

Sequential Intercept Mapping for Clinicians

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Sequential Intercept Model Mapping

- 1 Collaborate Across Systems**
- 2 Map the Local System**
- 3 Agree on Priorities**
- 4 Develop an Action Plan**

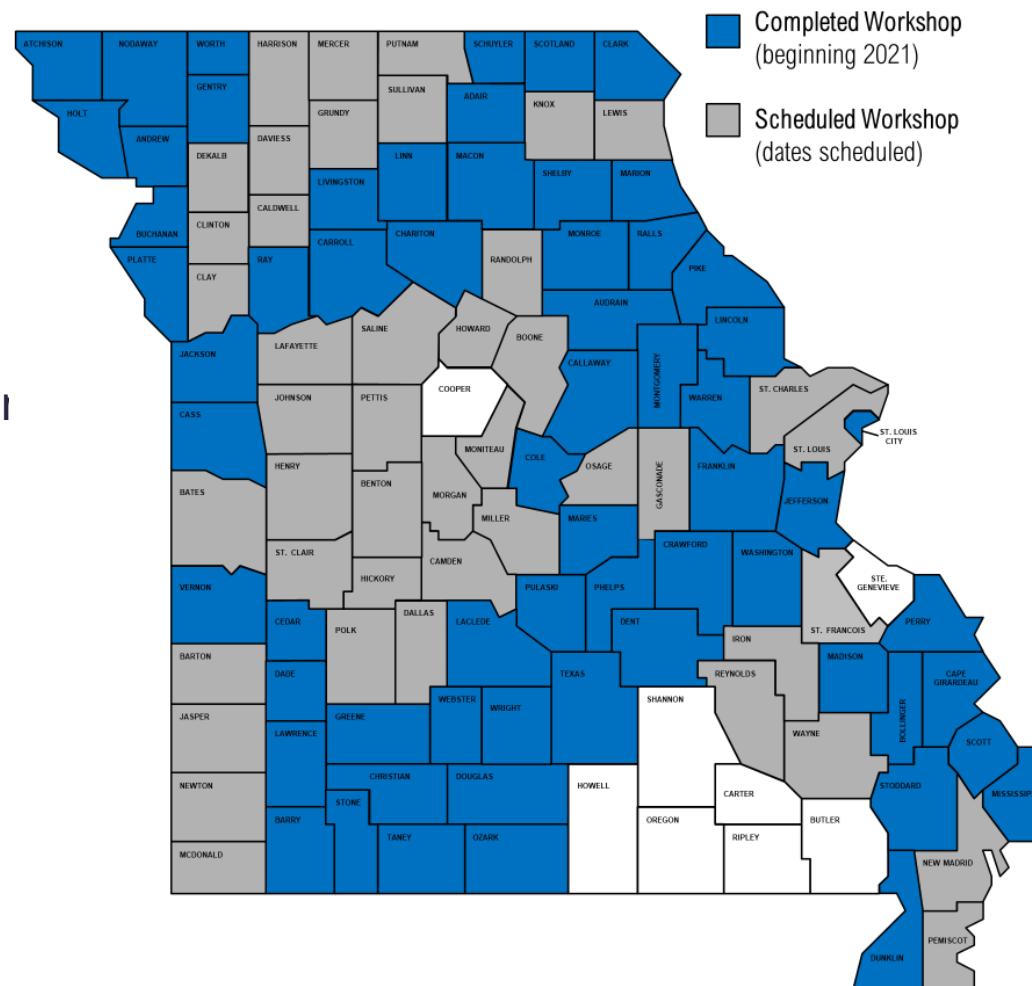
Background from Missouri's SIM Project

KC RAFFERTY

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Sequential Intercept Model (SIM)
Mapping Workshops
Statewide SIM Collaboration Project

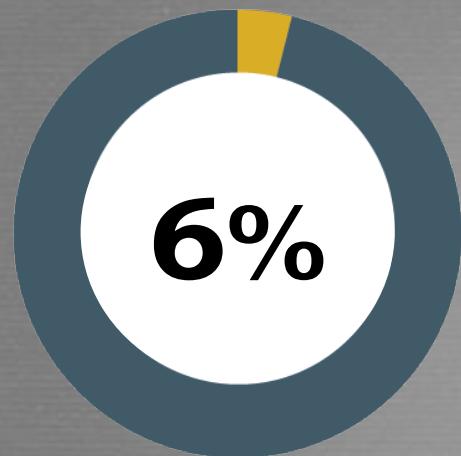


Evolution of the Sequential Intercept Model

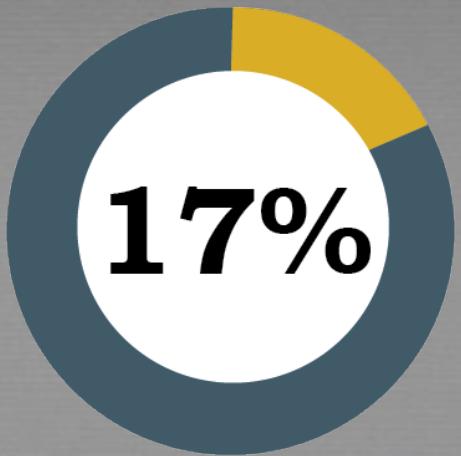




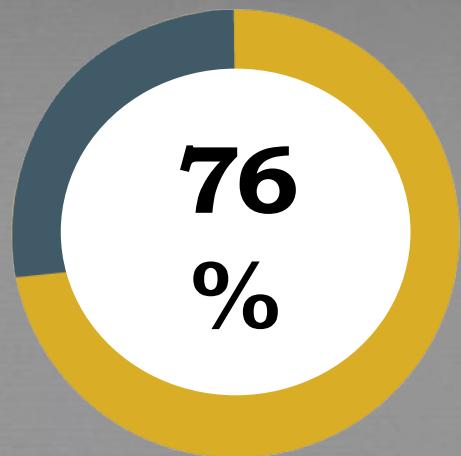
Jails and Mental Disorders



of the general population have SMI



of those in jail have SMI



of those in jail with SMI have a co-occurring disorder

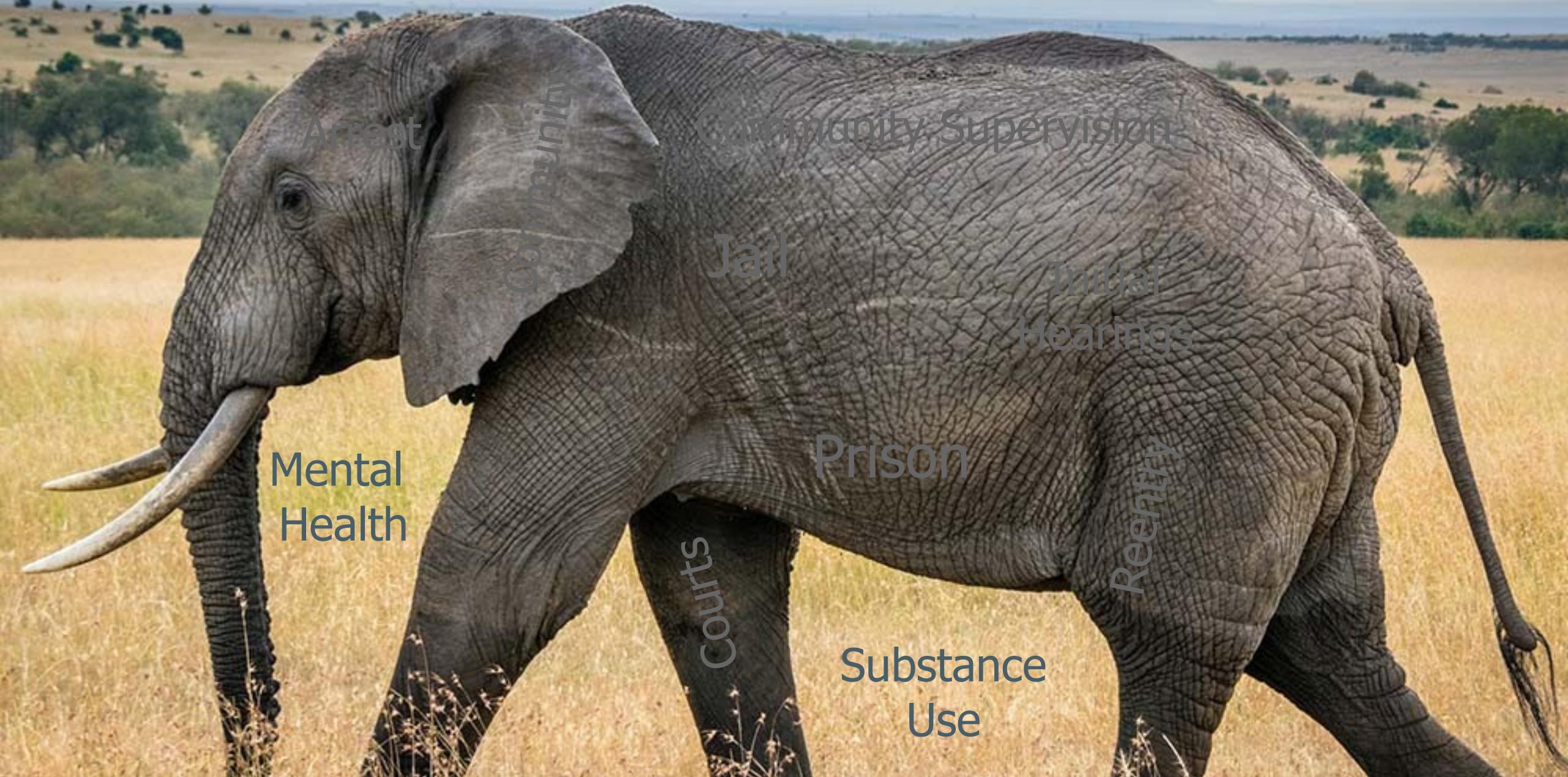
National Survey of Drug Use and Health, 2021; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1990

Teplin, Abram, & McClelland, 1996; Abram, Teplin, & McClelland, 2003

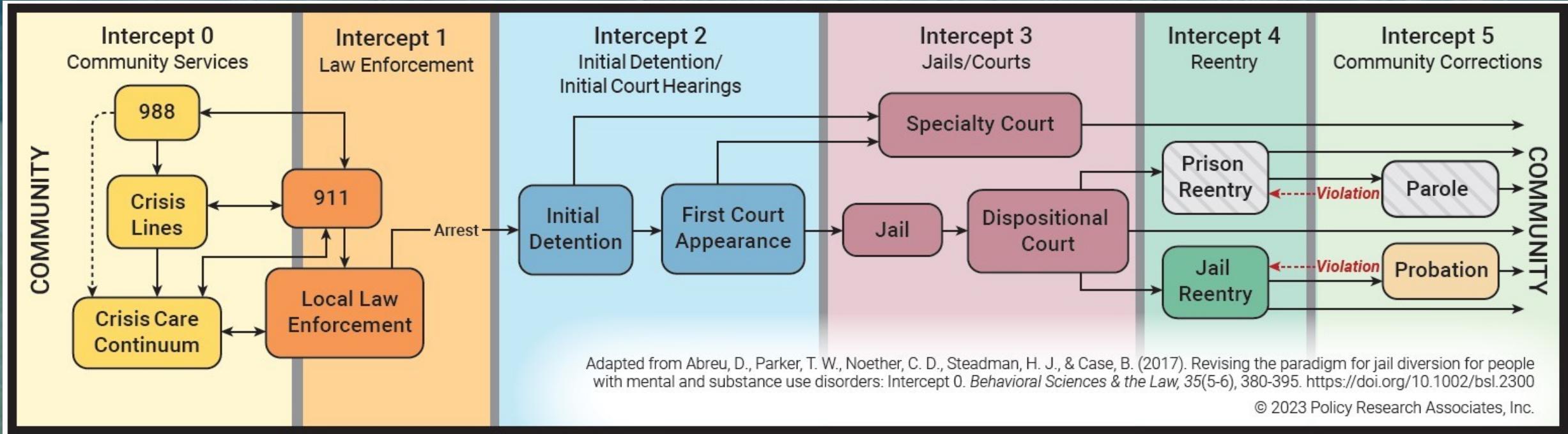
Origins of the SIM

- Many challenges for behavioral health and criminal justice systems, especially in finding ways to collaborate effectively to address this issue
 - Multiple Complex Problems and Multiple Complex Systems (complex solutions)
 - Community problem: No single system is responsible

The “Unsequential” Model



Sequential Intercept Model



Munetz & Griffin, 2006; Abreu, Parker, Noether, Steadman, & Case, 2017; PRA, 2019

The Sequential Intercept Model

Mark Munetz and Patty Griffin with Hank Steadman

Sequential: People move through criminal justice system in predictable ways

Intercept: Envisions a series of points of interception to prevent individuals from entering or penetrating deeper into the criminal justice system

- Ensure:
 - Prompt access to treatment
 - Opportunities for diversion
 - Timely movement through criminal justice system
 - Linkage to community resources

Conceptual Framework

- A conceptual framework for communities
- For considering interface between criminal justice and behavioral health systems
- An organizing tool

Munetz & Griffin 2006; Abreu, Parker, Noether, Steadman, & Case, 2017; Griffin, et al. eds. 2015

work

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WILEY

SPECIAL ISSUE ARTICLE

Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0

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A conceptual model for community-based strategic planning to address the criminalization of adults with mental and substance use disorders, the Sequential Intercept Model has provided jurisdictions with a framework that overcomes traditional boundaries

Use of the Sequential Intercept as an Approach to Decriminalization of People With Serious Mental Illness

Mark R. Munetz, M.D.
Patricia A. Griffin, Ph.D.

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention; jail; interim, pretrial, jail, court, forensic, psychiatric, pretrial, hospital commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. (*Psychiatric Services* 57:544–549, 2006)

Over the past several years, Summit County (greater Akron), Ohio has been working to address the problem of overrepresentation, or "criminalization," of people with mental illness in the local criminal justice system (1,2). As part of that effort, the Summit County Alcohol, Drug, Addiction, and Mental Health Services Board obtained technical assistance consultation from the National GAINS Center for People with Co-occurring Disorders in the Justice System. From that collaboration, a conceptual model based on

public health principles has emerged to address the interface between the criminal justice and mental health systems. We believe that this model—Sequential Intercept Model—can help other localities systematically develop initiatives to reduce the criminalization of people with mental illness in their community.

The Sequential Intercept Model: ideals and description

We start with the ideal that people with mental disorders should not "penetrate" the criminal justice sys-

tem at a greater point in the mental health system than necessary. Although this makes it difficult to implement, it is a conceptual model that can be used to identify points of intervention that are most effective. For example, one who commits a violent crime and is mentally ill should be accounted for at the earliest point of contact with mental health services, rather than at the point of arrest or if they are hospitalized or if their illness causes them to ag-

With both abilities in mind, the "points of intervention" for individuals with mental illness in the criminal justice system are as follows. Each point can be considered a "filter" that will either allow or disallow entry into the criminal justice system. The filters will be porous. Few will be intercepted early, and more people with mental illness will move through all levels of the criminal justice system. As systems and collaboration develop, the filter will become more

Behav Sci Law 2017;17:1–16.

Dr. Munetz is chief clinical officer of the Summit County Alcohol, Drug Addiction, and Mental Health Services Board, 100 West Cedar Street, Suite 300, Akron, Ohio 44307 (e-mail: munetz@summitcountyo.org). He is also affiliated with the department of psychiatry at Northeast Ohio Universities College of Medicine in Rootstown. Dr. Griffin is senior consultant for the National GAINS Center for People with Co-occurring Disorders in the Justice System and the Philadelphia Department of Behavioral Health.

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DOI

THE SEQUENTIAL INTERCEPT MODEL AND CRIMINAL JUSTICE

Promoting Community Alternatives For
Individuals with Serious Mental Illness

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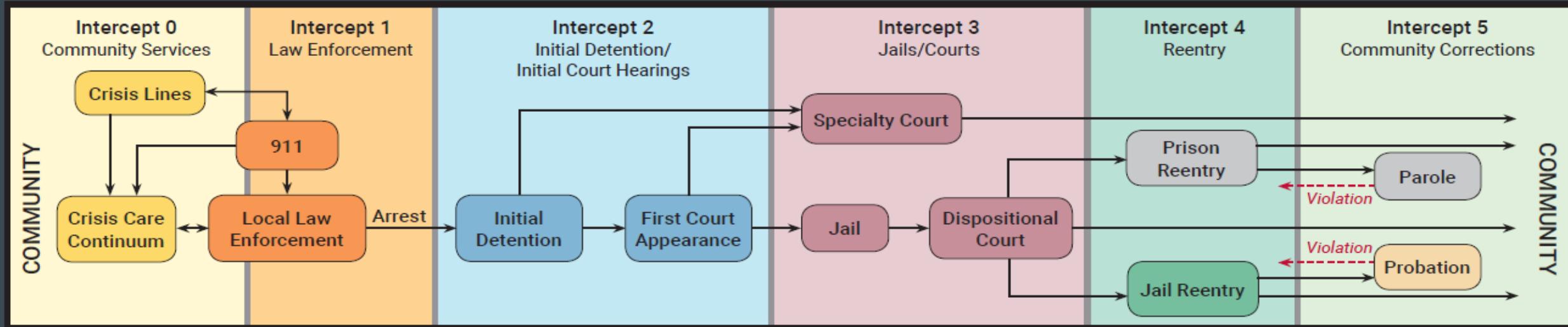
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Today: Six Intercepts

0. Community crisis services
1. Law enforcement
2. Booking/Initial court hearings/Pretrial
3. Jails/Courts
4. Reentry
5. Community corrections/Community support



The Sequential Intercept Model



Key Issues at Each Intercept

Intercept 0

Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a behavioral health crisis or co-respond to a police encounter.

Emergency Department diversion. Emergency Department (ED) diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis.

Police-friendly crisis services. Police officers can bring people in crisis to locations other than jail or the ED, such as stabilization units, walk-in services, or respite.

Intercept 1

Dispatcher training. Dispatchers can identify behavioral health crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.

Specialized police responses. Police officers can learn how to interact with individuals experiencing a behavioral health crisis and build partnerships between law enforcement and the community.

Intervening with super-utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce super-utilizers of 911 and ED services through specialized responses.

Intercept 2

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.

Data matching initiatives between the jail and community-based behavioral health providers.

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.

Intercept 3

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.

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.

Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.

Intercept 4

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.

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.

Warm hand-offs from corrections to providers increases engagement in services. Case managers that pick an individual up and transport them directly to services will increase positive outcomes.

Intercept 5

Specialized community supervision caseloads of people with mental disorders.

Medication-assisted treatment for substance use disorders. Medication-assisted treatment approaches can reduce relapse episodes and overdoses among individuals returning from detention.

Access to recovery supports, benefits, housing, and competitive employment. Housing and employment are as important to justice-involved individuals as access to behavioral health services. Removing criminal justice-specific barriers to access is critical.

Best Practices Across the Intercepts



Cross-systems collaboration and coordination of initiatives. Coordinating bodies improve outcomes through the development of community buy-in, identification of priorities and funding streams, and as an accountability mechanism.



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 instruments and follow-up assessment as warranted.



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.



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.



Information-sharing and performance measurement among behavioral health, criminal justice, and housing/homelessness providers. Information-sharing practices can assist communities in identifying super-utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.

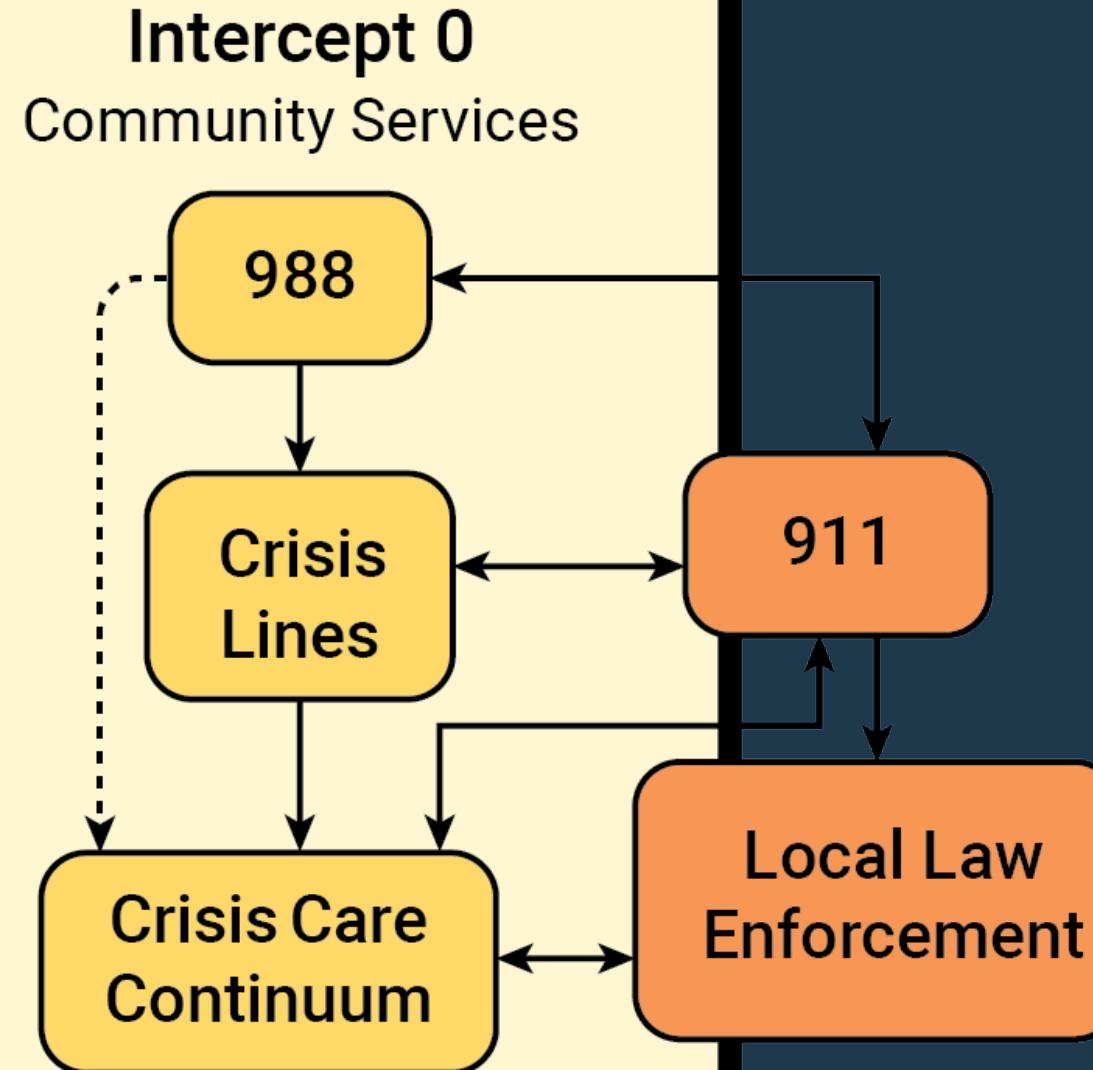


Review of Intercepts

Intercept 0

Community Services

COMMUNITY



Crisis to Stabilization Care Continuum

- 911-988 Integration
- Mobile Crisis Outreach/Police co-response
- 24/7 Walk-in/Urgent Care w/connectivity
- ER Diversion and Peer Support/Navigators
- Crisis Stabilization – 16 beds, 23 hours-5 days
- Crisis Residential – 18 beds, 10-14 days
- Crisis Respite – Apartment-style 30 days
- Transitional Residential – Apartment-style 90 days
- Peer Respite Residential
- Critical Time Intervention: up to 9 months



Intercept 0 Deep Dive

Mecklenburg County (Charlotte), NC (2016)

PRE-CRISIS (PREVENTIVE)	CRISIS, NOT EMERGENCY	EMERGENCY	POST-CRISIS OR EMERGENCY
<p>National Alliance on Mental Illness Family and consumer education, resource information, and advocacy</p> <p>Monarch Walk-in Clinic Evaluations, medication management, therapy</p> <p>Anuvia Prevention and Recovery Center Detox Services 24/7/365 Social Detox</p> <p>Amara Wellness Walk-in Clinic Evaluations, medication management, therapy</p> <p>Promise Resource Network Recovery Hub</p> <p>Urban Ministry Homeless diversion w/street outreach</p> <p>Charlotte Community Based Outpatient Clinic Charlotte Health Care Clinic For Veterans Individual, group, family counseling</p> <p>Charlotte Vet Center Range of social and psychological services</p>	<p>Davidson LifeLine Crisis hotline, training</p> <p>National Alliance on Mental Illness Family/consumer education, resource recommendations, advocacy Family/consumer support thru crisis</p> <p>Cardinal Innovations Call Center Crisis referral/info 24/7/365</p> <p>Mobile CriSys 24/7/365 Assess, triage, refer</p> <p>Monarch Walk-in Clinic Evaluations, medication management, therapy</p> <p>Amara Wellness Walk-in Clinic Evaluations, medication management, therapy</p> <p>Anuvia Prevention and Recovery Center Detox Services 24/7/365 Social Detox</p>	<p>911 Dispatch Over 100 Telecommunicators 16-hr Crisis Intervention Team (CIT) training</p> <p>Cardinal Innovations Call Center Crisis referral/info 24/7/365</p> <p>MEDIC 24/7/365 Assess, triage, transport</p> <p>Carolinas Healthcare System Behavioral Health – Charlotte 24/7/365 Psychiatric Emergency Department Inpatient unit Observation unit</p> <p>Behavioral Health – Davidson Psychiatric hospital</p> <p>Presbyterian Hospital Acute Care Emergency Department Behavioral health beds Child/adolescents unit</p> <p>Central Regional Hospital Broughton Hospital</p>	<p>National Alliance on Mental Illness Family and consumer education, resource info, and advocacy Support groups Recommendations for on-going recovery support</p> <p>Promise Resource Network Recovery Hub Peer support transition from inpatient setting</p> <p>Peer Bridger Program Transition from Hospital and Jail Peer support transition from inpatient setting</p> <p>HopeWay Residential treatment Day treatment Two transitional living centers</p> <p>Charlotte Community Based Outpatient Clinic Charlotte Health Care Clinic For Veterans Individual, group, family counseling</p> <p>Mecklenburg County Reentry Services For Formerly Incarcerated Individuals Housing, employment, educational support; refer to mental health/substance abuse provider for appointments</p>

Recovery Advocacy

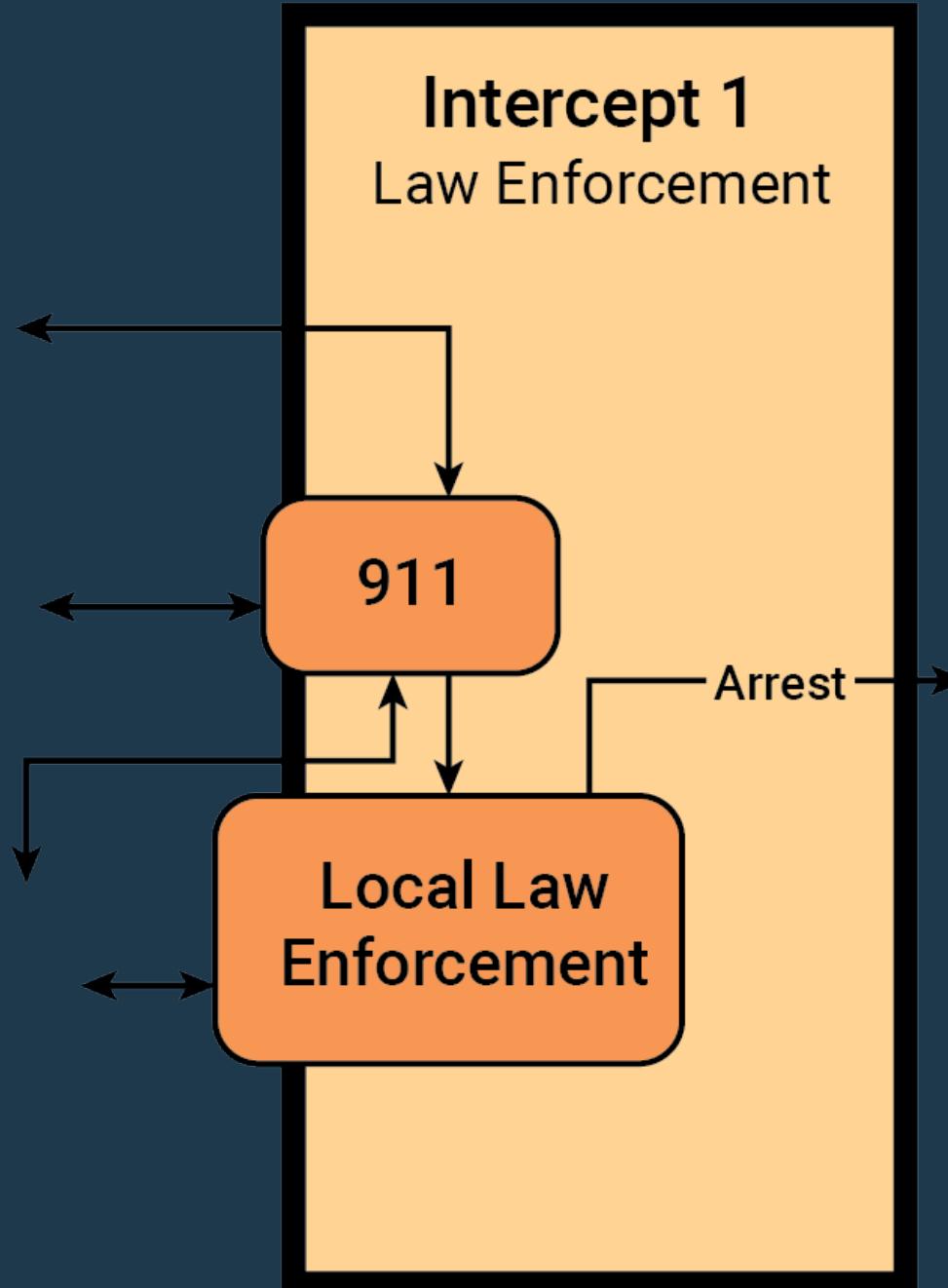
Promise Resource Network; Mental Health America; National Alliance on Mental Illness

Unifying Principles of a Crisis System

1. Timely
2. Safe
3. Accessible
4. Least restrictive setting
5. Reduce justice system contact
6. Minimized emergency department boarding
7. Connect people to services and coverage
8. Person- and family-centered
9. Meeting the complex needs of patients

Intercept 1

Law Enforcement



Law Enforcement and Emergency Services Models

- Crisis Intervention Teams (CIT)
 - Community partnership
 - 40-hour training
 - Accessible, responsive crisis care system
- Co-Responder Model
 - Mental health professionals employed by, or working along side police department
- Mobile Crisis Teams
- Off-site Support
 - Telephone support to on-scene officers
 - Video-based virtual crisis response to on-scene officers
- Specialized EMS Response
 - EMS co-response with mental health clinicians and law enforcement or specially training EMS

Crisis Intervention Team (CIT)

- **40-hour training program** of police-based first responder crisis intervention
 - Understanding behavioral health, developing empathy, navigating community resources, de-escalation skills, practical application
- Bridges gap between police response and behavioral health care by **forming community partnerships**
- **Core components:** community collaboration, accessible crisis system, training for law enforcement/first responders, behavioral health staff training, family/peer/advocate participation
- **Benefits** may include reduced use of force, officer/citizen injuries, increased officer confidence in skills, reduced unnecessary arrests, reduced wrongful death suits

Developed in 1988 by the Memphis Police Department in conjunction with the University of Memphis and the local chapter of National Alliance for Mental Illness

Essential Elements for Police Diversion

- Central drop off
 - Co-location with SUD services
- Police-friendly policies
 - No refusal policy
 - Streamlined intake
- Consider legal foundation
 - Criminal/civil codes
 - LE transport statutes
- Cross-training
 - Ridealongs
- Post-crisis community linkages
 - Case management
 - Care coordination
 - Co-response or warm hand-off
 - Post-crisis stabilization and follow-up services

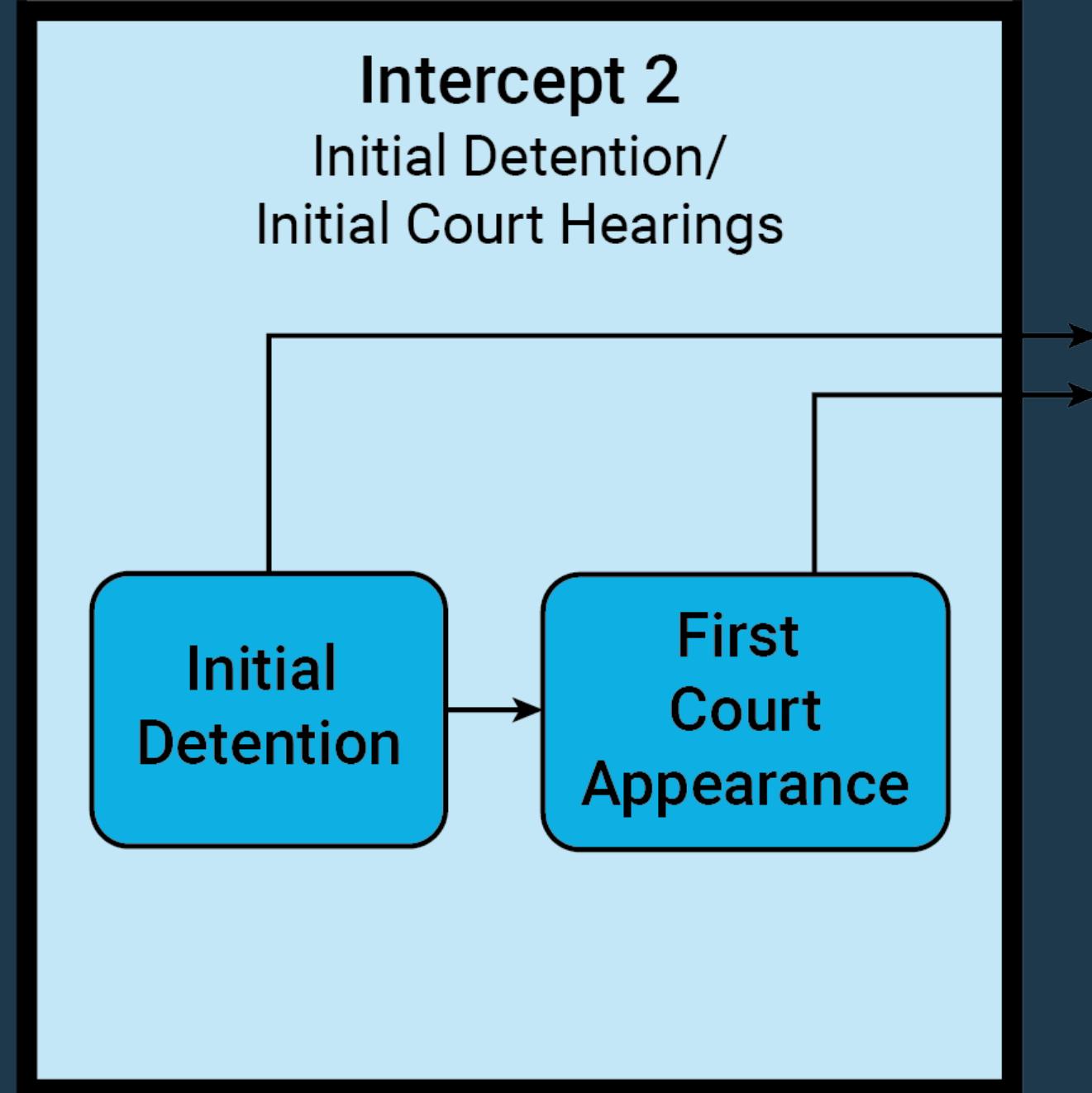
Targeted Diversion for Nuanced Populations

- Law Enforcement Assisted Diversion (LEAD)
 - Low-level drug offenses (Seattle)
 - Police Assisted Addiction and Recovery Initiative (PAARI)
- Human Trafficking Diversion
 - Prostitution
 - Drug/Opioid Diversion
 - Homelessness Diversion

Common Gaps at Intercepts 0 and 1

- Lack of Crisis Stabilization Units and continuum of crisis services, including detox
- Lack of sufficient Mobile Crisis Response
- Lack of MH or CIT training for 911 Dispatch
- Lack of planning for 988 implementation

Intercept 2
Initial Detention/
Initial Court Hearings/
Pre-trial



Bail Reform

- Many people detained pretrial due to inability to pay
- People with MI are less likely to make bail & remain in jail longer before bail (48 days vs. 9 days) (CSG, 2012 & 2015)
- Strategies:
 - Eliminate cash bail for low-level charges
 - Expand unsecured bond or use nonfinancial conditions
 - Use pretrial supervised release with unbiased risk assessment tools
 - Send court date text reminders to reduce FTAs
- NJ and Washington, DC: *rates of appearance and rearrest are similar or better than before bail reform*
(NJ Courts, 2018 and Harvard Law School, 2020)
- LA County: Mental health misdemeanor detention rate 10x general population detention rate.

Identification and Referral

Systems

Law enforcement

Pretrial services

Booking officers

Jail medical staff

Prosecutors

Public defenders

Judges

Strategies

Law enforcement observations

Validated risk-based screening/assessment

Identification and classification

Medical/BH current & future needs

Charging and initial diversion options

Identify potential options

Weighing risk and options

Goal:

Balancing public safety, personal rights, and appropriate use of jail

Brief Jail Mental Health Screen

- 3 minutes at booking by corrections officer
- 8 yes/no questions
- General, not specific mental illness
- Referral rate: 11%
 - Correctly classified 73% of men
 - Correctly classified 61% of women

BRIEF JAIL MENTAL HEALTH SCREEN				
Section 1				
Name: _____ First _____ MI _____ Last _____	Detainee #: _____	Date: _____ / _____ / _____	Time: _____	AM _____ PM _____
Section 2				
Questions	No	Yes	General Comments	
1. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?				
2. Do you currently feel that other people know your thoughts and can read your mind?				
3. Have you currently lost or gained as much as two pounds a week for several weeks without even trying?				
4. Have you or your family or friends noticed that you are currently much more active than you usually are?				
5. Do you currently feel like you have to talk or move more slowly than you usually do?				
6. Have there currently been a few weeks when you felt like you were useless or sinful?				
7. Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?				
8. Have you ever been in a hospital for emotional or mental health problems?				
Section 3 (Optional)				
Officer's Comments/Impressions (check all that apply):				
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Under the influence of drugs/alcohol	<input type="checkbox"/> Non-cooperative		
<input type="checkbox"/> Difficulty understanding questions	<input type="checkbox"/> Other, specify: _____			
Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered: <ul style="list-style-type: none">• YES to item 7; OR• YES to item 8; OR• YES to at least 2 of items 1 through 6; OR• If you feel it is necessary for any other reason				
<input type="checkbox"/> Not Referred				
<input type="checkbox"/> Referred on _____ / _____ / _____ to _____				
Person completing screen _____				

INSTRUCTIONS ON REVERSE

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COMPETENCE TO STAND TRIAL (CST)



HOSPITAL



JAIL.



COMMUNITY



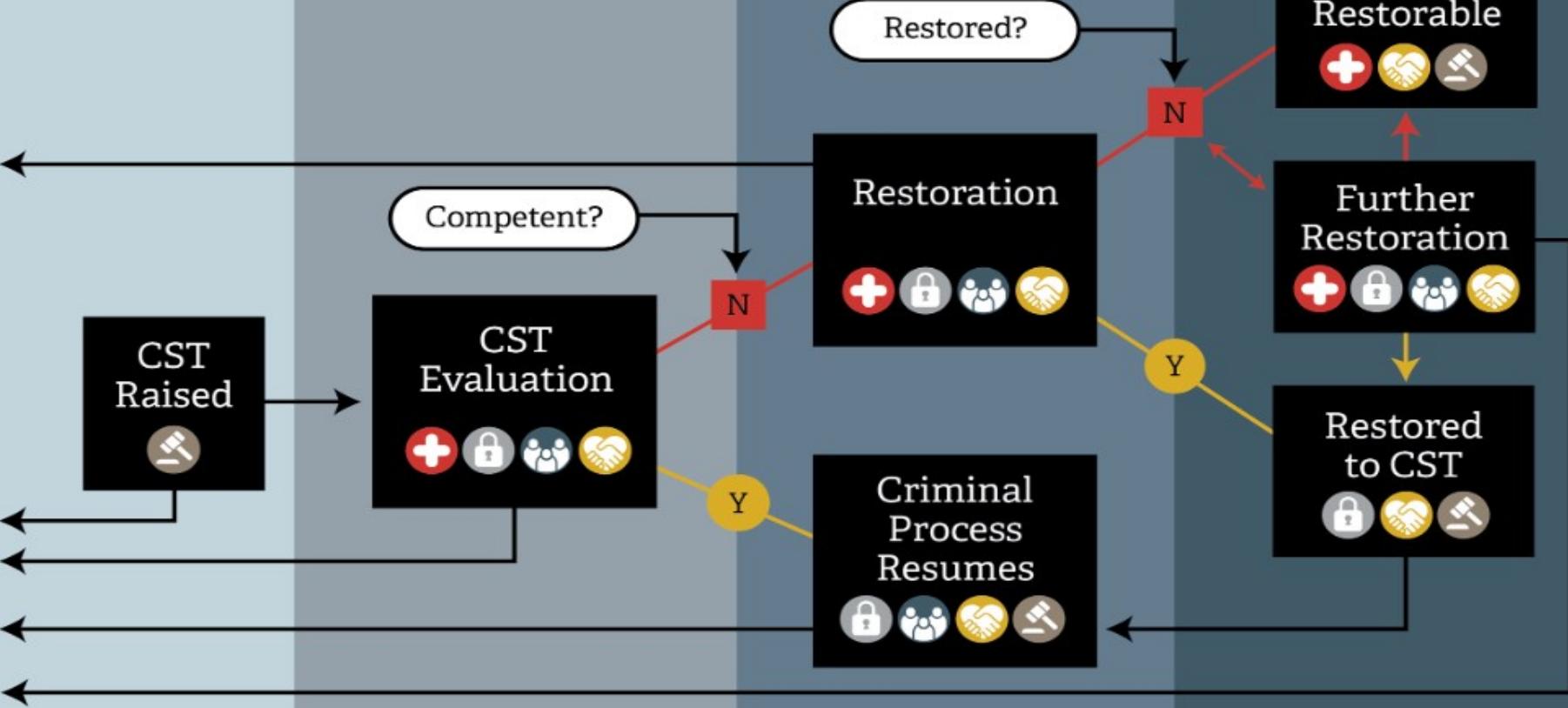
SUPPORT



COURT

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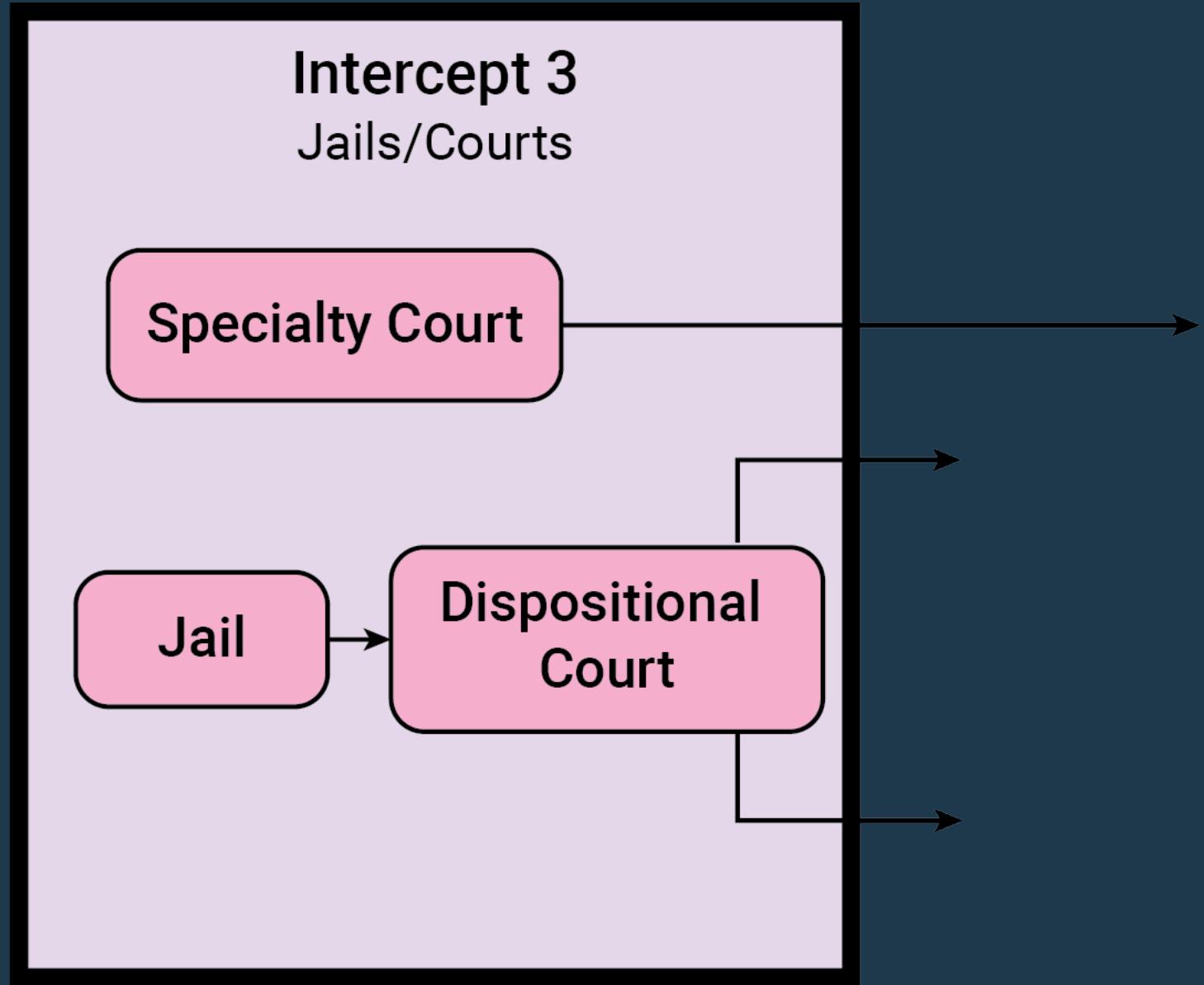
DIVERSION



Common Gaps at Intercept 2

- Lack of diversion opportunities
- Lack of specialized supervision for people with mental disorders on pretrial supervision
- Lack of multiple mental health screening strategies

Intercept 3 Jails/Courts



Jails and Courts



Medication-assisted Treatment (MAT)

FDA-approved Medication for Substance Use Treatment and Tobacco Cessation

Medications for Alcohol Dependence

Naltrexone (ReVia®, Vivitrol®, Depade®)
Disulfiram (Antabuse®)
Acamprosate Calcium (Campral®)

Medications for Opioid Dependence

Methadone
Buprenorphine (Suboxone®, Subutex®, and Zubsolv®)
Naltrexone (ReVia®, Vivitrol®, Depade®)

Medications for Smoking Cessation

Varenicline (Chantix®)
Bupropion (Zyban® and Wellbutrin®)
Nicotine Replacement Therapy (NRT)

Using Criminal Charges as Treatment Leverage

- Pre-plea: diversion to services in lieu of further case processing
- Post-plea: deferred or modified sentence, often to treatment court
- Probation-Based: conviction with treatment as a term of probation



Common Gaps at Intercept 3

- Jails
 - Lack of screening for veterans/military service
 - Medication continuity/off-formulary medication
 - Insufficient data about the SMI population with the jail census
- Courts
 - Over reliance on treatment courts
 - Treatment courts limited to post-conviction models
 - Only misdemeanor or only felony models
 - Co-occurring disorders not understood

Intercept 4 Reentry

Intercept 4 Reentry

Prison
Reentry

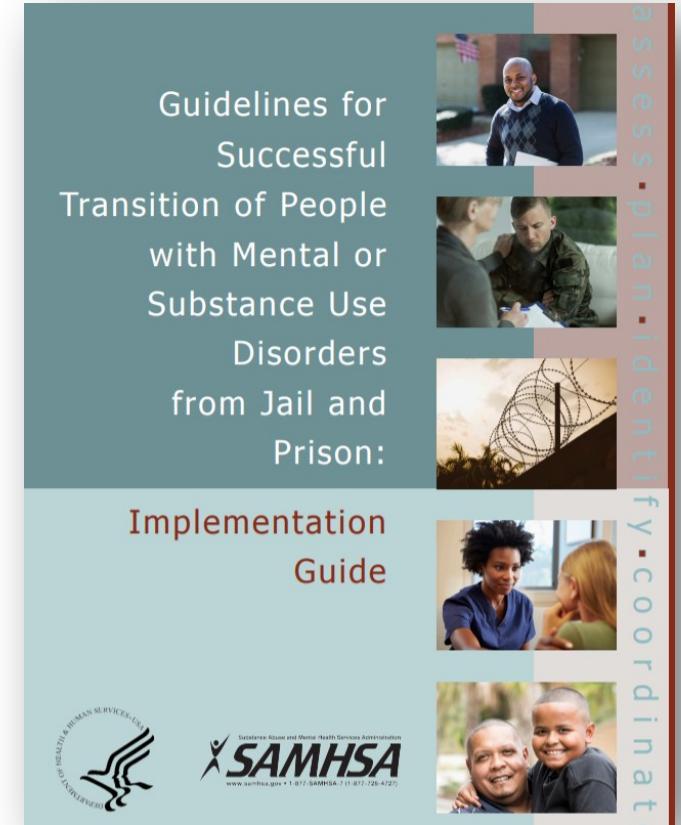
Jail
Reentry

Reentry: A Matter of Life and Death?

- Study of 30,000 people released from WA State prison (2007)
 - 443 died during follow-up period of 1.9 years
 - Death rate 3.5 times higher than general population
 - Primary causes of death
 - Drug overdose (71% of deaths)
 - Other: heart disease, homicide, and suicide
- Consider suicide risk both during and after release
- Opioid-related overdose is the leading cause of death among people released from jails or prisons (2019)

Facility-to-Community Transition

- Begin *person-centered, recovery-oriented reentry planning* upon entry into a correctional facility.
- Facilitate “refer out” AND “in reach” for providers.
- Focus on addressing stability needs in the first: *24 hours, 1 week, 3 months and 9 months.*
- Submit paperwork to reinstate or start *medical insurance coverage* upon release.
- Utilize *peer support services.*
- Embrace an equity lens to identify/address the *racial inequities and discrimination* a person may face upon reentry.



Case Management is Critical

Multiple Needs

- Mental health
- Medications
- Housing
- Substance abuse
- Health
- Income support/benefits
- Food/clothing
- Transportation
- Other (often used for childcare needs)



Multiple Systems

- Mental health services
- Substance use services
- Health services
- Food, clothing
- Medicaid
- SSA
- Veteran benefits
- Parole/probation
- Housing
- Transportation

Common Gaps at Intercept 4

- Timing is everything...
 - Insufficient medications or prescriptions upon release
 - Lack of Medicaid/SSI enrollment
 - Insufficient connection to community-based services
 - Court releases
 - Limited transportation
 - Lack of treatment providers who can meet needs

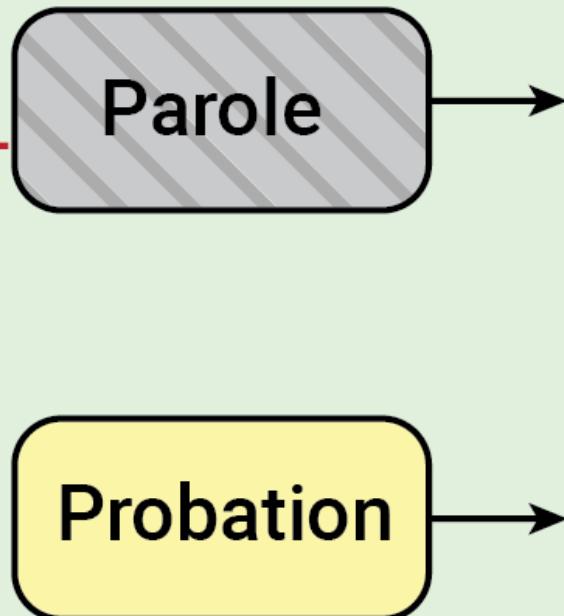
Intercept 5

Community Corrections/ Community Supports

←
Violation

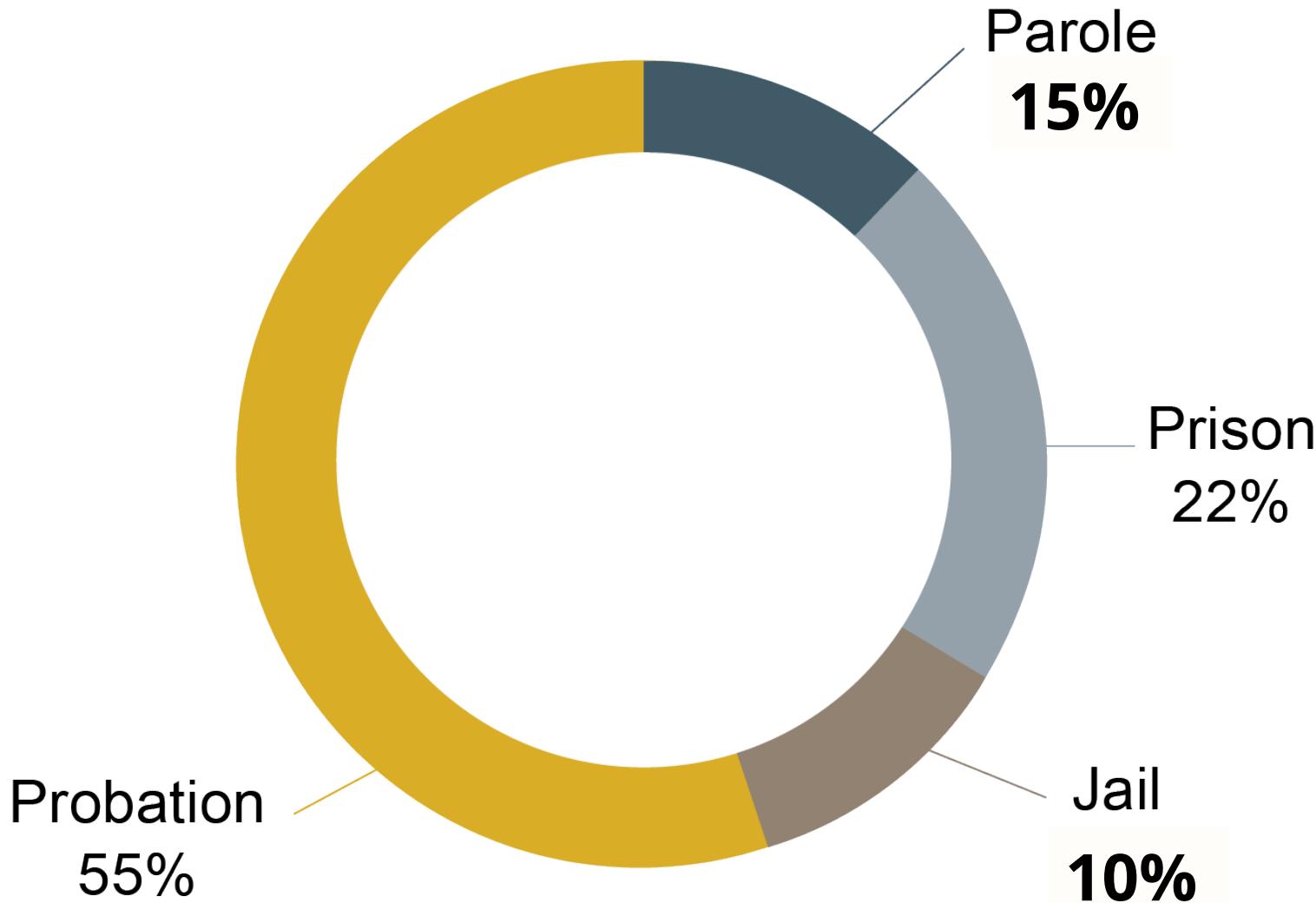
Intercept 5

Community Corrections



COMMUNITY

5.5 Million Under Correctional Supervision



Strategies to Improve Success for Probationers/Parolees with Mental Illness

- Specialized caseloads
- Reduce caseloads to allow specialty probation officers to:
 - Develop knowledge about MH and community resources
 - Establish and maintain relationships with clinicians
 - Advocate for services
- Recognize multiple roles
 - Probation/parole officers take on both a legal/surveillance role and a therapeutic/problem-solving role
 - Quality of relationship between officer and probationer can strongly influence outcomes
- Use problem-solving strategies to resolve issues of noncompliance
 - Examine the specific inabilities or barriers for each individual in order to increase compliance
- Maximize limited resources in creative ways to address the specialized needs of this population

Common Gaps at Intercept 5

- Lack of alternatives to technical violations
- Caseloads
 - Lack of specialized caseloads
 - Caseloads with high ratios of probationers to officer
- Limited housing
- Behavioral health providers
 - Lack of agreements on what information is shared with probation
 - Implementation of RNR strategies
 - Medication-Assisted Treatment access



Conducting the SIM Mapping

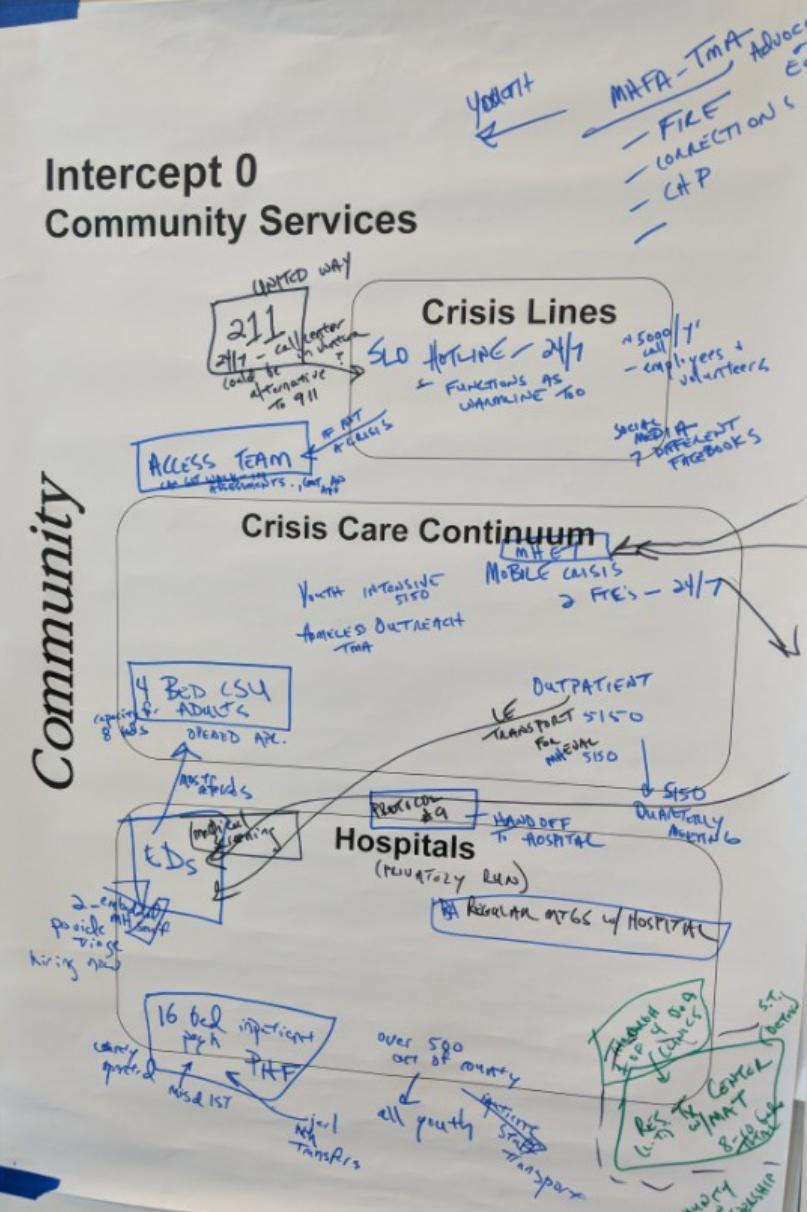
Broad Invitation

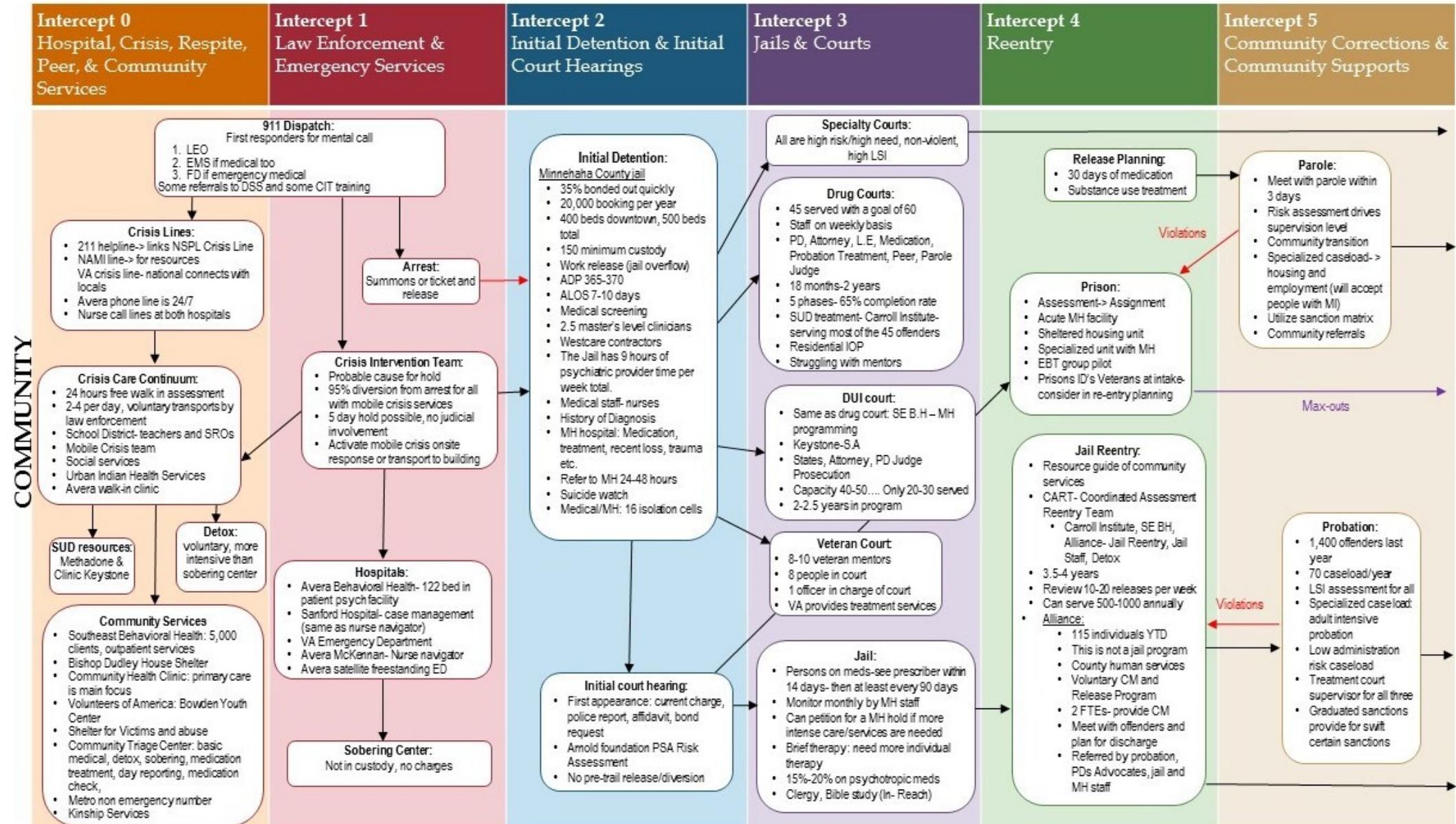
- Ensure that everyone is invited. Everyone.
- Ask if you are including historically excluded groups.
- Introductions are key, often the first time people meeting

Inventory Each Intercept

- **At each intercept, what is available?**
 - Description AND Data
 - Treatment interventions and options
 - Diversion options
 - Data:
 - Jail census
 - Numbers with mental illness, substance use disorders, and/or co-occurring disorders
 - Staffing patterns
 - Outcomes/recidivism
 - Costs
 - **Identify gaps and resources**

Intercept 0 Community Services







Then,
create a list
of priorities



Based on the gaps identified
during the inventory of
services

What's missing?
Who's missing?

Common Top Priorities

Crisis Response

Housing

Data Collection, Analysis, & Sharing

Discharge & Reentry

Peer Support

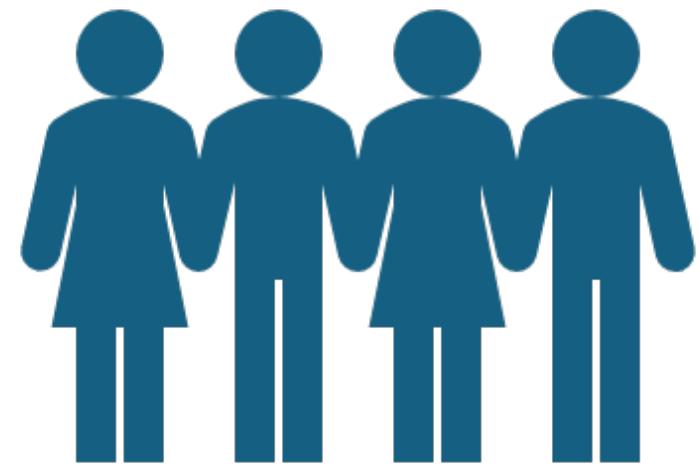
Communication and Collaboration

Continuum of Care

Diversion

Training

Funding



Then it is time for ACTION

Break out
into small
groups to
begin
planning
action steps
for each
priority

- WHAT is the first thing that needs to happen to make change for this priority and WHO is tasked with completing that
- Assign timelines to assist with accountability

Action Planning

Priority Area 1:

	Objective	Action Step	Who?	When?
1.1	What is to be achieved or larger goal to move the priority forward?	▪ XXXXXX ▪ XXXXXX ▪ XXXXXX	Steps on how to achieve the objective.	Who in the current action group is willing to move the action step forward?
1.2		▪ XXXXXX ▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX		What is the general timeframe for completing the action step? Try to be as specific as possible.
1.3		▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX		
1.4		▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX		
1.5		▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX ▪ XXXXXXXXXXXXXXXX		

Group Members' Names:

Priority Area #2: Enable public defender's office to meet with client in-person prior to first appearance and connect with DA Diversion Program

Participant Names: XXXXX, XXXX

Objective	Action Step	Who	When
Increase Sheriff's transportation staff	Continue to recruit/hire deputies	Ask Sheriff	Ongoing
Clearly defined roles for court transport	Training/policy/accountability from Sheriff	Captain XXXX, Sheriff /Dr. Smith	2 months
Go back to multiple first appearance settings per day	Ask magistrate to agree to multiple first appearances per day; ask Sheriff to agree to transport Ask Public Defender and District Attorney to staff first appearances	Sheriff/Public Defender/District Attorney	3 months
Clearly defined policy on what/when incarcerated individuals are transported to court settings (Days? 6 at time?)	Document/memorialize policy/procedure and shape with Public Defender/District Attorney	Sheriff	2 months
Improve Wi-Fi capabilities in jail if first appearances are going to take place at jail court for extenuating circumstances	Sheriff work with IT	Sheriff/IT Dept	3-month timeline given
Ensure all individuals in jail are transported to court for every setting unless documented reason for no transport	Assess how many incarcerated individuals are not being transported to court daily -Are they being transported to docks? -Why not brought?	CourtWatch Sheriff/Court	4 months
Screen individuals for substance use/mental health needs and share with District Attorney for diversion recommendation at first appearance	Train DA/other staff to screen for mental health/substance use needs Share information once identified	DA/Magistrate	6 months

Planning for Action

Working in Self-Facilitated Small Groups





But What Does it Look Like?





PRA Generates a Final Report

- Includes the map
- Priorities list
- Action plan
- Planning references
- Support for future funding applications
- Support for strategic and annual plans

It is intended for wide distribution across the county, tribal nation, state etc...

THE **STEPPING UP** INITIATIVE

**A National Initiative to
Reduce the Number of People
with Mental Illnesses in Jails**

3 counties are Stepping Up to reduce the number of people with mental illness in jails.



- **Reduce** the number of people with serious mental illnesses who are booked into jail.
- **Reduce** the length of time people with SMI stay in jail.
- **Increase** the number of people with SMI getting connected to community-based services and supports.
- **Reduce** the number of people with SMI returning to jail.

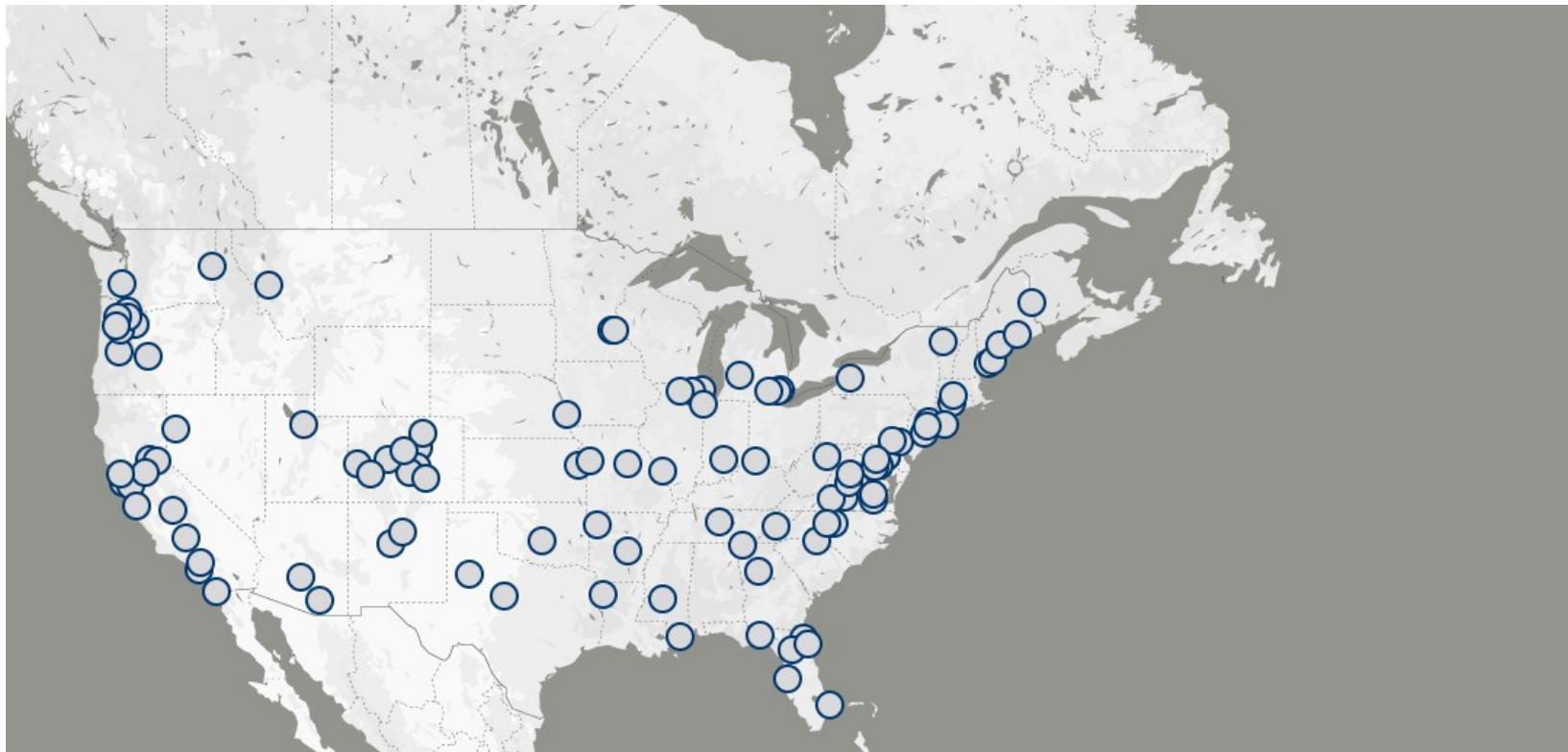


- Johnson County
- Marion County
- Vanderburgh County

Built for Zero

MISSOURI

- Kansas City
- Columbia-Boone County
- St. Louis



107

**Communities are
participating in
Built for Zero**

These communities are dedicated to
measurably and equitably ending
homelessness.

Progress Indicators

Purpose

- Gather qualitative information from SIM Mapping Workshop communities at two time points following the workshop: 6 months and 12 months
- Along the following domains:
 - (1) Policies, (2) Programs, (3) Trainings, (4) Coordinating Bodies, (5) Screening and Assessment, (6) Data-Sharing, Information-Sharing, and Analytics, and (7) Funding

Sequential Intercept Model Mapping Workshop: Progress Indicators

Policies - Intercept

5. What intercepts of the Sequential Intercept Model are impacted by new or revised policies?

Intercept 0 - Community Services

Intercept 1 - Law Enforcement

Intercept 2 - Initial Detention/Initial Court Hearings

Intercept 3 - Jails and Courts

Intercept 4 - Reentry

Intercept 5 - Community Corrections



The Perceived Impact of Sequential Intercept Mapping on Communities Collaborating to Address Adults with Mental Illness in the Criminal Justice System

Natalie Bonfine¹  · Nikhil Nadler²

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Abstract

Sequential intercept mapping is an approach to address the overrepresentation of adults with mental illness in the criminal justice system. This approach follows the sequential intercept model, a nationally recognized framework conceptualizing the linear movement of people with mental illness through the criminal justice system. During the sequential intercept mapping process, community stakeholders identify service and policy gaps and opportunities to address the needs of this target population. This qualitative study describes the perceived impact of sequential intercept mapping among community stakeholders. Sequential intercept mapping appears to be well-received, with the potential to improve collaboration and enhance community policy and practices.

Sequential Intercept Mapping: Developing Systems-Level Solutions for the Opioid Epidemic

Natalie Bonfine, Ph.D., Mark R. Munetz, M.D., Ruth H. Simera, M.Ed., L.S.W.

Sequential intercept mapping, a community-based application of the sequential intercept model, was recently adapted in Ohio to address the complex challenge of the opioid crisis. Sequential intercept mapping for opioids provides a framework for criminal justice, mental health and addictions treatment providers, family members and opioid-involved individuals, and other stakeholders to develop

community-based responses that emphasize prevention, regulation, and treatment for opioid dependency, with a goal of reducing unintended deaths and overdoses. The authors describe a promising approach to using sequential intercept mapping to address the opioid crisis.

Psychiatric Services 2018; 69:1124–1126; doi: 10.1176/appi.ps.201800192



The SIM for
clinicians



A close-up photograph of two hands shaking. One hand is dark-skinned and wearing a light-colored, long-sleeved shirt. The other hand is light-skinned and wearing a dark-colored, long-sleeved shirt. The hands are clasped firmly, representing collaboration. The background is a plain, light-colored wall.

Improve integrated service
delivery by promoting

collaboration

How does a SIM impact clinicians?

- In mental health centers
 - Do all other programs and agencies know about your availability, specialty programs, admission criteria?
 - Are you connected to all the support services that your patients could benefit from?
 - What is your role at each of the intercepts?
- Solo practice or small group practice
 - Do you know all the appropriate referral options for your clients?
 - Are you willing to take on specialty referrals and ensure that the community knows about the offering?

The goal is to improve treatment outcomes for everyone

How does a SIM impact clinicians?

- Urge clinicians to be connected to their local advocacy groups and licensure chapters
 - Missouri Psychological Association
 - NAMI
 - NASW-MO
- Make sure that this group is invited to SIMs to share the priorities of their membership and the solutions that they can bring



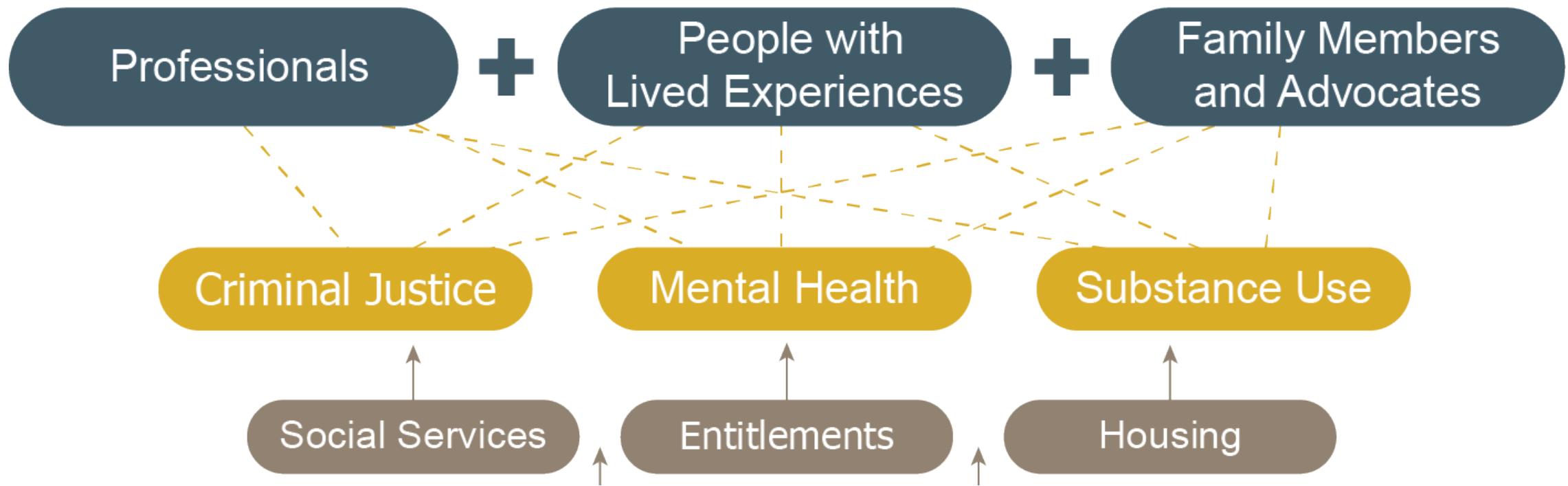
Challenges to Collaboration

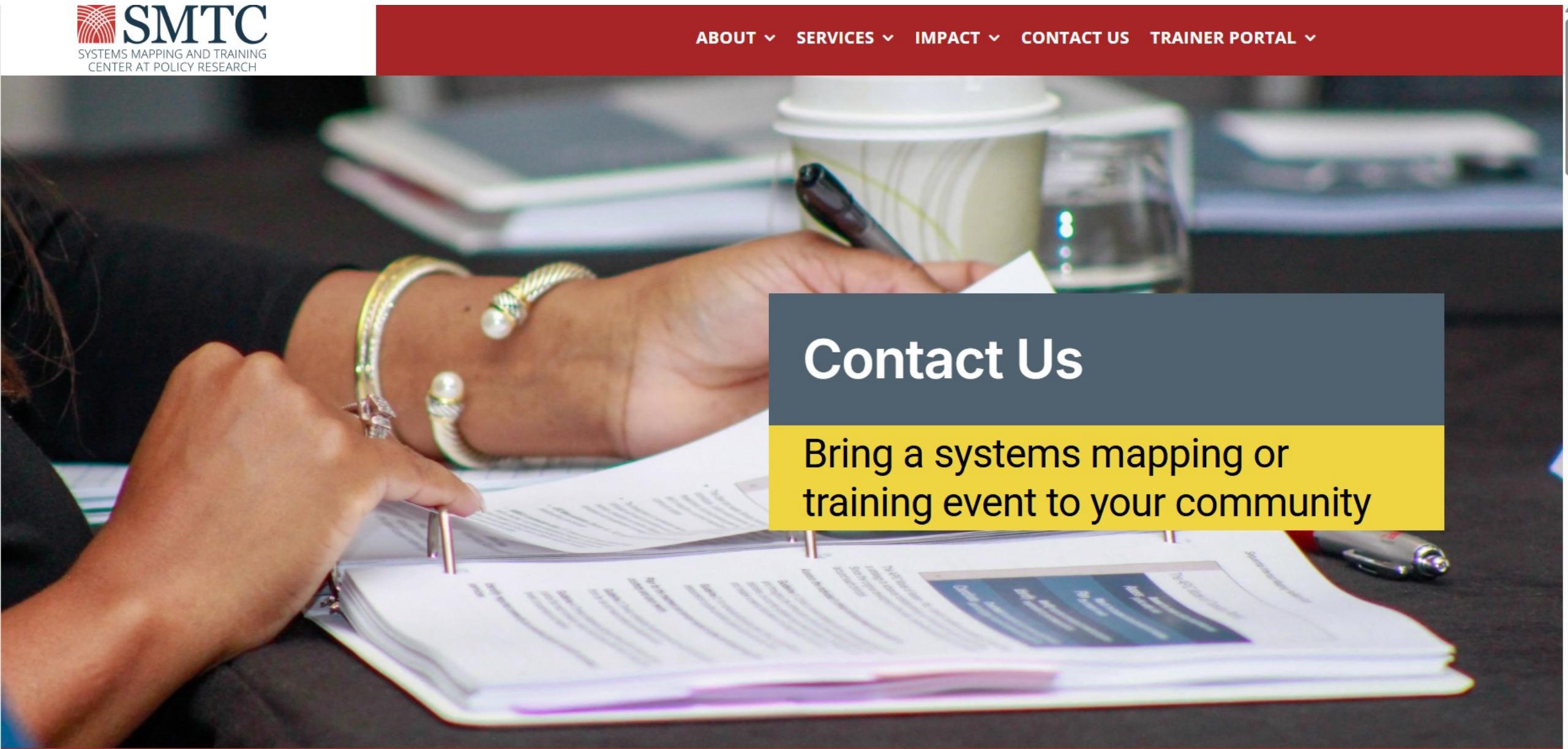
Funding
silos

Limited resources
create a competitive
and/or protective
environment

System
cultures

TASK FORCE COLLABORATION





Contact Us

Bring a systems mapping or
training event to your community

Policy Research Associates, Inc.

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Troy, NY 12180

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*Creating positive social change through technical assistance,
research, and training for people who are disadvantaged .*