial hearings annually for people identified as having a mental or substance use disorder
- Rate of referrals to community-based services, including pretrial services, at initial hearings for this population, by agency initiating or requesting the referral (e.g., magistrate, public defenders' office, prosecutor's office, judge)
- Rate of diversion to community-based services at initial hearings, as indicated by active engagement with service provider, by agency initiating or requesting the diversion (e.g., magistrate, public defenders' office, prosecutor's office, judge)
- Type of pretrial services available and capacity of specialized mental health or substance use pretrial caseloads
 - # of clinicians with specialized caseloads
 - Average monthly caseload

Local Spotlight: Johnson County, Kansas

In 2016, the Johnson County Jail integrated an electronic version of the Brief Jail Mental Health Screen (BJMHS) at the point of booking to identify people with mental illness. Using this data, the county is able to track and analyze the prevalence, length of stay, and recidivism of people with mental illness in the local jail. Additionally, individuals needing follow-up are flagged in a shared electronic database, and follow-up is provided by the county's mental health department either within the jail or in the community if the person is released. For more information, see <https://www.prainc.com/bjmhs-johnson-co-ks/>.

INTERCEPT 3: Courts and Incarceration in Jail or Prison

At Intercept 3, individuals with mental or substance use disorders who have not yet been diverted at previous intercepts may be held in pretrial detention while awaiting disposition of their criminal cases. This intercept centers around diversion of individuals from the jail or prison into programs or services that allow criminal charges to be resolved while also addressing the defendant's mental and substance use disorder needs. The intercept also involves jail- and prison-based programming that supports defendants in a trauma-informed, evidence-based manner during their incarceration.

Courts

- **The Issue:** Courts often have specific dockets or programs for moving individuals with mental or substance use disorders through the system to a final disposition. Often, issues of "competency" are raised during the court process for which specific evaluations and restoration services are required. However, persons found incompetent to stand trial may sometimes decompensate in jails when

evaluations are not conducted in a timely manner and information regarding the defendant's status is not reviewed regularly. Most jurisdictions have treatment courts to address populations with mental disorders, those facing driving while impaired charges, or people with other types of substance use disorders. Yet, many court systems do not fully understand the level of need for these programs, nor do they track outcomes.

- **Sample Questions Data Can Answer:** On average, how long does it take for people to be evaluated when issues of competency are raised? What is the average length of stay in jail for people found not competent before being transferred to treatment? Does the capacity of the treatment courts reflect the need for diversion and services at this intercept?
- **Challenges:** Data collection may not be prioritized when staff members have limited capacity to conduct client supervision, note taking, case management activities, court reporting, and court appearances. Leadership buy-in is critical to ensure that time, technology, and supports are in place to ensure adequate data entry and regular analysis of a treatment court's short- and long-term outcomes.
- **Recommended Variables and Measures:**
 - General:
 - Annual caseload of the court system
 - Caseload processing rate
 - # and % of persons sent for evaluation of competency to stand trial
 - Treatment courts:
 - # of referrals to each treatment court
 - % of referrals accepted into each court
 - Current capacity of each court
 - Rate of successful program completion ("graduation") of each court
 - Rates of recidivism after program completion (define in accordance with National Association of Drug Court Professionals recommendations)

Jail/Prison

- **The Issue:** Jails are the largest de facto mental health facility in many counties, so it is critical that their environments, programs, and processes enable support for people with mental and substance use disorders. Prisons often hold people for more extended periods than jails; it is important that those institutions' programs and processes provide appropriate treatment during incarceration. Data regarding the daily population experiencing mental or substance use disorders, their treatment needs, medications, and services received should be gathered on an ongoing basis. Data from intake, booking, and previous incarcerations should be merged with this information to create a comprehensive understanding of the extent to which the jail or prison is providing behavioral health services for the community and to clarify the need for community-based treatment and follow-up.

- **Sample Questions Data Can Answer:** How many people with mental or substance use needs are in the jail or prison on any given day? What are the most common treatment needs? How often are these treatment needs being met by jail or prison services? How many suicide watches are conducted each year?
- **Challenges:** In many jails, medical services, including behavioral health services, are provided by private, contracted agencies. This can pose challenges in accessing the data, particularly if the agency neither is locally based nor has a vested interest in the local community. Partnerships will need to be forged both with the contracted medical provider agency and with the jail administrator overseeing its contract to ensure that the right data is collected and shared for analysis. Jail leadership should also be engaged to ensure that data is collected regarding other behavioral health programming that is provided apart from the contracted medical provider, such as therapy provided by community-based agencies, etc.
- **Recommended Variables and Measures:**
 - # and % of individuals with a history of or currently experiencing a mental or substance use disorder (either self-reported or confirmed through health records)
 - Average length of incarceration among people with mental illness versus the general population
 - # of individuals connected to supportive services and programming (faith-based groups, employment training, education, etc.)
 - # of suicide watches and # of days the facility is on suicide watch, annually
 - # and % of individuals receiving facility-based behavioral health treatment services
 - # of individuals seeing a psychiatrist
 - # of individuals receiving psychotropic medications
 - # of individuals receiving withdrawal protocol, by type of substance
 - # of individuals placed or continued on medication-assisted treatment
 - Capacity of mental health and substance use treatment staff to provide services

Local Spotlight: Adams County, Colorado

Stakeholders in Adams County, Colorado, created a justice and behavioral health information sharing dashboard and analytics tool that allows for the sharing of information between the jail and the Community Resource Center. Legal agreements, including a project charter, business associate agreements, and management control agreements were put into place to enable this collaboration. As a result, jail custody and behavioral health diagnostic information can be merged and analyzed. To experience a demonstration of the dashboard and analytics tool, please follow the links below:

- <http://demo.ojbc.org/saiku-ui/>
- <http://demo.ojbc.org/ocpu/library/DemoJailBookingDashboard/www/index.html>

INTERCEPT 4: Reentry

At Intercept 4, individuals transition from detention or incarceration in a jail or prison back to the community. This intercept requires transition planning with specific considerations to ensure people with mental and substance use disorders can access and utilize medication and psychosocial treatment, housing, healthcare coverage, and services from the moment of release and throughout their reentry back into the community.

Reentry

- **The Issue:** Planning for reentry begins upon entry into jail or prison, with validated screening and assessment tools used to identify the risks and needs associated with people planning to reenter the community, to shape services delivered to them while in custody, and to inform their transition following release. Effective planning and transition back to the community may require data sharing at different points in the criminal justice process and from numerous partners, such as the release pod, mental and substance use treatment providers inside the jail or prison, reentry case managers, and community-based organizations.
- **Sample Questions Data Can Answer:** How many people with mental or substance use disorders are released with adequate medications or prescriptions to last until their first appointment with a medical provider? What proportion are released with a follow-up appointment already scheduled with a primary care, mental health, or substance use treatment provider?
- **Challenges:** Many jails do not have the processes or procedures in place to ensure data are gathered or integrated at the reentry phase. If data are gathered, they may be captured by different staff depending on their roles, including reentry case managers, psychiatrists, correctional officers in the release pod, court officials, pretrial services staff, or others, depending on the processes of the jail or prison. It will be important to ensure that a mechanism for gathering, combining, and analyzing the data is in place in order to develop a coordinated approach and produce a complete understanding of reentry service outcomes.
- **Recommended Variables and Measures:**
 - # and % of persons receiving assessment(s) to shape reentry plan
 - # and % of persons with mental or substance use disorders released annually
 - # and % of persons released with psychotropic medications
 - # of days of psychotropic medication or prescription coverage in possession upon release
 - Average # of days between release and contact with community-based prescribing treatment provider
 - # of persons discharged to homelessness, a shelter, or unknown address
 - # of persons released with health insurance coverage (reactivated Medicaid, private insurance, etc.)
 - Rate of linkage to reentry services
 - Rate of recidivism after release

Local Spotlight: Camden Coalition of Healthcare Providers' Camden RESET, New Jersey

In collaboration with the Camden County Re-Entry Committee, the Camden Coalition of Healthcare Providers' Re-Entering Society with Effective Tools (RESET) program leverages data to serve people reentering the community. Potential participants are identified through a database—using integrated real-time data from jails and hospitals—that sorts local residents based on their history of admission to jail, the hospital, or the ED. Participants are enrolled into the program at the Camden County jail, where an interdisciplinary team of nurses, social workers, and community health workers creates patient-centered care plans to support the individuals in attaining medical and social wellness goals. The plans are continued as the person transitions from the jail to the community. Both the Camden Coalition Health Information Exchange and the Homeless Management Information System help to coordinate care, increase information sharing, and reduce duplication of efforts across the multiple systems involved in individuals' recovery.

INTERCEPT 5: Community Corrections

At Intercept 5, community corrections agencies (also called probation and parole) provide essential community-based supervision, as an arm of the court, to individuals released to the community. People with mental and substance use disorders may be at risk for probation or parole violations and benefit from added supports at this intercept. Use of validated assessment tools, staff training on mental and substance use disorders, and responsive services, such as specialized caseloads, are vital to reducing unnecessary violations, decreasing criminal re-offense, and improving behavioral health outcomes, through enhanced connections to services and coordination of behavioral health treatment and criminal justice supervision goals.

Community Corrections

- **The Issue:** By the time a person is placed under community corrections, it is possible they have already provided a wealth of information to and completed numerous assessments conducted by other justice system partners or behavioral health providers. It is essential to link this information, as appropriate, to ensure community corrections officers are equipped with the information needed to develop effective supervision plans. Other community-based programs with meaningful information could include medication-assisted treatment, assisted outpatient treatment, individualized employment programs, housing-first programs, and other recovery supports. On a systems level, stakeholders should understand the local level of need or demand for specialized responses, such as specialized mental health or substance use caseloads, to improve behavioral health outcomes and reduce further justice involvement of people with mental or substance use disorders under community supervision.
- **Sample Questions Data Can Answer:** How many people under community corrections' oversight have a mental or substance use disorder? What are the main reasons for revocations among people

with mental or substance use disorders? Are community corrections officers with specialized caseloads more effective at reducing rates of revocation?

- **Challenges:** Due to privacy constraints, it can be challenging for community corrections officers to track whether someone is accessing treatment offerings. As covered entities, behavioral health treatment providers may not share information with community corrections without authorization. To address this limitation, some courts have made this authorization a condition of release; other community corrections agencies seek to gain consent from people under supervision to access information from providers.
- **Recommended Variables and Measures:**
 - # and % of persons being served by community corrections with identified mental or substance use disorders
 - # of community corrections officers (both with and without specialized caseloads)
 - # of hours of mental health and substance use training of community corrections officers (both with and without specialized caseloads)
 - Average monthly caseload of community corrections officers (both with and without specialized caseloads)
 - Rate of revocations, by reason
 - Rate of revocations of individuals with mental illness, by reason

Local Spotlight: Denver, Colorado

The Division of Community Corrections, through contracts with community-based organizations, gathers data on mental and substance use disorders among people under community corrections oversight. This information is used to match services to each individual's needs and, as necessary, to flag people requiring further evaluations. The data is entered into a state database; however, local stakeholders can pull information specific to their jurisdiction. The information is shared through an annual report to support the Community Corrections Board in placement decisions and to educate local providers on the importance of timely services that match each individual's needs.

Across All Intercepts: Housing

- **The Issue:** Many people with mental or substance use disorders and experiencing homelessness are often channeled into the justice system. Having data systems that share information about a person's housing status may inform the decisions made by law enforcement officers in the streets, reentry coordinators in the jails or prisons, and community corrections officers. This requires coordination across housing providers, justice system agencies, and local housing coalitions.

- **Sample Questions Data Can Answer:** Do community housing resources meet the need for housing people with mental or substance use disorders and justice involvement?
- **Challenges:** A centralized database tracking housing information in the community may not be available; where it is available, the use of different identifiers may limit stakeholders' abilities to link individuals across systems. In many communities, housing partners are not yet included in strategic planning to improve the behavioral health service continuum.
- **Recommended Variables and Measures:**
 - # of units available, by housing type
 - Average wait time on housing program lists
 - # of persons experiencing homelessness with self-reported or confirmed mental or substance use disorders
 - # of persons under criminal justice supervision who are experiencing homelessness
 - # of persons housed, by payment type
 - Average tenure in public housing for persons with mental and substance use disorders versus those without

Across All Intercepts: Diagnosis

- **The Issue:** Jurisdictions that are able to gather and share diagnosis data can more effectively create a comprehensive system of care across the healthcare and criminal justice sectors. Understanding the specific types of mental and substance use disorders that are impacting the community can increase the effective allocation of local and state funds to critical treatment and diversion programs.
- **Sample Questions Data Can Answer:** What are common diagnoses driving referrals to the mental health court or drug treatment court? What are the most common diagnoses of incarcerated individuals in the jail or prison? What are the diagnoses most frequently associated with probation or parole revocations?
- **Challenges:** Due to confidentiality and privacy laws, it may not always be possible or legal to share an individual's diagnosis with criminal justice partners. Some communities may need to create arrangements to ensure that diagnoses data can be shared in the aggregate without the risk of identifying individuals receiving treatment. These arrangements may require substantial commitments of staff time and clear data sharing agreements.
- **Recommended Variables and/or Measures:**
 - # and % of individuals presenting with a primary or secondary diagnosis related to mental or substance use disorders or impairments (specific diagnosis codes may be needed)

Local Spotlight: Boone County, Missouri

Through a grant from the Corporation for Supportive Housing, this jurisdiction is creating a data integration tool that will integrate homelessness and criminal justice data and produce matched lists of frequent users of the homelessness and criminal justice systems. Since the individuals booked into the local jail are administered a mental health screen, information regarding mental disorders will be available to merge with data on homelessness, enabling the jurisdiction to have a more complete picture of what services and supports are needed for people utilizing system resources at high rates.

Substance Abuse and Mental Health Services Administration. (2019, August).
Data Collection Across the Sequential Intercept Model (SIM): Essential
Measures. PEP19-SIM-DATA.

As part of its coursework, Quantum Units Education uses the above-referenced article published by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). HHS and SAMHSA have no affiliation with Quantum Units Education and have not endorsed Quantum Units Education's course or business in any way.

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