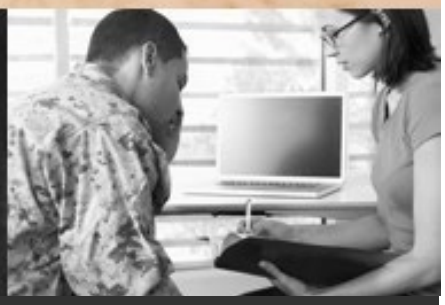

Sequential Intercept Model Mapping Report

Johnson County, Iowa April 2025

The GAINS Center Arnold Remington, MA, LIMHP, CPC & Carol Speed Policy Research Associates, Inc.

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Sequential Intercept Model Mapping Report for Johnson County, Iowa

Final Report
April 2025

The GAINS Center
Policy Research Associates

Arnold Remington, MA, LIMHP, CPC

Carol Speed

ACKNOWLEDGMENTS

This report was prepared by Arnold Remington, MA, LIMHP, CPC & Carol Speed of Policy Research Associates, Inc., for The GAINS Center for Behavioral Health and Justice Transformation. The GAINS Center thanks Abbey Ferenzi for coordinating the workshop and to the Johnson County Attorney's Office for hosting this event. The GAINS Center thanks Rachel Zimmerman from the County Attorney's Office for her opening remarks on the first day of the workshop. Three goals were identified for the workshop, including: 1) To improve data sharing, 2) To identify local priorities for change, and 3) to align service delivery with the HHS service-delivery alignment process.

RECOMMENDED CITATION

The GAINS Center for Behavioral Health and Justice Transformation. (2025). *Sequential intercept model mapping report for Johnson County, IA.* Troy, NY: Policy Research Associates, Inc.

RESEARCH AND INTERACTIVITY

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TABLE OF CONTENTS

INTRODUCTION

Since 1995 The GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, has worked to expand community-based services and reduce justice involvement for adults with mental and substance use disorders in the criminal justice system. The GAINS Center is support by the Substance Abuse and Mental Health Services Administration to focus on five areas:

- Criminal justice and behavioral health systems change
- Criminal justice and behavioral health services and supports
- Trauma-informed care
- Peer support and leadership development
- Courts and judicial leadership

Background

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available opportunities, 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, peers, family members, and many others.

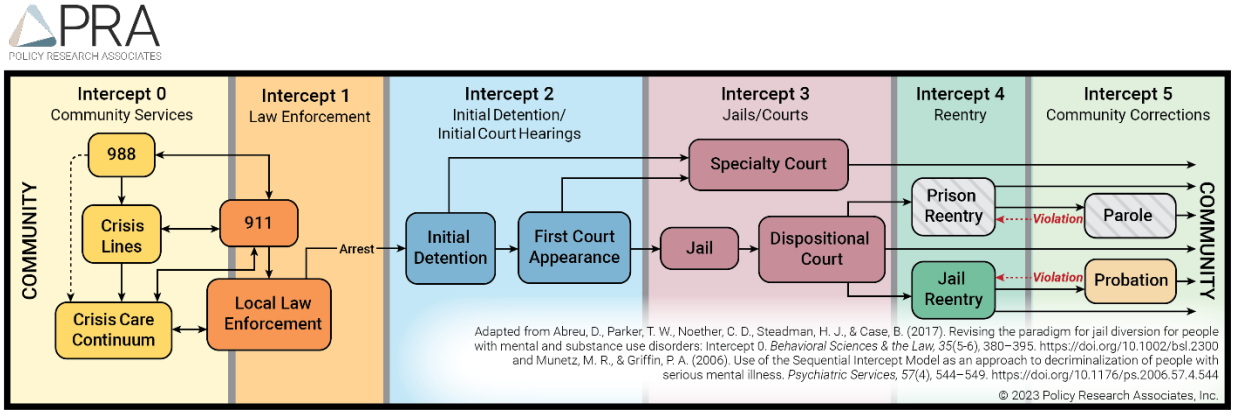
A Sequential Intercept Mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

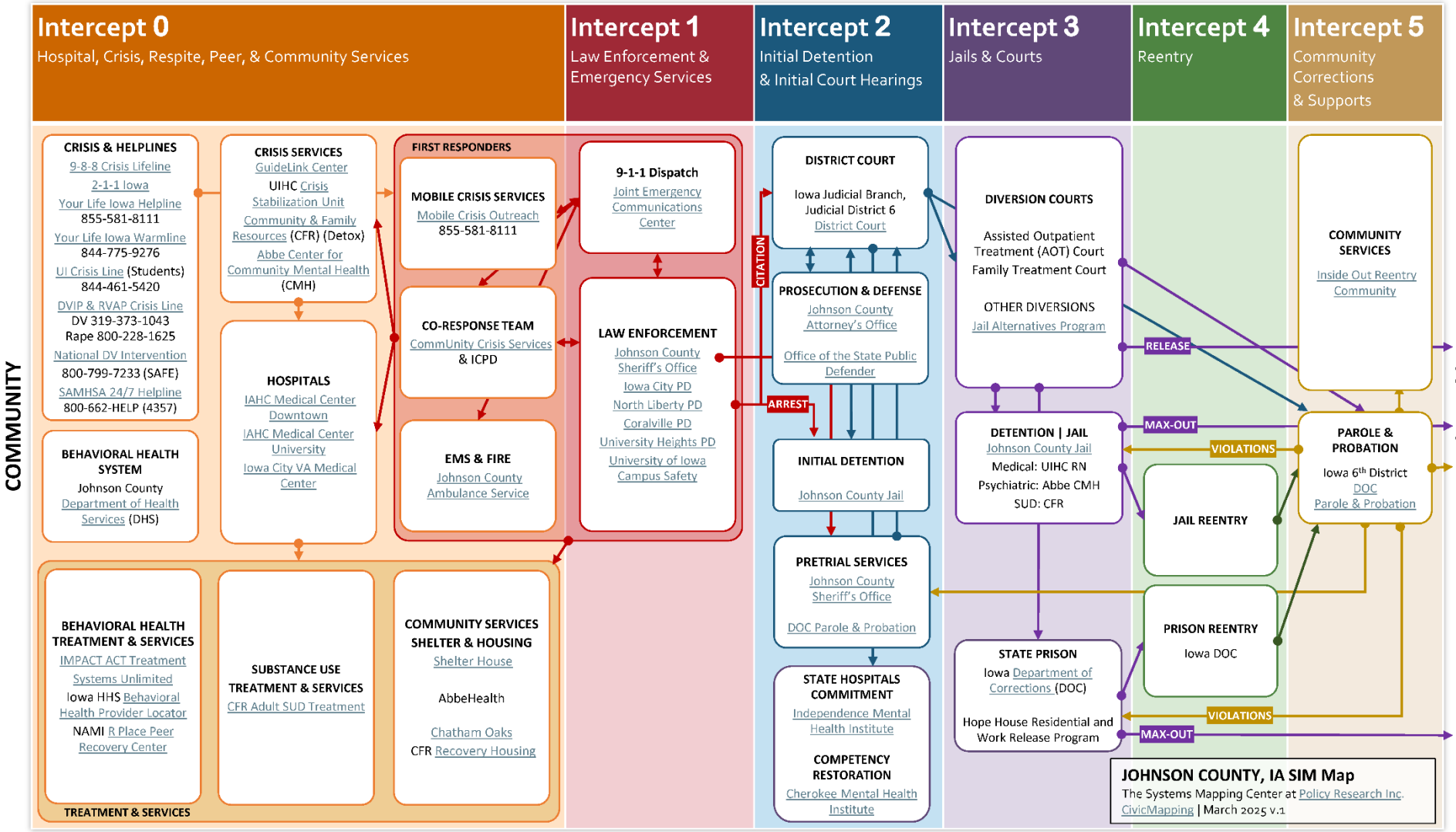
2. Identification of gaps, opportunities, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

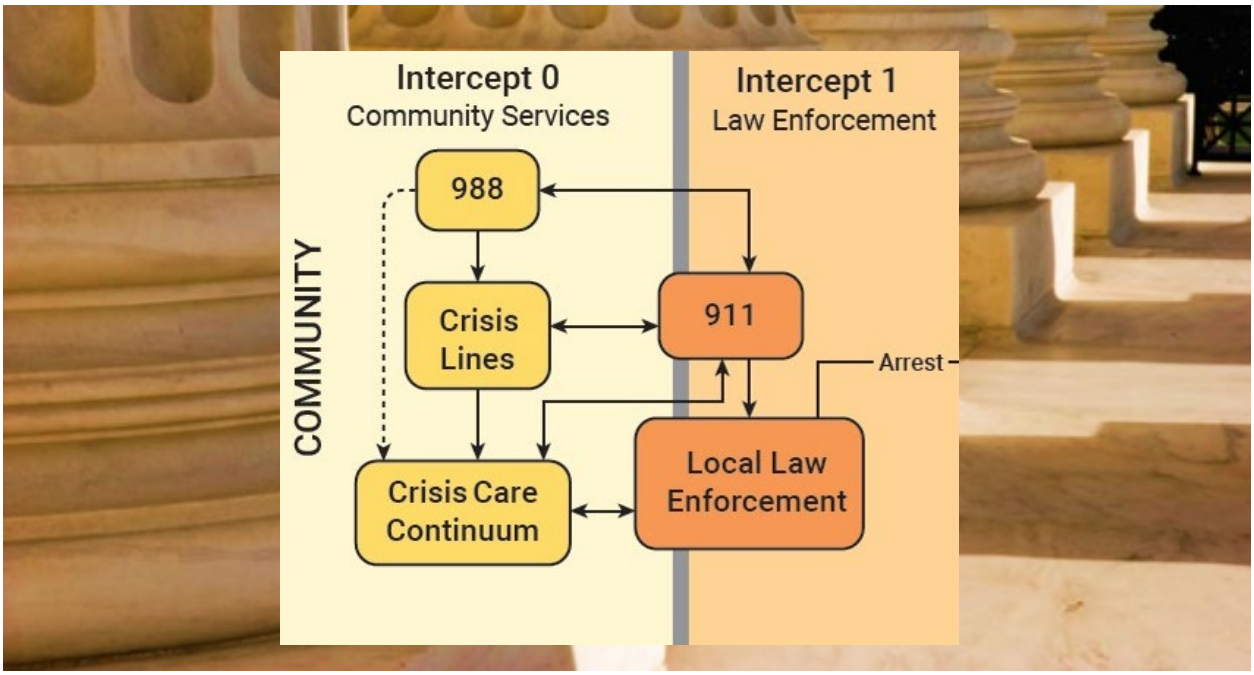
Sequential Intercept Model Map for Johnson County, Iowa



Opportunities and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model map. As part of the mapping activity, the facilitators work with the workshop participants to identify opportunities and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the opportunities and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing opportunities.

Note: the resources included in this report and map are reflective of the conversation and participants present during the Sequential Intercept Model (SIM) Mapping Workshop and may not be exhaustive of all relevant resources, programs, or organizations present in the mapped community.



INTERCEPT 0: COMMUNITY SERVICES; AND INTERCEPT 1: LAW ENFORCEMENT

OPPORTUNITIES

Crisis Call Lines

Service & Description	Connections and Website
9-1-1	**Call or Text:** 911 **Visit:** Website
9-1-1 Emergency law enforcement, fire, and emergency medical services (EMS) are provided by the Joint Emergency Communications Center (JECC) of Johnson County. People may also Text-to-911 for services when calling is not an option, a service available through all major carriers (Verizon, US Cellular, AT&T, T-Mobile) and other carriers when available for people with text and data plans.	
9-8-8 Crisis Helpline Services (9-8-8)	**Call or Text:** 988 **Chat:** Chat **Visit:** Website
CommUnity Crisis Services (CCS) provides a low-barrier, nonjudgmental helpline for individuals in Iowa experiencing emotional distress or behavioral health challenges. Services include crisis counseling, suicide risk assessment, and collaborative safety planning. The helpline is designed to be accessible to anyone in need of support, without requiring a formal diagnosis or law enforcement involvement. CCS is one of two primary 9-8-8 providers serving the state of Iowa. All 9-8-8 calls originating in Iowa are routed to these in-state providers, with overflow supported by the national 9-8-8 Lifeline network. national 9-8-8 Crisis Lifeline office.	
2-1-1 Iowa – Johnson County	**Call:** 211 **Visit:** Website

Service & Description	Connections and Website
2-1-1 Iowa, managed by United Way, is an updated human resources directory portal anyone can query by phone or website search for thousands of statewide and Johnson County-specific resources.	
Mobile Crisis Outreach (MCO)	**Call:** 855-581-8111 **Visit:** Website
Mobile Crisis Response (MCR) is a community-based service that delivers in-person support to individuals experiencing a behavioral health crisis. In Johnson County, MCR services are provided by CommUnity Crisis Services (CCS) through the Your Life Iowa network.	
Your Life Iowa helpline	**Call:** 855-581-8111 **Visit:** Website **Text:** 855-895-8398 or **Chat:** Chat
A statewide phone, text, and chat helpline for anyone seeking help for themselves, loved one, colleague or community member who are experiencing a behavioral health challenge or crisis, including substance use, suicidal ideation, gambling or other challenge. Trained operators provide support and encouragement as well as connections to providers of programs, services, and other resources.	
Iowa Warm Line	**Call:** 844-775-9276 **Visit:** Website
For people experiencing emotional distress, Warm Line staff will listen, share their own personal recovery experiences, and provide support and encouragement. Callers can be connected with a Peer Support Specialist and receive additional support.	
University of Iowa (UI) Crisis Line	**Call:** 844-461-5420 **Visit:** Website
A crisis line dedicated to serving UI students, faculty, and staff. Calls are monitored by CCS Crisis Line.	
DVIP & RVAP Domestic & Sexual Assault Crisis Line	**DV Crisis Line:** 319-373-1043 **Visit:** Website **Rape Crisis Hotline:** 800-228-1625 **Report Human Trafficking:** 855-614-4692.
The Johnson County Domestic Violence Intervention Program (DVIP) and Rape Victim Advocacy Program (RVAP) lines provide support for victims of domestic violence, sexual assault, dating violence, stalking, and human trafficking. Trafficking tipline by the Iowa Office to Combat Human Trafficking.	
National Domestic Violence (DV) Intervention Services	**Call:** 918-743-5763 **Chat:** Chat **Visit:** Website **Toll-Free:** 800-799-7233 (SAFE) **Text:** 88788
The Hotline provides Domestic Violence (DV) intervention and support services by phone, chat, or SMS text messaging. The services is provided by the National Domestic Violence Hotline.	
Trevor Project	**Call:** 866-488-7386 **Visit:** Website
24/7 Crisis Phone and Chat for LGBTQ&I young people.	
Crisis Text Line	**Text:** HOME to 741741 **Visit:** Website
Anyone in crisis can connect virtually and receive 24/7 crisis support with a trained crisis counselor. View metrics from over 11 million conversations since 2013 to learn who calls, when, and topics.	
SAMHSA's National Helpline	**Call:** 800-662-HELP (4357) **Visit:** Website
Also known as the Treatment Referral Routing Service (TRRS), this National Helpline is a confidential, 24/7 information service, in English and Spanish, for individuals and family members facing mental, substance use, or co-occurring disorders. Provides referrals to local treatment facilities, support groups, and community-based organizations.	
Veteran's Crisis Text Line	**Call:** 800-273-TALK (8255) **Visit:** Website **Text:** 838255

Service & Description	Connections and Website
24/7 National helpline by phone or SMS-text for any veteran, without needing to be enrolled in VA benefits or health care systems.	

Crisis Lines (Cont.)

- Iowa 9-8-8 services, including by phone, text message, or chat, are provided by two Iowa call centers:
  - In Iowa, 9-8-8 contacts are answered by two in-state crisis centers: CommUnity Crisis Services in Iowa City, and Foundation 2 Crisis Center in Cedar Rapids. CommUnity responds to all text and chat contacts statewide and provides backup support for phone calls, while Foundation 2 serves as the primary responder for phone contacts.
- The call centers utilize a common resource database to provide referrals to primarily local, as well as to state and national human service providers and other resource providers.
  - The most common referral is to additional local crisis response and care services.
- IA 9-8-8 receives warm transfers from Johnson County's two 9-1-1 call centers described below.
- IA 9-8-8 provides warm transfers to all mobile crisis providers in the state.
- When local call centers are unavailable due to call volume, other incoming calls are automatically routed through the national 9-8-8 Crisis Lifeline backup network.
- Statewide, Iowans contact IA 9-8-8 approximately 4,500 times each month.
  - Approximately 2,500 contacts are made by phone.
  - Approximately 2,000 contacts are made using the chat or text messaging
  - Approximately 75% of all contacts are made by adults 18 years and older.
- For comparison purposes, 9-8-8 Lifeline performance metrics from across the nation illustrate the national impact of 9-8-8.
- Although 9-8-8 counselors do not need to be licensed, both centers provide standardized Lifeline core trainings in addition to their own crisis response training programs.
- Both 9-8-8 centers are accredited by the American Association of Suicidology (AAS) that meets accreditation standards required by Iowa Administrative Code, Chapter 24.

9-1-1/Dispatch

- Johnson County 9-1-1 emergency call services are provided by two Federal Communications Commission (FCC) Public Safety Answering Point (PSAP) operations that dispatch law enforcement, fire, and emergency medical services (EMS):
  - The Johnson County Joint Emergency Communications Center (JECC) serves the entire non-university population with Enhanced 9-1-1 (E911) services, which include the automatic display of a caller's phone number and street address for landline callers. Their non-emergency number is 319-356-6800.
    - Johnson County is one (1) of three (3) Iowa counties piloting 9-1-1 dispatchers rerouting calls for service directly to 9-8-8 Crisis Helpline Services.
      - Operators first review the inclusion and exclusion criteria before transferring the calls.
    - Once JECC 9-1-1 dispatchers complete the Iowa BASIC telecommunicator course and serve six to seven (6-7) months of on-the-job training, they receive Iowa NCIC Certification.
    - The state provides mental health-related training over one week.

- The University of Iowa Campus Safety, and non-emergency number is 319-335-5022.

Healthcare

- The University of Iowa Hospitals and Clinics (UIHC) includes three primary locations:
  - The Medical Center University campus (200 Hawkins Dr.) hosts most of the behavioral health units;
  - The Medical Center Downtown, a 234-bed full-service hospital with an emergency department (ED) and,
  - The North Liberty Campus, a 36-bed hospital and ED.
- The VA Hospital (emergency department and adult psychiatric inpatient unit)
- Two Iowa HHS state hospitals serve clients with serious mental health challenges:
  - Independence Mental Health Institute (IMHI) is a 75-bed state hospital that provides inpatient psychiatric services for people of all ages who Iowa's counties have referred.
  - Cherokee Mental Health Institute (CMHI) for adults, including those ordered by the courts for competency restoration and others acquitted of a crime by reason of insanity.
- The Veterans Administration Iowa City VA Medical Center hospital provides Veterans and their families and caregivers with health care services, while advocates help them navigate the system. The VA services include mental health care. The average new patient waiting period for visits at the time of this report is 32 days, and up to four (4) days for existing patients.

Law Enforcement and First Responders

- Several law enforcement agencies serve within Johnson County. Many of the agencies have dedicated staff or external-provider officer/mental health clinician co-response team members, described in more detail in the Crisis Services section below, who can be dispatched at varying times by agency, including:

Agency	Sworn	Liaison-staff and Co-Response Team Availability
Johnson County Sheriff's Office (JCSO)	84	One (1) Sheriff's staff Mental Health Liaison co-responds between 9:30 a.m. and 6:00 p.m.
Iowa City Police Department (ICPD)	85	One CCS-CR clinician co-responds with officers on weekdays between 7:00 a.m. and 3:00 p.m. and between 2:00 p.m. and 10:00 p.m.
North Liberty Police Department (NLPD)	25	One CCS-CR clinician co-responds with officers on weekdays co-responds between 9:30 a.m. and 6:00 p.m.
Coralville Police Department (CPD)	35	One CCS-CR clinician co-responds with officers on weekdays co-responds between 9:30 a.m. and 6:00 p.m.
University Heights Police Department	4	
University of Iowa Police Department	~40	

- Law enforcement officers receive a wide range of training, including how to address individuals they come into contact with who present behavioral health issues. Some of their requirements include:

- All Johnson County law enforcement officers are required to receive Crisis Intervention Team (CIT) training and certification.
- Additionally, all Iowa law enforcement officers are required to have received at a minimum four (4) hours of Mental Health First Aid (MHFA) or crisis intervention training under the Memphis Model or similar curriculum.

- Iowa created a code (Chapter §228.7A) allowing law enforcement access to an individual's health record when they are acting in good faith and the information may help reduce or eliminate an imminent threat to public safety. Mental health professionals cannot be criminally liable for failing to disclose the individual's health record to law enforcement, unless they failed to do so after learning the individual was presenting a danger to themselves or others.
- The Johnson County Ambulance Service (JCAS) provides emergency medical services (EMS) and transportation for county residents experiencing a medical and/or behavioral health crisis.
  - JCAS deploys seven (7) ambulances, of which five (5) are available 24/7, 6th available 07:00-23:00 seven days a week, the 7th is staffed 7:00-23:00, seven days a week and is dedicated solely to transfers between the three UIHC campuses.
  - Staff includes one (1) community paramedic Monday through Friday, 8:00-16:00. The Community Paramedic identifies High EMS/ED users or those at high risk of readmission post discharge. The Community Paramedic focuses on short term care-coordination, building multidisciplinary care teams around clients in order to reduce unnecessary EMS/ED use. The Community Paramedic evaluates social determinates of health and reduces barriers to healthcare.
  - Although JCAS was licensed to transport individuals exclusively to hospitals, in the last year, they have been able to transport people to the GLC, described in more detail in the Crisis Services section below.

Crisis Services

- Two mobile crisis co-response teams serve Johnson County, responding to approximately 150 calls-for-service each month:
  - The CommUnity Crisis Services (CCS) and ICPD co-response team pairs a specially trained CCS mental health specialist with an ICPD officer to respond to 9-1-1 dispatched calls involving behavioral health concerns, such as a welfare check or incidents involving self-harm or suicidal behaviors.
    - The team operates during two weekday shifts from 7:00 a.m. to 3:00 p.m. and 2:00 p.m. to 10:00 p.m.
    - Any one of several specially trained officers can be dispatched alongside the CCS specialist.
    - To document the interaction, officers complete a crisis intervention form.
    - If the call occurs in the evening, the team follows up with the individual the next morning.
    - 9-8-8 does not contact the co-response team directly allrequests go through 9-1-1 dispatch. The co-response team also collaborates with local organizations to provide education and awareness about the program.
    - Between September and December 2024, ICPD reported receiving 427 calls-for-service involving the co-response team reflecting approximately a 15% increase

compared to the same period in 2023 when only station-based officer responses were used.
    - The CCS clinician-liaison is also shared among the JCSO and municipal law enforcement agency co-responder units through a memorandum of understanding with CCS.
- CCS provides Mobile Crisis Outreach (MCO) residents experiencing behavioral health crisis including those presenting with suicidal or self-harm behaviors, in need of crisis de-escalation, or considering psychiatric hospitalization.
    - MCO teams are two-person units dispatched from the CCS facility and are available to respond face-to-face at any community location—whether that be a private residence, shelter, school, business, hospital, or other community settings—upon request by any law enforcement agency or community member in the county.
    - Community members can call MCO directly at 855-581-8111 to request a response for themselves or on behalf of someone else.
    - Over the years, access to and availability of MCO crisis staff have greatly expanded to meet community needs.
    - While anyone can request an MCO response, engagement with the team is always voluntary and based on the individual's willingness to participate.
    - Recently, the MCO team has increased its presence by responding more frequently to calls involving individuals at area shelters and other community locations.
- The City of Iowa City contracts the Shelter House Street Outreach program to serve residents experiencing homelessness by connecting them with services to meet their basic needs, including healthcare, shelter, food, and clothing. Anyone can request help for an individual in need.

- The UnityPoint Health, Abbe Center for Community Mental Health (Abbe CCMH) is the state-designated Community Mental Health Center serving Johnson County residents of all ages with federal or private insurance, as well as those on a no-cost or co-pay basis through a sliding-fee scale.
    - Abbe CCMH provides walk-in emergency crisis services, as well as assessments, care plan development, and scheduling additional services.
    - The Iowa City Free Mental Health Clinic provides UI Carver College faculty- and student-led mental health services, including evaluation, therapy, counseling referrals, and medication management services. The clinic is held bi-monthly on Saturdays at the Abbe CCMH, and appointments can be made by calling or texting 515-346-8083.
- The UIHC Medical Center University campus Crisis Stabilization Unit (CSU) provides emergency crisis stabilization services for people experiencing a behavioral health crisis.
    - The CSU is staffed with several psychiatrists and nurse practitioners, a physician assistant, and support staff.
    - The CSU provides a range of stabilization and psychiatric services, including developing a stabilization plan.
    - Referrals to the CSU are made by the UIHC hospital's ED, which conducts a medical evaluation and determines whether to transfer individuals to the CSU.

- The GuideLink Center (GLC), is a 24/7 walk-in and behavioral health and substance use crisis care center serving county and non-county residents in need. GLC can be reached 24/7 at 319-688-8000.
    - GLC was designed to be a critical initial component of Johnson County's crisis services care delivery system and is primarily funded through Medicaid while receiving funding through county and state resources.
    - GLC has a capacity of 16 beds, with 8 beds dedicated to serve people who need crisis stabilization services, and 8 beds dedicated to serve people in need of medical withdrawal services for periods of up to five (5) days. There are an additional 4 beds for those who are in need of a safe and medically monitored space while sobering up from intoxication.
    - Clients served at the GLC do so voluntarily and are free to leave at any time. Clients must be able to consent to services and willing to comply with triage and admission procedures. Those who refuse to complete intake paperwork and/or sign Release of Information work with staff to determine appropriate steps that can provide them help outside of GuideLink Center services. As of this report GLC has served 6,500 individuals.
    - Psychiatric prescribers, licensed therapists, Peer Support Specialists, and support staff provide services.
    - Minor medical first aid is available at the GLC.
    - GLC provides triage, crisis stabilization, SUD evaluation, sobering, medically managed withdrawal, counseling, and other behavioral health services. Services are delivered through several contracted providers, including:
        - GLC Crisis Stabilization (GLC CSU) in which clients have a typical stay of two to five (2-5) days.
        - CCS provides initial triage crisis counseling.
        - The Community & Family Resources (CFR) provides Medically Managed Withdrawal services (Level 3.7 ASAM Medically Managed Residential facility), located within the GLC facility.
            - Nursing staff provide 24/7 monitoring of clients detoxing and in withdrawal.
        - CFR provides oversight of the GLC Sobering Unit which gives individuals a safe space to sober up from the intoxicating effects of alcohol or other substances for periods of up to 23 hours. Clients are also provided with crisis counseling and resources information tailored to their interests, as well as consideration of SUD and/or mental health treatment programs upon request.
- CFRs Outpatient Clinic, located down the street from GLC, administers SUD evaluations for walk-in clients on weekdays from 10:00 a.m. to 2:00 p.m. A typical evaluation takes up to two and one-half (2.5) hours to administer. The intake process can be expedited by completing intake forms in advance through the CFR's Patient Portal.
- The Intensive Outpatient Program includes 9 plus hours of programming per week.
- Other Outpatient programming can vary from up to 5 hours per week to as little as 1 hour per month depending on client needs.
- CFR offers adult residential SUD treatment services that include over 50 hours of programming each week, provided by trained clinical staff.

- NAMI's R Place Peer Recovery Center (R) is a drop-in center for county residents experiencing mental health challenges, where they can learn, collaborate, and recover. R has a range of peer-led activities, classes, and groups for everyone. People can also connect virtually with their Peer Support Specialist on a weekly basis to receive support, encouragement, connections, and referrals to resources, as well as assistance with developing coping skills.
    - The drop-in center is open from 1:00 to 5:00 p.m., Monday through Friday.
    - NAMI also places a Peer Support Specialist at the GLC for four (4) hours one to two days a week.
- State legislation in mid-2024, House File 2673 (5/2024), amended several elements of the statewide behavioral health service system. The legislation improved access to services through streamlining and reducing administrative barriers to improve access. The legislation also standardized core services to ensure more consistent care statewide.

Housing

- The Shelter House provides emergency shelter beds for 160 people during the winter months from December through March, and for 70 people between May and November.
    - The program includes an 80-unit supportive housing complex where residents can reside for up to one (1) year.
    - Shelter House publishes the Housing In The Area List to provide people seeking residential placement with available properties in the community.
    - Shelter House's permanent supportive housing programs provide the opportunity for clients to move towards long-term, sustainable housing. Projects include:
        - Cross Park Place is a complex of 24 one (1) bedroom apartments for people experiencing chronic homelessness.
        - The 501 Project provides 36 one-bedroom apartments for people experiencing chronic homelessness.
        - The Fairweather Lodge program helps individuals with severe mental illness at increased risk of homelessness establish a permanent home and a supportive community. The model is a demonstration project with the State of Iowa built on the premise that people who live and work together, who have control over their lives, become contributing members of society.
- The Domestic Violence Intervention Program (DVIP) has a 75-bed shelter providing free and confidential shelter and care services for victims of domestic violence and sexual abuse. Programs include the shelter, outreach office, transitional housing, scattered housing, and mobile offices. The DVIP & RVIP Confidential Hotlines are 800-373-1043 and 800-228-1625.
- CCS provides financial assistance to individuals experiencing difficulty paying their residential rent.
    - The CCS Food Bank CommUnity Food Pantry at Pepperwood Plaza program provides a wide range of groceries, baby products, and hygiene items for people in need once a week. The pantry is open Monday through Saturday from 9:30 a.m.to 7:00 p.m. See the website for current hours of operation.
- Abbe Center for Community Mental Health also provides short term- and long-term treatment care services for individuals facing mental health challenges through Chatham Oaks Residential Care Facility (RCF). Psychiatric staff are on-call 24/7, while medical services are provided off-site

by a physician, podiatrist, and physical and occupational therapists. The program includes social and nursing services as well as activities geared toward skills development and community reintegration.
    - AbbeHealth also has two programs for clients needing additional supportive services.
        - Daily Home-Based Habilitation Services provides supportive housing for people experiencing mental health challenges. Services for the individual can be supported 24/7.
        - Hourly Home-Based Habilitation Services provides supportive services to individuals in their own homes, with an emphasis on helping them develop skills and abilities to take charge of their recovery.
- Systems Unlimited is an RCF serving clients with mental health and Intellectual and Developmental Disabilities (I/DD) who qualify for Medicaid Waiver or Habilitation programs.
- In the past, Johnson County offered 100 RCF beds and now offers 15.
- The CFR Family Recovery Housing program features 12 apartments, comprising 10 2-bedroom and 2 3-bedroom units, designed for parents of families actively engaged in their treatment process. Clients are required to remain substance-free and are subject to periodic testing. They must be working towards or have at least 50% custody of their children.
    - Clients receive counseling and case management services that address their health and mental health care needs, as well as the development of parenting and financial management skills, and guidance as they secure childcare, transportation, and employment.
- The UI Integrated Multidisciplinary Program of Assertive Community Treatment (IMPACT) Assertive Community Treatment (ACT) service is for people who have experienced chronic homelessness or incarceration as a result of their mental illness, and those who have had frequent and prolonged hospitalizations.
    - People in ACT programs have a primary diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or chronic major depression, and many have an SUD.
    - Multidisciplinary teams of clinicians, physicians, nurses, and rehabilitation specialists guide individuals through the program, providing life skills guidance in areas such as housing, employment, utilizing government benefits, maintaining medication routines, and other daily living skills.
- There is an opportunity to develop similar programs that provide placement in housing units suitable for frequent service users, as well as pairing individuals with a system navigator who would monitor their progress and support them throughout the process.
- There is an opportunity to identify and deploy existing resources to address the shortage of suitable housing for all levels of care.
- Some people who have presented as a danger to the community or themselves may require being held under Iowa's Involuntary Commitment statutes to be assessed, stabilized, and either hospitalized or released.
    - The involuntary hospitalization statute for people with SUD challenges is detailed in Iowa Code Chapter 125, and for those with mental health challenges, in Iowa Code Chapter 299.
    - People can initially be held for up to 72 hours for observation and stabilization.

- UIHC's CSU provides 23-hour observation holding services for people under commitment orders.

Peer Support

- Iowa's Peer Support Specialist (PSS) program trains and certifies peers who are seeking employment or other engagement opportunities to support people experiencing similar conditions to their own. Certification requires a minimum of 46 hours of training.

Collection and Sharing of Data

- The Iowa Health and Human Services (HHS) offers a Behavioral Health Provider locator and publishes an Accredited Provider Listing.

GAPS

- There were no representatives from the CCS Crisis Line at the workshop.
- Many stakeholders are unclear about how to serve people effectively, and those that do share existing laws are often not strong enough, including through the state commitment process or when individuals are transported to a detox facility, where they can leave without restriction, resulting in people returning to their harmful behaviors.
  - For those who leave, a pickup order is put in place; however, with no next step, the process becomes a revolving door.
  - Some SUD providers will place individuals in residential housing programs and services and then remove them from commitment to break the cycle.

9-1-1/Dispatch

- There is interest in the 9-8-8 and 9-1-1 agencies collaborating on call exchange practices to increase effectiveness and efficiency.
- When students with phone area codes from across the country attempt to use the 9-8-8 service, their call is routed to their home-county call center, which may result in the person being unable to access local resources efficiently.

Healthcare

- There is a belief that there is a higher demand for human services in Johnson County because of the number of people from outside the county seeking their services.
- Approximately one-half of the beds at the hospital are being filled because there are no options for staff to place people with behavioral health challenges. Approximately 11% of all admissions are due to the inability of these individuals to be released into the community.
- There is a need for longer-term hospitalization care and services.
- When hospitals discharge people who are experiencing homelessness, the individuals are often rebooked into jail.
- There is a lack of data being collected that helps define the need and demand for affordable housing.

Law Enforcement and First Responders

- Mental health-related calls for EMS services consume a significant amount of time, resulting in the EMS unit being unavailable for extended periods.
- There is a general challenge in identifying the demand for resources within the community, which could be useful for enhancing the tracking of individuals.
- Although Iowa code allows law enforcement to request medical documentation from people they contact, they often are not aware of when to use it-not knowing the need of collection, resulting in their not utilizing the resource. This is the same for providers in the community and knowing when they are allowed to release information and what kind of information is eligible under an emergency.
    - There is a general lack of information exchange due to legal restrictions or operating policies of agencies and departments.
    - The Shelter House could benefit from additional funding to increase its capacity and meet the growing demand.
- EMS technicians are not provided in-depth training on psychiatric conditions and handling people experiencing behavioral health challenges. Their initial training is heavily biased towards quickly identifying and treating life-threatening emergencies. Most rely solely on experience to manage behavioral/mental health encounters.
- When transporting them to the hospital, the hospital requires that LE stay as long as the hospital needs them, or until the individual chooses to leave.
- Cultural and philosophical norms from service providers in the community regarding law enforcement continue to affect practices in officers' response to calls for service with a mental health component.
-

Crisis Services

- There are challenges when transporting people to the GLC, who may decide they don't want to stay and may leave at any time. Additionally, if the individual refuses to sign intake forms or ROIs they may need to be transported back to the hospital or seek other services.
- There is a need for more crisis services provider serving in a 24/7 capacity.
- When family members call requesting the Mobile Crisis Response team the unit will not be dispatched unless the individual of concern has requested the service.
- There is a challenge in identifying and hiring nursing staff across all levels of crisis services.
- Although Iowa statutes provide for the ability to require people to see a psychiatrist, take prescribed medications, and participate in outpatient SUD treatment services, if a pick-up order is not created, the co-response and MCO teams never learn about the individual's status and cannot intervene.
- Mobile crisis teams will only respond if the individual is willing to engage with the team.
- There is a lack of funding for medications at GLC when someone is brought from the hospital or jail without a supply of medications.
- There is a lack of locked psychiatric units to place people experiencing a crisis. The only option is typically a state hospital which is often at capacity.
- When co-response teams are too busy to respond to calls for service, law enforcement must fill the gap and transport the individual to the hospital or jail, without options.

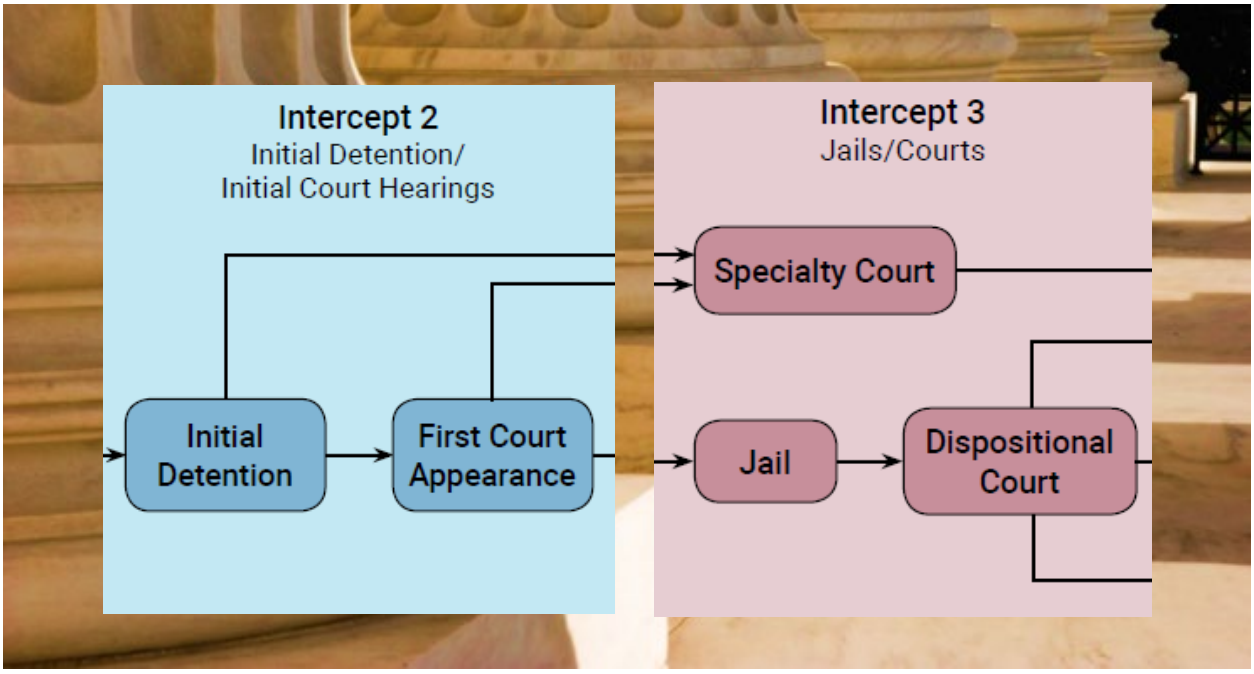
- Information details from co-response calls is diminished as it is recorded and reported within the existing system.

Housing

- Johnson County partnered with the city of iowa City and Veterans Affairs to build a the first low-barrier HUD Veterans Assisted Supportive Housing (VASH) project in the state of Iowa.
    - This HUD program is unique in that the housing voucher is attached to the unit, not the individual Veteran.
    - Veterans making less than 30 percent of the area median income, or about $27,500. For a household of two, are eligible for placement.
    - Veterans will receive case management and clinical care services provided by the VA.
    - The project consists of 15 apartment units
    - The county purchased the property, and the city will lease the property at no cost and manage the project over a 20-year period.
- There is a general lack of affordable housing options for people at all levels of care. Housing is often forgotten in the coordination of care planning.
- There is a challenge with people who are aging, losing their housing, and needing assistance with activities of daily living (ADL).
- There is a general lack of housing options for people who are experiencing chronic mental illness and homelessness who have had a violent act in the community. C
- There is a lack of housing options for others with complex needs. Johnson County has the most expensive housing costs in the state of Iowa.
- There is a lack of sufficient behavioral health services provided in an individual's home.
- There is a lack of assisted outpatient treatment providers in the county.
- There is a lack of staffing and working hours to provide continuous 24/7 monitoring and follow-up with people experiencing homelessness.
- Many stakeholders are unclear about how to serve people effectively, and those that do share existing laws are often not strong enough, including through the state commitment process or when individuals are transported to a detox facility, where they can leave without restriction, resulting in people returning to their harmful behaviors.
    - For those who leave, a pickup order is put in place; however, with no next step, the process becomes a revolving door.
    - Some SUD providers will place individuals in residential housing programs and services and then remove them from commitment to break the cycle.

Collection and Sharing of Data

- There is a general lack of communication and data-exchange policies and agreements across intercepts.



INTERCEPT 2: INITIAL DETENTION & COURT HEARINGS; AND INTERCEPT 3: JAILS/COURTS

OPPORTUNITIES

Booking

- People arrested in Johnson County are booked into the Johnson County Jail and held until an initial court appearance. (Some defendants may post bond or sign an initial appearance waiver). The jail is managed by the Johnson County Sheriff's Office (JCSO) Jail Division.
- Individuals being booked are screened to identify their Veteran status, if any, their medical condition, as well as being administered screening tools that assess the presence of behavioral health challenges, including the potential for self-harm or suicidal risk.
    - For individuals staying in the jail, a Brief Jail Mental Health Screen (BJMHS) is administered to assess any behavioral health challenges.
    - SUD assessments can be administered virtually.

Jail Structure and Personnel

- The JCJ has an operational capacity of 65 people. The average length of stay in jail is approximately five (5) days, and the majority of people are released within the first 12 hours of their booking.
    - The JCJ transports individuals to other area county jails to handle the overflow population.

- All JCJ staff are CIT trained.
- The JCJ will soon begin offering educational opportunities to people in the jail, which will be delivered virtually through computer tablets.

Jail Services

- JCJ health services are provided by staff and contracted providers, and include:
    - 24-hour, 7 days a week medical services are also available through the UIHC and the Emergency Room.
    - On-site medical services are provided by a Registered Nurse (RN) stationed at the Jail during weekday business hours. The Registered Nurse is an employee of the Sheriff's Office.
        - The RN also dispenses medications, including those for individuals following a Medication-Assisted Treatment (MAT) protocol.
            - Approximately 76% of the people in the jail are on some form of medication.
            - Family members can bring in medications with proof of prescription, and the RN will dispense them if they are warranted.
    - Psychiatric services are provided by the contracted provider Abbe CMH.
        - A JCJ staff Corrections Social Worker provides services 40 hours per week on weekdays. They provide crisis intervention as well as behavioral skill development, education, and information about area resources.
        - In 2023, the CSW met with 174 individuals for a total of 695 meetings.
    - SUD treatment services are provided by the contracted provider, Community and Family Resources (CFR).
    - In preparation for releasing people from the JCJ, a 7-day supply of medications is provided to help the person until they meet with their community health provider, who has been alerted about their impending release.

Pre-trial Services

- The Department of Corrections provides pretrial evaluations for the courts. These evaluations help the court decide on conditions of release when considering setting bail or releasing the individual on their own recognizance, supervising the individual while they are on bail, or electronically monitoring the individual. Initial Appearance
- The Johnson County Attorney's office prosecutes criminal cases on behalf of the county.
- The Iowa Office of the State Public Defender provides criminal case defense services for people who are indigent or cannot otherwise afford private defense attorney services.
- The Iowa Judicial Branch, Judicial District 6, Johnson County District Court Associate Court Judge or Magistrate, depending on the day of the week, hears criminal case arraignments for people charged with criminal offenses.
    - The Iowa Judicial Branch Guide to Criminal Court Procedure explains the various stages of the court hearing process.
- Initial court arraignment hearings are held for both JCSO and Iowa Department of Corrections (DOC) prisoners.
    - The initial hearing is held at 8:00 a.m. virtually seven (7) days a week, and approximately 10 arraignment hearings are held each day.

- If the individual needs a higher level of care, law enforcement will share information with the court.

Problem-Solving Courts

- Johnson County alternative courts provide opportunities for typically first-time offenders to be diverted from jail or prison and into behavioral health treatment programs and services.
  - The Assisted Outpatient Treatment (AOT) court, a civil mental health court, is offered as an opportunity for people charged with lower-level drug-related offenses.
    - The court has a capacity of 40 individuals, and 11 people are currently participating.
    - The court piloted in May 2023 with the contracted provider Abbe CMH and was the first of its kind within the state of Iowa.
    - The AOT court is a 12- to 18-month program, and successful graduates could receive a dismissal of their commitment and charges.
    - AOT Court participants must be county residents with civil commitment orders requiring treatment and typically focus on those with serious mental illness.
    - A multidisciplinary team manages each participant's program under the oversight of the judge. The team comprises a director, coordinator, treatment program liaison, case manager, peer support specialist, hospital referee (an individual appointed to handle specific cases), and a legal representative.
  - The Family Treatment Court (FTC) is for parents experiencing SUD challenges who may have had their children removed from their homes and are seeking recovery to reunify with their family.
    - CFR provides SUD treatment and recovery services in partnership with the court.
    - CRF provides education on parenting and other life skills.
    - The FTC has a capacity of 10 parents and is currently at capacity.
    - The program consists of five (5) phases and typically takes up to 12 months until they can be reunited with their children.
      - CFR connects parents with a parent-partner advocate who encourages and supports their efforts.
  - A Mental Health Court is in the planning stages, and upon confirmation of funding by the Iowa Primary Care Association (IPCA) in July, the project will proceed.
- The former Johnson County Drug Court was merged into the Linn County Drug Court, located in the city of Cedar Rapids, about a 30-minute drive north of Iowa City. Although Johnson County courts allow residents to participate in the Linn County Drug Court, transportation and other issues have prevented many from completing and graduating from the program.

Competency

- The defense attorney or the judge can raise the issue of the individual being competent to stand trial.
  - Individuals facing prison sentences who are determined to be incompetent are placed on a waitlist for competency restoration services, which typically involves a wait of approximately seven to eight months (7–8 months).

- Iowa Code Chapter 812 delineates between criminal competency, or the ability to stand trial, and civil competency, or the ability to make certain legal decisions.

GAPS

Jail Structure and Personnel

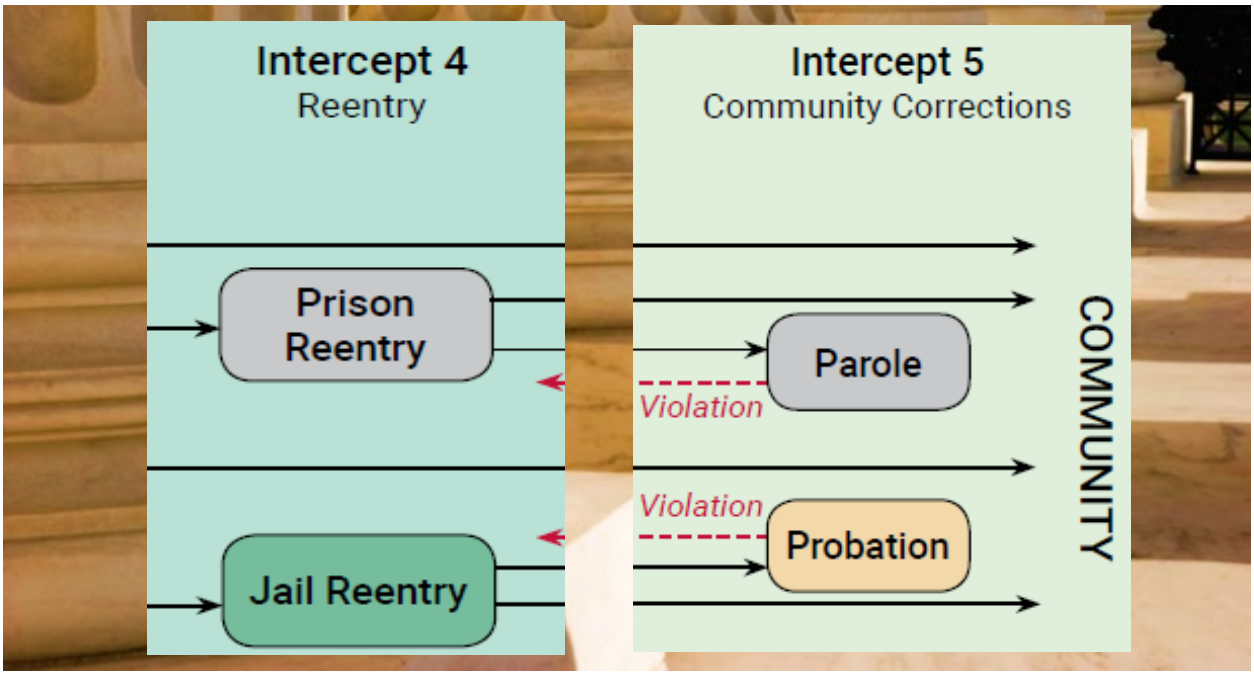
- Several beds have been unavailable for the general population due to their being needed to separate the population of people with mental health challenges.
- There is a general lack of available dedicated space within the LCJ for treatment and other services.
- The JCJ is aged and in relatively poor condition, and a new structure is needed. Exterior renovations are underway and are expected to be completed by the end of the year.
- The JCJ is typically at capacity, which requires the JCSO to divert people to other area jails at a cost of approximately $15.8 million over the last 20 years.
- When people exit the jail and reenter the community, they are doing so without having any tangible connection to behavioral healthcare providers or a prescription for medications, beyond a seven (7) day supply at release.

Jail Services

- All outside groups holding in-person 12-step and other meetings at the JCJ were suspended during the COVID-19 era and have not been restarted due, largely in part, to the lack of dedicated space.
- Although SUD assessments can be administered virtually, any subsequent treatment services are not offered virtually.
- There is a lack of care options and resources for people entering the JCJ who are experiencing co-occurring behavioral health challenges, Intellectual/Developmental Disabilities(I/DD), traumatic brain injuries, personality disorders, and other high medical needs.
- People can be released from the JCJ at any time of the day or night, which can be disruptive to their successful connections with community care providers on a timely basis.

Problem-Solving Courts

- There are few to no programs and services to serve people seeking SUD treatment services, instead of placing them in the JCJ.
- The AOT Court serves people who have high needs and pose a low risk to public safety. How does a person who has high needs, who is also a high risk, get the needed help and treatment? The burden is typically felt by defense attorneys, whose job is to address the case, rather than the individual's behavioral health needs.
- There are three (3) entities engaged in the AOT Court program: two (2) that have access to information and can collaborate freely, and one (1), the court overseeing the program, that does not have access and cannot freely collaborate.
- There are no PSSs with a forensic specialization who are working in the field, whose lived experience can be invaluable when connected with others seeking recovery.



Intercept 4: Reentry; and Intercept 5: Community Corrections

OPPORTUNITIES

Jail Reentry

- The JCJ Corrections Social Worker partners with several area agencies and organizations, encouraging individuals to connect with their programs, services, and resources upon release.

Community Reentry

- The Inside Out Reentry Community (IORC) is a community-based drop-in center and programs serving county residents returning to the community from jail or prison.
  - In 2024, IORC worked with approximately 300 people reentering the community.
  - Referrals to IORC come from a wide range of sources, including counselors, care providers, and peers inside the JCJ.
  - The majority of participants are reentering from prison, with a smaller number coming out of the JCJ, typically those people who are presenting with high needs.
  - IORC does not enter the jail to provide reentry preparation services. When individuals arrive at IORC, they meet with a team member to develop their reentry plan.
  - The IORC reentry house, Page Street House, is a 6-bedroom transitional residence for six (6) men. Residents are expected to pay rent, and the average length of stay is six (6) months.
  - The IORC connects peers to share their lived experience and provide encouragement and support to people reentering.

- When Veterans connect with IORC, they receive support from the Veterans Justice Service Office (VJSO).

- In July 2023, Iowa legislators changed their practice by contracting a single entity to perform reentry services statewide. This has resulted in Parole Officers losing some abilities to manage their caseloads on a more personalized basis, or the ability to adjust their practices locally.
  - This resulted in parole officers having little to no say.
- The jail in-reach program connects with people up to six (6) months prior to their release to begin developing a plan of action regarding their care and recovery, as well as challenges they may face during their reentry transition.

Prison Reentry

- The Iowa 6th District Department of Corrections (DOC) oversees the state's prison and parole operations as well as county Probation services.

Probation

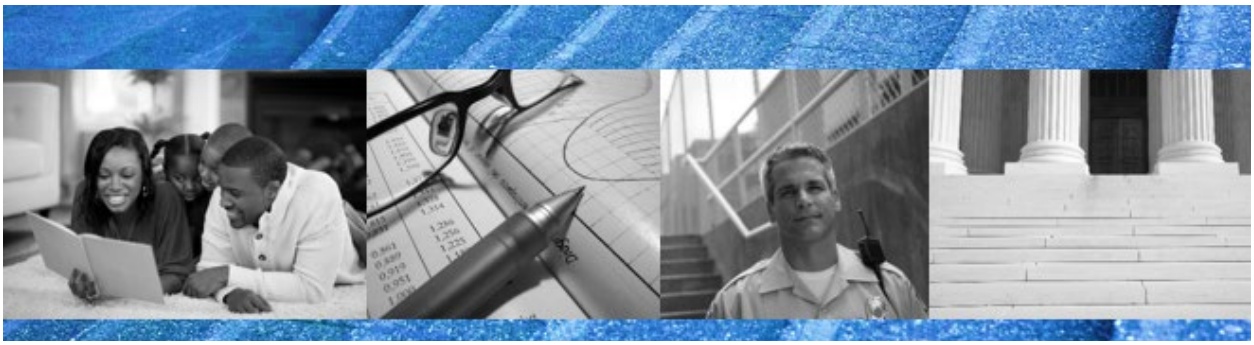
- The DOC also manages probation services for Johnson County residents.
  - 50 Probation and Parole Officers (PPOs) serve the 6th District, which, in addition to Johnson County, includes Benton, Iowa, Jones, Linn, and Tama Counties.
  - 12 PPOs are located in Johnson County, including:
    - Two (2) specialized PPOs focused on sex offender cases.
    - Two (2) PPOs focused on pretrial diversion cases.
  - All PPOs have received CIT training.
  - Three (3) levels of PPO case managers include:
    - Level 3, including 24-20 people who pose the highest public safety and criminal risk;
    - Level 2, for individuals with a moderate risk of recidivism, and,
    - Level 1, including approximately 200 people who pose a risk of violence.
  - Approximately 100 people are experiencing mental health challenges and homelessness.
- Hope House Residential Facility is a 58-bed Iowa DOC facility for men located in Coralville, IA. A Resident Handbook provides details on work release and other program information. Hope House is where individuals under PPO supervision who are on work release or receiving direct services with supervision stay until their release.
  - The program works on a graduated level system where, over four to six (4-6) months, participants move up the ladder as they accomplish the program's objectives.
  - IORC facilitates a two (2) hour group session at Hope House each week. The first hour is dedicated to client check-ins and connections to resources, and the second hour focuses on the topic questions of the week.

GAPS

Community Reentry

- There is a lack of affordable and available housing units for people reentering the community, an issue that often circles them back to Intercept 0. Some of these individuals have high medical needs while facing SUD challenges, making it more difficult to identify housing options.

- There is a need for low-barrier housing to accommodate people reentering, who may not yet meet community expectations.



PRIORITIES FOR CHANGE

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote by each participant. The voting took place on April 1, 2025. The top three (3) priorities are in highlighted text. Additional Notes were provided by Alton Poole with the University of Iowa Police Department.

Rank	Votes	Priority
1	**27**	**Secure Supported housing; long-term hospital-level care.**
2	**26**	**Support the development of a jail that can provide adequate and supportive treatment.**
3	**13**	**Interagency cooperation in the Intercepts / system.**
	13	**Collecting and sharing of data to support shared goals.**
5	12	Transitional / Emergent housing.
6	11	Hotspotting, identifying high utilizer's whereabouts (HN/HR).
7	3	Communication of information across Intercepts.
	3	Adding and integrating forensic peers into system.
	3	Access to medication.
8	0	Access to Behavioral Health services for youth.
	0	Identify boundary spanner in mental health system.

Action Plans

Priority Area #1: Develop long-term, secure treatment with high-intensity clinic services (Locus Level 6).

Objective	Action Step	Who	When
Identify population needing these services.	▪ *Data gathering – UIHG & GLC ○ Patients over 12 months with >| no level of service or >5 admissions ▪ Diagnoses, legal status, housing, payor, criminal justice involvement. ▪ Why are they stuck?	▪ UIHL-MF, GLL-AF, RF, SH – ES ▪ Briljent	1 month
	▪ Cost analysis of these highest users ○ Develop strategies to get cost data	▪ UHL-MF	4 months
Engage stakeholders with a financial and system interest, focus on currently less-engaged.	▪ Use data to present to stakeholders (UIHL, JPH, HHS, Iowa PC, MCD's) about costs and benefits, and report.		1 month
Examine limitations of current subacute services.	▪ Evaluate Iowa Admin Code for subacute. ▪ Compile examples of limitations. ▪ Write a position paper?	▪ MJ	3 months
Intensive case management / boundary spanners.	▪ Critical Time Interventions between Level 6 to Level 5. ▪ Shelter House starting with a grant. ▪ Who provides? Level 6 provider vs. community provider? ▪ Evaluate opportunities of existing structures and new outcomes.	MF & SOC	1 year
Staff cross-training – BH and SUD.			1 year
Evaluate and assess outflow opportunities when ready to step down to lower levels of care.	▪ Mapping of supportive housing units and supportive placements in the community.	▪ ES / CSH	6 – 8 months.

Additional Notes

Secure Supported Housing and Long-Term Hospital Level Care

Key Components:

- Development of secure supported housing facilities.
- Establishment of long-term hospital-level care units.
- Integration of mental health and substance use disorder treatment.

Tasks:

1. **Assess Community Needs:** Conduct a needs assessment to determine the demand for secure supported housing and long-term care.
2. **Funding and Resources:** Secure funding through grants, government programs, and partnerships with healthcare organizations.
3. **Facility Development:** Identify and develop suitable locations for housing and care units.
4. **Staff Training:** Train staff in mental health and substance use disorder treatment.
5. **Community Outreach:** Engage with community stakeholders to ensure support and collaboration.

Responsible Organizations/Points of Contact:

- **Local Health Departments:** Oversee the needs assessment and funding applications.
- **Housing Authorities:** Manage the development of housing facilities.
- **Healthcare Providers:** Provide long-term hospital-level care and staff training.
- **Community Organizations:** Facilitate outreach and stakeholder engagement.

Continued…

*Data Elements

- Level 5 – RCF
- 6 – no hospital > 5 > 4
- Secure.
- Services – 24/7 nursing
- Provider Services 2x week
- Intensive Case management

- Calculate costs.

- Data gathering – UIHL / GLC.
    - Patients over 12 months >/month.
    - Patients over 12 months > 5 admissions.

Transitional/Emergent Housing

Key Components:

- Provision of transitional housing that offers long-term, hospital-level care.
- Support services for individuals transitioning from crisis situations.

Tasks:

1. **Identify Transitional Housing Needs**: Determine the specific needs for transitional housing in the community.
2. **Develop Housing Programs**: Create programs that offer both short-term and long-term care.
3. **Collaborate with Healthcare Providers**: Partner with hospitals and clinics to provide necessary medical and behavioral health services.
4. **Implement Support Services**: Offer case management, counseling, and other support services to residents.

Responsible Organizations/Points of Contact:

- **Social Services Agencies**: Identify housing needs and develop programs.
- **Healthcare Providers**: Collaborate to offer medical and behavioral health services.
- **Non-Profit Organizations**: Implement support services and case management.

Priority Area #2: Support development of the jail that can provide adequate and supportive treatment.

Objective	Action Step	Who	When
Define what "supportive and adequate" treatment means.	▪ Identify needs.	▪ CJCC	CJCC has timeline in place.
	▪ Research evidence-based best practices.		
	▪ Identify providers of needed services.		
Replace the jail.	▪ Secure funding.	▪ CJCC ▪ Bar Association	
	▪ Educate: o Voters o Board of Supervisors o Media		
	▪ Provide more space for treatment.		
Humanizing the corrections process.	▪ Identify and secure community partners / service providers.	▪ CJCC ▪ JCSO ▪ IDOC	
	▪ Space to offer individualized care.		
	▪ Data through storytelling. o Multiple perspectives.		
	▪ Monitor and evaluate the effectiveness of services.		

Group Participants: Denise Brotherton, Michelle Heinz, Jes Lang, Dustin Liston, Andrew McKnight, Becky Moses, Brian Mullinnix, Alton Poole, Keinna Pope, Lynne Rose, Courtney Rust, Unity Stevens, Deb Summers, and Emily Voss.

Additional Notes:

Support the Development of a Jail that Can Provide Adequate and Supportive Treatment

Key Components:

- Development of jail facilities that offer adequate treatment.
- Integration of behavioral health services within jails.
- Collaboration with external healthcare providers.

Tasks:

1. **Assess Jail Needs**: Conduct an assessment to determine the specific needs for treatment within jails.
2. **Facility Upgrades**: Upgrade jail facilities to accommodate treatment services.
3. **Hire Qualified Staff**: Employ healthcare professionals to provide behavioral health services.
4. **Establish Partnerships**: Collaborate with external healthcare providers for additional support.
5. **Monitor and Evaluate**: Continuously monitor and evaluate the effectiveness of treatment services.

Responsible Organizations/Points of Contact:

- **Correctional Facilities**: Assess needs and upgrade facilities.
- **Healthcare Providers**: Provide behavioral health services and staff.
- **Government Agencies**: Facilitate partnerships and funding.
- **Monitoring Teams**: Oversee the evaluation of treatment services.

Priority Area #3: Improve data sharing and inter-agency cooperation.

Objective	Action Step	Who	When
Understand legal restrictions on flow of information (client information – ID)	▪ Legal review of polity and confidentiality of medical information and records.	▪ RZ (JoCo Attorney)	June SOC meeting.
	▪ Education / Develop role to track privacy law changes. ▪ ID stakeholders not at SOC.	▪ AS (GuideLink Center)	June SOC meeting.
	▪ Create flow-chart / map for interagency information sharing / restrictions.	▪ SOC Agenda?	AS flowchart – August.
Develop HUG (High Utilizers Group).	▪ Identify existing high utilizer groups.	▪ LW send email requesting feedback and collect.	May SOC meeting.
	▪ Research / choose evidence-based model.	▪ KB-F w/JSCO and ICPD reps.	August
	▪ Setup meeting infrastructure.	▪ JoCo programs.	1st meeting projected January 2026.
	▪ Agree upon roles / Values	▪ HUG group – Lindsey agenda	January 2026
	▪ Mission Statement		
Report data / savings outcomes to community.	▪ ID most meaningful KPIs.	▪ HUG group – Carrie	January 2026
	▪ ID person to analyze.	▪ Request KPD assist.	December 2026
	▪ Use report to educate community.	▪ PIO	February 2027

Group Participants: Kyle Burke, Patrick Butler, Carrie Crain, Kristie Davis, Kayla Borja Frost, Lori Hancock-Muck, Faraji Hubbard, Mike Mothershed, Ashley Salinas, Laura Semprini, Kelsie Tomlin, Lindsey White, and Rachel Zimmerman Smith.

Additional Notes:

Collecting and Sharing Data to Support Shared Goals

Key Components:

- Enhanced communication between agencies.
- Creation of shared data points and goals.
- Data integrity and collection methodology.
- Boundary spanners to connect all intercepts.
- Cross-system training and community education.

Tasks:

1. **Develop Data Sharing Protocols:** Establish protocols for data sharing between agencies.
2. **Create Shared Goals:** Define shared goals and metrics for success.
3. **Implement Data Collection Methods:** Develop standardized methods for data collection and ensure data integrity.
4. **Train Boundary Spanners:** Identify and train individuals to act as boundary spanners across intercepts.
5. **Community Education:** Educate the community on the importance of data sharing and collaboration.

Responsible Organizations/Points of Contact:

- **Data Management Teams:** Develop and oversee data-sharing protocols.
- **Community Health Organizations:** Define shared goals and metrics.
- **Training Institutes:** Provide training for boundary spanners.
- **Educational Institutions:** Facilitate community education initiatives.

RECOMMENDATIONS

1. **Recommendation: Increase and improve housing options.**

   Communities around the country have begun to develop more formal approaches to housing development, including use of the Housing First model. The 100,000 Home Initiative identifies key steps for communities to take to expand housing options for persons with mental illness.

   A strong housing continuum includes emergency shelters, landlord support and intervention, rapid rehousing, Permanent Supportive Housing (with or without Housing First but including supportive services such as case management, treatment, employment, etc.), Supported Housing (partial rent subsidies), transitional housing, affordable rental housing, and home ownership. In addition, consider how dependent care, institutional care, home-based services such as FACT, FUSE and ACT, halfway houses, and respite care can support specific populations needs.

   Housing needs were listed as one of the priorities, as a gap in every intercept and one of the topics addressed in action planning. Housing needs identified included emergency, transitional and long-term housing options. The action plan developed during the workshop and the additional notes developed by Office Alton Poole start to address this area. Building off those efforts and due to the scope of this problem, we would suggest that a cost-benefit analysis be done to look at the impact types of housing or lack thereof have on the community. For example, if you were to find that 70% of the incarcerated population are released to homelessness and then are rearrested you could associate a cost that is being incurred by the county. You could potentially use that as a basis to as an example, support a PEER run transitional house that individuals go to and then track the savings that resources has on the system. There are many areas you could look at for emergency, transitional and permanent housing but again the focus is to analyze current cost and use that to support a solution in one area rather than expecting to solve and fund all the housing needs.

   The following resources are suggested to guide strategy development. See also Housing under Resources below.

- GAINS Center. Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System.
- Stefancic, A., Hul, L., Gillespie, C., Jost, J., Tsemberis, S., and Jones, H. (2012). Reconciling Alternative to Incarceration and Treatment Mandates with a Consumer Choice Housing First model: A Qualitative study of Individuals with Psychiatric Disabilities. Journal of Forensic Psychology Practice, 12, 382–408.
- Tsemberis, S. (2010). Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction. Center City, MN: Hazelden Press.
- Stefancic, A., Henwood, B. F., Melton, H., Shin, S. M., Lawrence-Gomez, R., and Tsemberis, S. (2013). Implementing Housing First in Rural Areas: Pathways Vermont, American Journal of Public Health, 103, 206–209.
- Shifting the Focus from Criminalization to Housing. Funders Together for Housing Justice. (2016) Maria Foscarinis, Executive Director National Law Center on Homelessness & Poverty.
- Lehman, M.H., Brown, C.A., Frost, L.E., Hickey, J.S., and Buck, D.S. (2012). Integrated Primary and Behavioral Health Care in Patient-Centered Medical Homes for Jail Releases with Mental Illness. Criminal Justice and Behavior, published online.
- Built for Zero (formerly Zero: 2016) is a rigorous national change effort working to help a core group of committed communities end veteran and chronic homelessness. Coordinated by Community Solutions, the national effort supports participants in developing real time data on homelessness, optimizing local housing resources, tracking progress against monthly goals, and accelerating the spread of proven strategies.

2. **Recommendation: At all stages of the Sequential Intercept Model, gather data to document the processing of people with mental health and substance use disorders through the criminal justice system locally.**

   This was another area discussed throughout the intercepts and included in the list of priorities and action planning during the workshop.

   Improving cross-system data collection and integration is key to identifying high-user populations, justifying expansion of programs, and measuring program outcomes and success. Creating a data match with information from local/state resources from time of arrest to pre-trial can enhance diversion opportunities before and during the arraignment process.

   It is important for each organization to define terms initially, so there is a common definition developed of what populations/issues communities/organizations are trying to understand. Learn from each system how that data point is collected, coded and stored. Seek common identifiers to match populations.

   Data collection does not have to be overly complicated. For example, some 911 dispatchers spend an inordinate amount of time on comfort and support calls. Collecting information on the number of calls, identifying the callers and working to link the callers to services has been a successful strategy in other communities to reduce repeated calls. In addition, establishing protocols to develop a “warm handoff”

or direct transfers to crisis lines can also result in directing calls to the most appropriate agency and result in improved service engagement.

Dashboard indicators can be developed on the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation, etc.

A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to better identify opportunities for programming and to determine where existing initiatives require adjustments.

Consider joining the Arnold Foundation and National Association of Counties (NACo) Data-Driven Justice Initiative (DDJ). The publication "Data-Driven Justice Playbook: How to Develop a System of Diversion" provides guidance on development of data driven strategies and use of data to develop programs and improve outcomes.

See also the Data Analysis and Matching publications in the Resources section.

3. **Recommendation: Address Cross intercept communication at all intercepts.**

   Knowledge is power and when resources are scarce, knowledge is critical. From different contact points to include the emergency room, crisis teams, law enforcement, jail booking and release, attorneys, judges and all other points throughout the Sequential Intercept Model information is obtained on justice involved individuals. Some information gets passed along while other information does not. With confidentiality limitations and other resource limitations it would be beneficial as a system to review what information is needed and create a process for that information to follow the individual. This is not about comprehensive data but rather capturing and sharing relevant data (e.g. the person has walked out of treatment 3 times or the person has funding for an apartment but is missing the deposit.) at transition points throughout the intercepts. This knowledge can be crucial in creating a diversion opportunity and can be managed by a document or an advocate (case manager or peer) that is assigned to the individual at the initial point of contact. Thinking in the terms of diversion versus handing off to the next step in the process creates opportunities to intervene and reduce future contacts with these individuals in prior intercepts

4. **Recommendation: Target strategies/interventions to address the arrest, incarceration, and re-arrest cycles of homeless individuals and other individuals that return to the healthcare and/or criminal justice system repeatedly.**

   Communities across the country have developed strategies to concentrate resources on "familiar faces" or high utilizers of services. Strategies involve a developing a coordinating committee composed of mid-level managers of provider agencies, direct service individuals and criminal justice personnel who are able to mobilize resources to engage individuals in a timely way and at periods of high need, e.g., ER visit, police contact or arrest. Often the individuals identified as high users have priority for intensive services including ACT, case management and housing. These initiatives commonly report reductions in ER use, inpatient stays, police contacts and homelessness.

Some of the gaps identified during the workshop that would support developing strategies for this population include:

- Many stakeholders are unclear about how to serve people effectively, and those that do share existing laws are often not strong enough, including through the state commitment process or when individuals are transported to a detox facility, where they can leave without restriction, resulting in people returning to their harmful behaviors.
    - For those who leave, a pickup order is put in place; however, with no next step, the process becomes a revolving door.
    - Some SUD providers will place individuals in residential housing programs and services and then remove them from commitment to break the cycle.
- Mental health-related calls for EMS services consume a significant amount of time, resulting in the EMS unit being unavailable for extended periods.
- There is a general challenge in identifying the demand for resources within the community, which could be useful for enhancing the tracking of individuals.
- Mobile crisis teams will only respond if the individual is willing to engage with the team.
- There is a lack of locked psychiatric units to place people experiencing a crisis. The only option is typically a state hospital which is often at capacity.

If Johnson County were to focus on "familiar faces" or high utilizers with the goal of diversion from the justice system this group could be "flagged" and connected with crisis response, peers or both so that when contact does occur, they are immediately diverted or handed off to a team that has more extensive knowledge about their history and can aid in diverting that individual. This approach would also be a great data point focused on cost savings but measure contacts frequencies over time.

The Center for Supportive Housing Frequently Used System Engagers (FUSE) Resource Center describes supportive housing initiatives for super utilizers of jails, hospitals, healthcare, emergency shelters and other public systems.

Camden New Jersey has developed a promising collaboration of healthcare, social service, and law enforcement services to address their "complex care" populations that have frequent contact with their hospitals and sometimes police. They have been showing success in reducing repeated contact and improving health.

See also the Crisis Care, Crisis Response, and Law Enforcement publications in the Resources below.

5. **Recommendation: The establishment or expansion of a 24/7 crisis services provider that can serve as a centralized access point for care, to improve access and outcomes for individuals experiencing behavioral health crises in Johnson County.**

   A centralized access point provider would operate continuously and offer integrated services including a crisis hotline, mobile crisis response teams, and crisis stabilization options. For example, a local model could mirror aspects of Oregon's CAHOOTS or the Deschutes County Stabilization Center, where

individuals in crisis can receive immediate, person-centered care instead of being routed through law enforcement or emergency departments.

The 24/7 service should be closely coordinated with law enforcement, 911 dispatch, emergency rooms, and community health providers to ensure smooth referrals and warm handoffs. This approach not only reduces strain on emergency systems but also builds community trust and increases long-term treatment engagement.

6. **Recommendation: Expand jail-based in-reach services to allow for consistent engagement from behavioral health and social service providers, including the use of virtual technology.**

   Updating in-reach services enables providers to begin discharge planning, conduct mental health assessments, and offer peer support before individuals are released. For instance, programs like the Multnomah County reentry model or Franklin County Peer Navigator initiative have demonstrated success by connecting individuals with supports before and after incarceration.

   Virtual in-reach—such as telehealth counseling and case management—also ensures continuity of care when in-person visits are limited. Formalizing and supporting in-reach programs can significantly reduce recidivism, improve mental health outcomes, and support smoother transitions back into the community through coordinated service delivery.

RESOURCES

Competence Evaluation and Restoration

- Policy Research Associates. Competence to Stand Trial Microsite.
- Policy Research Associates. (2007, re-released 2020). Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

- National Council for Behavioral Health. (2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response.
- National Association of State Mental Health Program Directors. Crisis Now: Transforming Services is Within our Reach.
- National Association of Counties. (2010). Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- Abt Associates. (2020). A Guidebook to Reimagining America's Crisis Response Systems.
- Urban Institute. (2020). Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices.
- Open Society Foundations. (2018). Police and Harm Reduction.
- Center for American Progress. (2020). The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call.
- Vera Institute of Justice. (2020). Behavioral Health Crisis Alternatives: Shifting from Policy to Community Responses.
- National Association of State Mental Health Program Directors. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.
- National Association of State Mental Health Program Directors and Treatment Advocacy Center. (2017). Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care.
- R Street. (2019). Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response.
- Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.
- Substance Abuse and Mental Health Services Administration. (2019). Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities.

- Substance Abuse and Mental Health Services Administration. (2020). Crisis Services: Meeting Needs, Saving Lives.
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- Crisis Intervention Team International. (2019). Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises.
- Suicide Prevention Resource Center. (2013). The Role of Law Enforcement Officers in Preventing Suicide.
- Bureau of Justice Assistance. (2014). Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.
- International Association of Chiefs of Police. One Mind Campaign: Enhancing Law Enforcement Engagement with People in Crisis, with Mental Health Disorders and/or Developmental Disabilities.
- Bureau of Justice Assistance. Police-Mental Health Collaboration Toolkit.
- Policy Research Associates and the National League of Cities. (2020). Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers.
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- Optum. (2015). In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program (CAMP) is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.

Brain Injury

- National Association of State Head Injury Administrators. (2020). Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs.
- National Association of State Head Injury Administrators. Supporting Materials including Screening Tools and Sample Consent Forms.

Housing

- The Council of State Governments Justice Center. (2021). Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails: Recommendations to California's Council on Criminal Justice and Behavioral Health.
- Alliance for Health Reform. (2015). The Connection Between Health and Housing: The Evidence and Policy Landscape.
- Economic Roundtable. (2013). Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.
- 100,000 Homes. Housing First Self-Assessment.
- Community Solutions. Built for Zero.
- Urban Institute. (2012). Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.
- Corporation for Supportive Housing. Guide to the Frequent Users Systems Engagement (FUSE) Model.

    - Corporation for Supportive Housing. NYC Frequent User Services Enhancement – Evaluation Findings.
    - Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Substance Abuse and Mental Health Services Administration. (2015). TIP 55: Behavioral Health Services for People Who Are Homeless.
- National Homelessness Law Center. (2019). Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities.

Information Sharing/Data Analysis and Matching

- Center for Policing Equity. (2020). Toolkit for Equitable Public Safety.
- Legal Action Center. (2020). Sample Consent Forms for Release of Substance Use Disorder Patient Records.
- Council of State Governments Justice Center. (2010). Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws.
- American Probation and Parole Association. (2014). Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.
- The Council of State Governments Justice Center. (2011). Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.
- Substance Abuse and Mental Health Services Administration. (2019). Data Collection Across the Sequential Intercept Model: Essential Measures.
- Substance Abuse and Mental Health Services Administration. (2018). Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide.
- Data-Driven Justice Initiative. (2016). Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. (2013). Justice Reinvestment at the Local Level: Planning and Implementation Guide.
- Vera Institute of Justice. (2012). Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.
- New Orleans Health Department. (2016). New Orleans Mental Health Dashboard.
- The Cook County, Illinois Jail Data Linkage Project: A Data Matching Initiative in Illinois became operational in 2002 and connected the behavioral health providers working in the Cook County Jail with the community mental health centers serving the Greater Chicago area. It quickly led to a change in state policy in support of the enhanced communication between service providers. The system has grown in the ensuing years to cover significantly more of the state.

Jail Inmate Information/Services

- NAMI California. Arrested Guides and Medication Forms.
- NAMI California. Inmate Mental Health Information Forms.
- Urban Institute. (2018). Strategies for Connecting Justice-Involved Populations to Health Coverage and Care.
- R Street. (2020). How Technology Can Strengthen Family Connections During Incarceration.

Medication-Assisted Treatment (MAT)/Opioids/Substance Use

- American Society of Addiction Medicine. Advancing Access to Addiction Medications.

- American Society of Addiction Medicine. (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.
    - ASAM 2020 Focused Update.
    - Journal of Addiction Medicine. (2020). Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.
- National Commission on Correctional Health Care and the National Sheriffs' Association. (2018). Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field.
- National Council for Behavioral Health. (2020). Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit.
- Substance Abuse and Mental Health Services Administration. (2019). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings.
- Substance Abuse and Mental Health Services Administration. (2019). Medication-Assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion.
- Substance Abuse and Mental Health Services Administration. (2015). Federal Guidelines for Opioid Treatment Programs.
- Substance Abuse and Mental Health Services Administration. (2020). Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder.
- Substance Abuse and Mental Health Services Administration. (2014). Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide.
- Substance Abuse and Mental Health Services Administration. (2015). Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.
- U.S. Department of Health and Human Services. (2018). Facing Addiction in America: The Surgeon General's Spotlight on Opioids.

Mental Health First Aid

- Mental Health First Aid. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
- Illinois General Assembly. (2013). Public Act 098-0195: Illinois Mental Health First Aid Training Act.
- Pennsylvania Mental Health and Justice Center of Excellence. City of Philadelphia Mental Health First Aid Initiative.

Peer Support/Peer Specialists

- Policy Research Associates. (2020). Peer Support Roles Across the Sequential Intercept Model.
- Department of Behavioral Health and Intellectual disability Services. Peer Support Toolkit.
- University of Colorado Anschutz Medical Campus, Behavioral Health and Wellness Program (2015). DIMENSIONS: Peer Support Program Toolkit.
- Local Program Examples:
    - People USA. Rose Houses are short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. They are 100% operated by peers.
    - Mental Health Association of Nebraska. Keya House is a four-bedroom house for adults with mental health and/or substance use issues, staffed with Peer Specialists.
    - Mental Health Association of Nebraska. Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.
    - MHA NE/Lincoln Police Department REAL Referral Program. The REAL referral program works closely with law enforcement officials, community corrections officers

and other local human service providers to offer diversion from higher levels of care and to provide a recovery model form of community support with the help of trained Peer Specialists.

Pretrial/Arraignment Diversion

- Substance Abuse and Mental Health Services Administration. (2015). Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System.
- CSG Justice Center. (2015). Improving Responses to People with Mental Illness at the Pretrial Stage: Essential Elements.
- National Resource Center on Justice Involved Women. (2016). Building Gender Informed Practices at the Pretrial Stage.
- Laura and John Arnold Foundation. (2013). The Hidden Costs of Pretrial Diversion.
- Washington State Institute of Public Policy. (2014). Predicting Criminal Recidivism: A Systematic Review of Offender Risk Assessments in Washington State.

Procedural Justice

- Center for Court Innovation. (2019). Procedural Justice at the Manhattan Criminal Court.
- Chintakrindi, S., Upton, A., Louison A.M., Case, B., & Steadman, H. (2013). Transitional Case Management for Reducing Recidivism of Individuals with Mental Disorders and Multiple Misdemeanors.
- American Bar Association. (2016). Criminal Justice Standards on Mental Health.
- Hawaii Opportunity Probation with Enforcement (HOPE) Program Profile. (2011). HOPE is a community supervision strategy for probationers with substance use disorders, particularly those who have long histories of drug use and involvement with the criminal justice system and are considered at high risk of failing probation or returning to prison.

Reentry

- Substance Abuse and Mental Health Services Administration. (2017). Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.
- Substance Abuse and Mental Health Services Administration. (2016). Reentry Resources for Individuals, Providers, Communities, and States.
- Substance Abuse and Mental Health Services Administration. (2020). After Incarceration: A Guide to Helping Women Reenter the Community.
- National Institute of Corrections and Center for Effective Public Policy. (2015). Behavior Management of Justice-Involved Individuals: Contemporary Research and State-of-the-Art Policy and Practice.
- The Council of State Governments Justice Center. (2009). National Reentry Resource Center
- Community Oriented Correctional Health Services. Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies.
- Washington State Institute of Public Policy. (2014). Predicting Criminal Recidivism: A Systematic Review of Offender Risk Assessments in Washington State.

Screening and Assessment

- Substance Abuse and Mental Health Services Administration. (2019). Screening and Assessment of Co-occurring Disorders in the Justice System.

- The Stepping Up Initiative. (2017). Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.
- Center for Court Innovation. Digest of Evidence-Based Assessment Tools.
- Urban Institute. (2012). The Role of Screening and Assessment in Jail Reentry.
- Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., and Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56, 816-822.

Sequential Intercept Model

- Policy Research Associates. The Sequential Intercept Model Microsite.
- Munetz, M.R., and 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.
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). The Sequential Intercept Model and Criminal Justice. New York: Oxford University Press.
- Urban Institute. (2018). Using the Sequential Intercept Model to Guide Local Reform.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states but also provides monthly income sufficient to access housing programs.

- The online SOAR training portal.
- Information regarding FAQs for SOAR for justice-involved persons.
- Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. Psychiatric Services, 65, 1081-1083.

Telehealth

- Remington, A.A. (2016). 24/7 Connecting with Counselors Anytime, Anywhere. National Council Magazine. Issue 1, page 51.

Transition-Aged Youth

- National Institute of Justice. (2016). Environmental Scan of Developmentally Appropriate Criminal Justice Responses to Justice-Involved Young Adults.
- Harvard Kennedy School Malcolm Weiner Center for Social Policy. (2016). Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21.
- Roca, Inc. Intervention Program for Young Adults.
- University of Massachusetts Medical School. Transitions to Adulthood Center for Research.

Trauma and Trauma-Informed Care

- SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.
- SAMHSA. (2014). TIP 57: Trauma-Informed Care in Behavioral Health Services.
- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. (2011). Essential Components of Trauma Informed Judicial Practice.

- SAMHSA's GAINS Center. (2011). Trauma-Specific Interventions for Justice-Involved Individuals.
- National Resource Center on Justice-Involved Women. (2015). Jail Tip Sheets on Justice-Involved Women.
- Bureau of Justice Assistance. VALOR Officer Safety and Wellness Program.

Veterans

- SAMHSA's GAINS Center. (2008). Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions.
- Justice for Vets. (2017). Ten Key Components of Veterans Treatment Courts.

Resources Effective June 3, 2024

APPENDIX

Appendix A	**Participant List** – Sequential Intercept Model (SIM) Mapping Workshop
Appendix B	**Agendas** – Sequential Intercept Model (SIM) Mapping Workshop
Appendix C	**Results –** Community Self-Assessment (CSA) Survey

APPENDIX A: SIM WORKSHOP PARTICIPANTS

Name	Title or Role	Agency or Organization
Kayla Borja Frost	Regional Director	Community and Family Resources GuideLink Center
Denise Brotherton	Captain, Field Operations	Iowa City Police Department
Kyle Burke	Community Member	
Patrick Butler		
Leslie Carpenter	Mental Health Advocate	Iowa Mental Health Advocate
Carrie Crain	AOT Director	AbbeHealth GuideLink Center
Kristie Davis	Crisis Co-Responder Officer	Iowa City Police Department
Abbey Ferenzi	Executive Director	AbbeHealth GuideLink Center
Dr. Michael Flaum	Psychiatrist	UIHC
Rachel Fry, RN	Nurse Manager	Community and Family Resources GuideLink Center
Lori Hancock-Muck	Statewide Behavioral Health Manager	Iowa Judicial Branch
Michelle Heinz	Executive Director	Inside Out Recovery Services
Faraji Hubbard	Peer Recovery Coordinator	AbbeHealth GuideLink Center
Monika Jindal, MD	Medical Director	AbbeHealth GuideLink Center
Brad Kunkel	Johnson County Sheriff	Johnson County Sheriff's Office
Jes Lang	Community Violence Prevention Coordinator	Johnson County Attorney's Office
Dustin Liston	Police Chief	Iowa City Police Department
Andrew McKnight		
Becky Moses	Jail Lieutenant	Johnson County Sheriff's Office
Mike Mothershed	Mobile Integrated Health	Johnson County Ambulance
Brian Mullinnix	Residential Supervisor – Hope House	6th Judicial DOC
Eric Neiland	Community Outreach Sargeant	Iowa City Police Department
Jude Pannell	Assistant County Attorney	Johnson County Attorney's Office
Alton Poole	Community Outreach Specialist	University of Iowa Police Department
Keinna Pope	Law Enforcement / Mental Health Liaison	Johnson County Sheriff's Office
Lynne Rose	Assistant County Attorney (AOT)	Johnson County Attorney's Office
Courtney Rust	Johnson County Jail Corrections Nurse	Johnson County Sheriff's Office
Ashley Salinas	Support Services Supervisor	AbbeHealth GuideLink Center
Laura Semprini	Remote Peer Support Coordinator	Johnson County NAMI
Unity Stevens	SCIP Lead	AbbeHealth GuideLink Center
Erin Sullivan	Director of Programs	Shelter House
Rod Sullivan	Supervisor	Johnson County Board of Supervisors
Deb Summers		Coralville Police Department
Kelsie Tomlin	Mental Health / Law Enforcement Liaison	ICPD/CommUnity Crisis Services
Emily Voss	Assistant County Attorney, Family Treatment Court	Johnson County Attorney's Office
Lindsey White	Priority Access Therapist	UIHC
Chris Wisman	Lieutenant	Johnson County Sheriff's Office
Rachel Zimmerman Smith	County Attorney	Johnson County Attorney's Office

APPENDIX B: SIM WORKSHOP AGENDA

SAMHSA's GAINS CENTER

SAMHSA

Sequential Intercept Model Mapping Workshop

Johnson County, IA

April 1, 2025

AGENDA

8:30 **Registration and Networking**

9:00 **Openings**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

The Sequential Intercept Model
- The Basis of Cross-Systems Mapping
- Six Key Points for Interception

Cross-Systems Mapping
- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities
- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up
- Review
- Setting the Stage for Day 2

4:30 **Adjourn**

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

SAMHSA's GAINS CENTER

SAMHSA

Sequential Intercept Model Mapping Workshop

Johnson County, IA

April 2, 2025

AGENDA

8:30 **Registration and Networking**

9:00 **Opening**
- Remarks
- Preview of the Day

Review
- Day 1 Accomplishments
- Local County Priorities
- Keys to Success in Community

Action Planning

Finalizing the Action Plan

Next Steps

Summary and Closing

12:30 **Adjourn**

There will be a 15 minute break mid-morning.

APPENDIX C: RESULTS – COMMUNITY SELF-ASSESSMENT

SIM Workshop Participants by Role and Level of Agreement
Where on the Sequential Intercept Model is your role most related?

SIM Role		Responses	
Intercept 0: Community Services		45%	9
Intercept 1: Law Enforcement		20%	4
Intercept 2: Initial Detention/Initial Court Hearings		5%	1
Intercept 3: Jails/Courts		20%	4
Intercept 4: Reentry		0%	0
Intercept 5: Community Corrections		5%	1
Other		5%	1
	Total	**100%**	**20**

Please indicate your level of agreement with the following statements about your community. **Answered: 17**

Key Theme: Collaboration	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE OR DISAGREE		AGREE		STRONGLY AGREE		DON'T KNOW	
	%	#	%	#	%	#	%	#	%	#	%	#
There is cross-system recognition that many adults involved with the criminal justice system are experiencing mental disorders and substance use disorders.	0%	0	0%	0	6%	1	53%	9	41%	7	0%	0
There is cross-system recognition that all systems are responsible for responding to these adults with mental and substance use disorders.	0%	0	47%	8	6%	1	47%	8	0%	0	0%	0
The criminal justice and behavioral health systems are engaged in collaborative and comprehensive efforts to foster a shared understanding of gaps at each point in the justice system.	12%	2	12%	2	18%	3	53%	9	6%	1	0%	0
Family members of people with mental disorders or substance use disorders are engaged as stakeholders on criminal justice and behavioral health collaborations, such as committees, task forces, and advisory boards.	6%	1	29%	5	41%	7	18%	3	6%	1	0%	0
People with lived experience of mental disorders, substance use disorders, and the justice system are engaged as stakeholders on criminal justice and behavioral health collaborations, such as committees, task forces, and advisory boards.	6%	1	18%	3	53%	9	24%	4	0%	0	0%	0
Stakeholders have established a shared mission and goals to facilitate collaboration in criminal justice and behavioral health.	12%	2	41%	7	18%	3	24%	4	6%	1	0%	0
Stakeholders engage in frequent communication on criminal justice and behavioral health issues, including opportunities, challenges, and oversight of existing initiatives.	6%	1	29%	5	24%	4	24%	4	12%	2	6%	1
Stakeholders focus on overcoming barriers to implementing effective programs and policies for justice-involved adults with mental disorders or substance use disorders.	6%	1	18%	3	35%	6	41%	7	0%	0	0%	0
Based on research evidence and guidance on best practices, stakeholders are willing to change beliefs, behaviors, practices, and policies relating to justice-involved adults with mental disorders and substance use disorders.	12%	2	18%	3	12%	2	53%	9	0%	0	6%	1
In the justice system, criminal justice and behavioral health agencies share resources and staff to support initiatives focused on adults with mental disorders or substance use disorders.	12%	2	24%	4	18%	3	47%	8	0%	0	0%	0
Criminal justice and behavioral health agencies share data on a routine basis for program planning, program evaluation, and performance measurement.	29%	5	18%	3	18%	3	24%	4	0%	0	12%	2
Criminal justice and behavioral health agencies engage in cross-system education and training to improve collaboration and understanding of different agency priorities, philosophies, and mandates.	18%	3	12%	2	29%	5	35%	6	0%	0	6%	1

Please indicate your level of agreement with the following statements about your community. **Answered 17**

Key Theme: Identification	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE OR DISAGREE		AGREE		STRONGLY AGREE		DON'T KNOW	
	%	#	%	#	%	#	%	#	%	#	%	#
Adults in contact with the criminal justice system are screened for mental disorders by standardized instruments with demonstrated reliability and validity.	**0%**	0	**12%**	2	**24%**	4	**35%**	6	**0%**	0	**29%**	5
Adults in contact with the criminal justice system are screened for substance use disorders by standardized instruments with demonstrated reliability and validity.	**0%**	0	**6%**	1	**24%**	4	**35%**	6	**0%**	0	**35%**	6
Adults in contact with the criminal justice system are screened for violence and trauma-related symptoms by standardized instruments with demonstrated reliability and validity.	**0%**	0	**29%**	5	**24%**	4	**0%**	0	**0%**	0	**47%**	8
Adults in contact with the criminal justice system are screened for suicide risk by standardized instruments with demonstrated reliability and validity.	**0%**	0	**6%**	1	**35%**	6	**12%**	2	**6%**	1	**41%**	7
There are procedures to access crisis behavioral health services for adults in contact with the criminal justice system.	**0%**	0	**12%**	2	**18%**	3	**47%**	8	**6%**	1	**18%**	3
Mental health assessments are conducted routinely whenever a screening instrument indicates any such need for adults in contact with the criminal justice system.	**0%**	0	**18%**	3	**24%**	4	**24%**	4	**6%**	1	**29%**	5
Substance use assessments are conducted regularly whenever a screening instrument indicates any such need for adults in contact with the criminal justice system.	**0%**	0	**18%**	3	**24%**	4	**12%**	2	**6%**	1	**41%**	7
Risk assessments are performed in conjunction with screening and assessments to inform treatment and programming recommendations that balance public safety and behavioral health treatment needs.	**0%**	0	**24%**	4	**29%**	5	**18%**	3	**0%**	0	**29%**	5
Information obtained through screening and assessments is never used in a manner that jeopardizes an individual's legal interests.	**0%**	0	**6%**	1	**29%**	5	**24%**	4	**6%**	1	**35%**	6
Screens and assessments are administered on a routine basis as adults move from one point in the criminal justice system to another.	**0%**	0	**24%**	4	**24%**	4	**12%**	2	**6%**	1	**35%**	6
Regular data-matching between criminal justice agencies and behavioral health identifies active and former consumers who have entered the criminal justice system.	**24%**	4	**18%**	3	**29%**	5	**6%**	1	**0%**	0	**24%**	4

Please indicate your level of agreement with the following statements about your community. **Answered 17**

Key Theme: Strategies	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE OR DISAGREE		AGREE		STRONGLY AGREE		DON'T KNOW	
	%	#	%	#	%	#	%	#	%	#	%	#
Justice-involved people with mental and substance use disorders have access to comprehensive community-based services.	12%	2	18%	3	24%	4	29%	5	18%	3	0%	0
There are adequate crisis services to meet the needs of people experiencing mental health crises.	6%	1	18%	3	18%	3	59%	10	0%	0	0%	0
Emergency communications call-takers and dispatchers can effectively identify and communicate details about crisis calls to law enforcement and other first responders.	0%	0	12%	2	12%	2	59%	10	0%	0	18%	3
Law enforcement and other first responders are trained to respond to adults experiencing mental health crises effectively.	0%	0	6%	1	12%	2	35%	6	41%	7	6%	1
Pre-trial strategies are in place to reduce detention of low-risk defendants and failure to appear rates for people with mental and substance use disorders.	0%	0	12%	2	24%	4	35%	6	6%	1	24%	4
Pre-adjudication diversion strategies are as equally available as post-adjudication diversion strategies for individuals with mental disorders and substance use disorders.	0%	0	18%	3	24%	4	24%	4	6%	1	29%	5
Treatment courts are aligned with best-practice standards and serve high-risk/high-need individuals.	0%	0	6%	1	35%	6	35%	6	0%	0	24%	4
Jail-based programming and health care meet the complex needs of individuals with mental disorders and substance use disorders, including behavioral health care and chronic health conditions (e.g., diabetes, HIV/AIDS).	12%	2	24%	4	24%	4	18%	3	0%	0	24%	4
Jail transition planning is provided to inmates with mental disorders to improve post-release recidivism and health care outcomes.	0%	0	24%	4	18%	3	18%	3	0%	0	41%	7
Psychotropic medication or prescriptions are provided to inmates with mental disorders to bridge the gaps from the day of jail release to their first appointment with a community-based prescriber.	0%	0	6%	1	24%	4	35%	6	6%	1	29%	5
Medication-assisted treatment is provided to inmates with substance use disorders to reduce relapse episodes and risk for opioid overdoses following release from incarceration.	0%	0	18%	3	18%	3	18%	3	6%	1	41%	7
Community supervision agencies (probation and parole) field specialized caseloads for individuals with mental disorders to improve public safety outcomes, including reduced rates of technical violations.	0%	0	12%	2	35%	6	6%	1	0%	0	47%	8
Strategies to intervene with justice-involved adults with mental disorders and substance use disorders are evaluated regularly to determine whether they are achieving the intended outcomes.	0%	0	18%	3	35%	6	12%	2	0%	0	35%	6
Evaluation results are reviewed by representatives from the behavioral health and criminal justice systems	0%	0	24%	4	29%	5	6%	1	0%	0	41%	7

Please indicate your level of agreement with the following statements about your community. **Answered 16**

Key Theme: Services	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE OR DISAGREE		AGREE		STRONGLY AGREE		DON'T KNOW	
	%	#	%	#	%	#	%	#	%	#	%	#
Adults with mental disorders and substance use disorders in contact with the criminal justice system have access to a continuum of comprehensive and effective community-based behavioral health care services.	**6%**	1	**38%**	6	**0%**	0	**44%**	7	**0%**	0	**13%**	2
Regardless of the setting, all behavioral health services provided to justice-involved adults are evidence-based practices. Evidence-based practices are manual-based interventions with positive outcomes based on repeated rigorous evaluation studies.	**6%**	1	**19%**	3	**25%**	4	**19%**	3	**0%**	0	**31%**	5
Behavioral health service providers understand how to put the risk-need-responsivity framework into practice with justice-involved adults with mental disorders or substance use disorders.	**13%**	2	**25%**	4	**19%**	3	**6%**	1	**13%**	2	**25%**	4
Justice-involved adults are fully engaged with behavioral health providers to develop their treatment plans.	**25%**	4	**38%**	6	**31%**	5	**0%**	0	**0%**	0	**6%**	1
Access to housing, peer, employment, transportation, family, and other recovery supports for justice-involved adults with mental and substance use disorders are significant priorities for behavioral health providers.	**13%**	2	**13%**	2	**31%**	5	**31%**	5	**6%**	1	**6%**	1
Justice-involved adults with mental disorders or substance use disorders receive legal forms of identification and benefits assistance (e.g., Medicaid/Medicare and Social Security disability benefits).	**6%**	1	**0%**	0	**44%**	7	**25%**	4	**0%**	0	**25%**	4
The services and programs provided to justice-involved adults by the behavioral health and criminal justice systems are culturally sensitive and designed to meet the needs of people of color.	**6%**	1	**6%**	1	**50%**	8	**0%**	0	**0%**	0	**38%**	6
There are gender-specific services and programs for women with mental disorders and substance use disorders involved with the criminal justice system.	**0%**	0	**13%**	2	**44%**	7	**13%**	2	**0%**	0	**31%**	5
Behavioral health providers, criminal justice agencies, and community providers share information on individuals with mental disorders or substance use disorders to the extent permitted by law to assist the effective delivery of services and programs.	**25%**	4	**19%**	3	**13%**	2	**31%**	5	**0%**	0	**13%**	2

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