THE SEQUENTIAL INTERCEPT MODEL

SYSTEM LEVEL CHANGE EFFORTS

- Develop a comprehensive state plan for BH/CJ collaboration
- Legislate task forces to address the issues present
- Encourage collaboration amongst stakeholders
- Engage people with lived experience in all phases of planning, implementation and operation
- Institute statewide Mobile Crisis Intervention Services with qualified personnel
- Legislatively establish/fund jail diversion programs

SYSTEM LEVEL CHANGE EFFORTS, CONT'D

- Improve access to benefits (Medicaid/SSI) by suspending rather than terminating benefits
- Make housing a priority and remove constraints
- Expand supportive services through the implementation of evidence-based programs and co-occurring treatment
- Expand supportive housing, sustained recovery, supportive employment
- Individualize transition plans back into home/community
- Ensure systems are culturally competent, trauma informed, and gender specific when necessary.

INTERCEPT #1- LAW ENFORCEMENT

- Action steps:
- 1) Train 911 dispatchers to accurately ID MH/D&A calls
- 2) Document police contact with target population
- 3) Provide police friendly drop off/diversion opportunities
- 4) Ensure positive linkages amongst police, emergency responders, crisis teams, and local service providers
- 5) Provide follow up services for those leaving crisis stabilization
- 6) Establish CQI process for monitoring ongoing activity

INTERCEPT #2-INITIAL DETENTION/COURT HEARINGS

- Action Steps:
- 1) Institute empirically valid screenings for MH/D&A issues, assess for criminal risk, and initiate a process to identify those eligible for diversion/treatment.
- 2) Maximize opportunities for pre-trial release and assist defendants with BH issues in complying with conditions of pre-release
- 3) Link to comprehensive services that include Integrated Dual Disorder Treatment.
- 4) Ensure prompt access to benefits, health care , peer supports and housing.

INTERCEPT #3-JAILS/COURTS

- Action Steps:
- 1) Ensure any identified need for treatment in Intercept #2 is followed through
- 2) Maximize potential/use of specialty courts
- 3) Link to comprehensive services and supports
- 4) monitor progress with a Team approach to Court Progress Hearings
- 5) Ensure that all jail based services are coordinated comprehensively with community providers

INTERCEPT #4-RE-ENTRY

- Action Steps:
- 1) Assess using widely applicable needs/risk instruments and establish a boundary spanner position within jails/prisons to facilitate re-entry.
- 2) Establish a checklist for re-entry issues and establish a treatment/recovery/transition plan
- 3) Identify required services and utilize best practice models for pre-release service engagement
- 4) Make sure multidisciplinary transition meetings are held before release to avoids gaps in treatment

INTERCEPT #5-COMMUNITY CORRECTIONS

- Action Steps:
- 1) Start criminal risk-needs-responsivity assessment for all people under community supervision
- 2) Maintain a community of care providers identified through the transition plan with regular progress meetings with all providers and court supervisors
- 3) Implement a supervision strategy that is front end intensive and then gradually reduces as treatment firmly takes hold
- 4) Institute graduated responses and address violations and/or non-compliance with conditions with diversion into treatment rather than jail/prison.

SIM AND ALBUQUERQUE

INTERCEPT #1

- Assets already in place:
- 1) CIT detectives and CIT trained officers
- 2) COAST
- 3) 911 Center with trained staff members
- 4) Social Workers in APD and BCSO

INTERCEPT #1

- Gaps in available services:
- 1) A Mobile Crisis Team comprised of MH professionals who are independently licensed
- 2) A 35-50 bed Crisis Stabilization Unit (or similar step down from inpatient) with the ability to hold for 72 hours
- 3) An ACT (or similar) team attached to the Unit for follow up with clients
- 4) A change in MH Law allowing independently licensed professionals to initiate a 72 hour hold based upon compassionate need for treatment.

INTERCEPT #1

- Conclusions:
- 1) Establishing a treatment based diversion alternative would likely reduce jail population simply because **there is now nowhere else to take them except jails or hospitals, and hospitals have very narrowly defined criteria**
- 2) Once established, the effectiveness of these programs can be tracked quire simply using the "Data Points to Track" document (attached)
- Establishing and funding services in the gaps noted will offers an opportunity to fund diversion that is sorely needed and doesn't exist.

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Data Points to Track

Intercept 1: Law Enforcement

The list below contains potential data points that a county might track in order to evaluate the impact of the law enforcement responses to mental health emergences. This list may be expanded to include data related to the specific "priorities" of the locale (identified during the mapping session)

System-level

1. Percent of officers currently trained in crisis intervention
2. Dispatch
    a. # of calls identified by dispatch as involving mental illness
    b. # of calls referred to: trained crisis workers, police, MH worker, other

Example of a question that systems-level data might inform: Is there an increase in the proportion of calls involving persons with mental illness that are referred to trained crisis workers?

Incident-level

3. Background/training of respondent
    a. Profession
    b. Age
    c. Training

4. Disposition from visit
    a. Arrest
    b. Arrest and transport to hospital for medical tx
    c. Arrest and transport to psychiatric evaluation;
    d. Involuntary transport to psychiatric evaluation
    e. Transport for medical tx
    f. Transport to mental health facility other than hospital
    g. Referred to mental health/social services
    h. Contact only/situation resolved on scene with no additional action
5. Characteristics of the actor
    a. Age/DOB
    b. Gender
    c. Ethnicity
    d. SSN (or any other information that may serve as a unique identifier across systems)
6. Description of the incident
    a. Date of incident
    b. Time of day

c. Location (Specific address or categories e.g. private residence, public place)
d. Weapon involved?
e. Violence against a person?

Example of question that incident-level data might inform: Is the frequency of use of crisis services by a target population decreasing over a defined period of time?

In order to understand the long-term impact of the change in police responses at the system level (e.g. decrease arrests for the MH population by X percent) and at the individual level (e.g. increased amount of time between the current incident and next incident involving the crisis intervention team across individuals with mental health issues) it will be necessary to also understand if and when subsequent police contacts occurred. Thus, it's important to track information beyond the current incident and, if necessary, plan for collaborations with agencies holding other data resources.

f. Identify unique identifiers that cross data systems for matching purposes
g. Date of subsequent incidents
h. Type of subsequent incidents

Steps	Rationale	Actions	No Progress	In Progress	Completed
1. Develop clear goals	Once core providers have made commitments to improve the criminal justice and mental health systems' response to persons with mental illnesses and co-occurring substance use disorders, they need to set discrete goals and identify shared objectives. Doing so can help reinforce buy-in from partners and establish a clear direction.	• Identify individuals who have substantive expertise in the criminal justice and behavioral health treatment systems.			
		• Working together, establish common goals that link the two systems and are specific and attainable (e.g., reduced recidivism, reduced technical violations, increased access to treatment, increased retention in treatment).			
		• Identify the unique goals of each system to clarify and resolve any differences or misunderstandings that may exist among group members.			
		• Develop objectives and a work plan to help identify roles and responsibilities within the group.			
		• Ensure that system leaders and change agents are involved, informed, and supportive of the collaborative efforts.			
2. Get support from system leaders	Criminal justice and treatment collaboration efforts should have the endorsement from all systems' leaders on the county or state level, as well as from policymakers such as the county executive, mayor, or commissioner, whose support may be valuable.	• Develop mechanisms for communication between the system leaders to cultivate and maintain their support.			
		• Develop mechanisms to integrate perspectives from relevant community members, elected officials, leaders of faith communities, victims, advocates and other stakeholders.			
3. Identify and engage stakeholders	A wide range of individuals in the community have a vested interest in reducing recidivism and increasing access to mental health and/or substance abuse treatment for justice-involved individuals and agencies should involve them as appropriate.	• Involve consumers and their family members.			
4. Identify existing services and supports and gaps	Individuals with behavioral health problems involved in the criminal justice system have multiple and complex needs. Understanding what services and resources are available, as well as those that are not, can help agencies anticipate challenges that may arise when trying to address the range of needs that individuals may have.	• Conduct a "community audit" to determine what services are offered and delivered to clients involved in the criminal justice system.			
		• Develop a "map" of how individuals access existing services.			
		• Identify missing or insufficient services, practices, and programs.			

SECTION TWO: ASSESSING AND IMPLEMENTING EFFECTIVE PROGRAMS

Community-based providers often struggle with how to address the needs of clients involved with the criminal justice system. Behavioral health professionals may be concerned that criminal justice agencies refer types of individuals for which service providers have developed few effective interventions (such as for those who have personality disorders) and have expectations that treatment alone is sufficient to change their criminal behavior. Criminal justice professionals may be frustrated by the lack of alternatives to incarceration and the revolving-door nature of the population. Deep budget cuts to all systems have led to staff reductions and a diminished capacity to offer services. In this context, agencies should allocate their limited resources to interventions that—if properly implemented—have demonstrated positive outcomes for these clients as well as for the system.

What is the Distinction Between Evidence-Based Practices and Programs (EBPs)?

Fixsen, D., at al. (2005) defined evidence-based practices as "skills, techniques, and strategies that can be used by a practitioner" (e.g., cognitive behavioral therapy). These practices can be thought of as interventions shown to be effective that can be used individually or in combination to form more comprehensive programs. Evidence-based programs, as defined by Fixsen et al., are "collections of practices that are done within known parameters (philosophy, values, service delivery structure, and treatment components) and with accountability to the consumers and funders of those practices" (e.g., Assertive Community Treatment).

The checklist below outlines the EBPs that researchers, experts, and practitioners identified as being applicable for adults involved in the criminal justice system.[3] It is not intended to be exhaustive and some EBPs may be more challenging to implement, may not be currently available, or may be insufficient to meet the demand in many communities.[4] For example, integrated treatment[5] has been demonstrated as an EBP for individuals with serious mental illnesses and co-occurring substance use disorders,[vii] but the availability of integrated services remains limited in most communities.[viii]

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[3] For more information, see Osher, F. C., & Steadman, H. J. (2007). Adapting evidence-based practices for persons with mental illness involved with the criminal justice system. *Psychiatric Services, 58*(11), 1472-1478. Retrieved June 5, 2012, from http://ps.psychiatryonline.org/data/Journals/PSS/3824/07ps1472.pdf

[4] In an effort to provide communities with guidance to develop and implement core services to create an Essential System of Care, the National Leadership Forum on Behavioral Health/Criminal Justice Services identified 8 components. More information can be found at http://gainscenter.samhsa.gov/pdfs/nlf/AmericanTragedy.pdf

[5] SAMHSA has developed a range of materials to help agencies adopt policies and practices that support the planning and delivering of co-occurring disorder treatment services which can be accessed at http://www.samhsa.gov/co-occurring/

Domains[6]	Description	Implementation and Access Status *Fully (F), Partially (P), Not at all (N)*			Agency Capacity to Implement EBP
MENTAL HEALTH TREATMENT					
Evidence-Based Programs					
Assertive Community Treatment (ACT)[7]	Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Illness Management and Recovery (IMR)[8]	An approach that involves teaching clients skills and techniques to minimize the interference of psychiatric symptoms in their daily lives.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Integrated Mental Health and Substance Abuse Services[9]	Treatment and service provision to support recovery from co-occurring mental illness and substance abuse through a single agency or entity.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Supported Employment[10]	An EBP for people with severe developmental, mental, and physical disabilities that matches them with and trains them for jobs where their specific skills and abilities make them valuable assets to employers.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Psychopharmacology	Treatment that uses one or more medications (e.g., antidepressants) to reduce depression, psychosis, or anxiety by acting on the chemistry of the brain.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Evidence-Based Practices					
Cognitive Behavioral Therapy (CBT)[11]	A therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behavior through brief, direct, and time-limited structured counseling.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Motivational Enhancement Therapy (e.g., Motivational Interviewing)[12]	A consumer-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)

[6] The precise combination of treatment and services provided for one person must be guided by thoughtful assessment of his or her needs

[7] For more information on ACT, FACT, and FICM, visit http://gainscenter.samhsa.gov/pdfs/ebp/ExtendingAssertiveCommunity.pdf

[8] For more information on IMR, visit http://gainscenter.samhsa.gov/pdfs/ebp/IllnessManagement.pdf

[9] For more information on Integrated Mental Health and Substance Abuse Services, visit http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367 and http://gainscenter.samhsa.gov/pdfs/ebp/IntegratingMentalHealth.pdf

[10] For more information on Supported Employment, visit http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365.

[11] For more information on Cognitive Behavioral Therapy, visit http://gainscenter.samhsa.gov/cms-assets/documents/69181-899513.rottercarr2010.pdf

[12] For more information on Motivational Interviewing, visit http://gainscenter.samhsa.gov/pdfs/ebp/Motivational_Interviewing2011.pdf.

Domains[13]	Description	Implementation and Access Status *Fully (F), Partially (P), Not at all (N)*			Agency Capacity to Implement EBP
Promising Programs					
Supportive Housing[14]	A system of professional and/or peer supports that allows a person with mental illness to live independently in the community. Supports may include regular staff contact and the availability of crisis services or other services to prevent relapse, such as those focusing on mental health, substance abuse, and employment.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Forensic ACT (FACT)[7]	ACT-like programs that have been adapted for people involved in the criminal justice system and focus on preventing arrest and incarceration. ACT involves treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Forensic Intensive Case Management (FICM)[7]	Like FACT, FICM involves the coordination of services to help clients sustain recovery in the community and prevent further involvement with the criminal justice system. Unlike FACT, FICM uses case managers with individual caseloads as opposed to a self-contained team.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Promising Practices					
Cognitive Behavioral Treatment Targeted to Criminogenic Risks (e.g., Reasoning and Rehabilitation or Thinking for a Change)[15]	CBT interventions that are designed to address criminogenic risks and may focus on anger management, problem-solving, and assuming personal responsibility for behavior.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Forensic Peer Specialists[16]	Justice-involved clients who are in recovery provide support to other clients who are also involved, or at risk of becoming involved, in the criminal justice system.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)

[13] The precise combination of treatment and services provided for one person must be guided by thoughtful assessment of his or her needs

[14] For more information on Supportive Housing, visit http://gainscenter.samhsa.gov/pdfs/ebp/MovingTowardEvidence-BasedHousing.pdf.

[15] For more information on specific Cognitive Behavioral Therapies, visit http://static.nicic.gov/Library/021657.pdf

[16] For more information on Forensic Peer Specialists, visit http://gainscenter.samhsa.gov/peer_resources/pdfs/Davidson_Rowe_Peersupport.pdf

Domains[17]	Description	Implementation and Access Status *Fully (F), Partially (P), Not at all (N)*			Agency Capacity to Implement EBP
SUBSTANCE ABUSE AND DEPENDENCE TREATMENT					
Evidence-Based Programs for Substance Abuse and Dependence					
Modified Therapeutic Community (MTC)[18]	MTCs alter the traditional TC approach in response to the psychiatric symptoms, cognitive impairments, and other impairments commonly found among individuals with co-occurring disorders. These modified programs typically have (1) increased flexibility, (2) decreased intensity, and (3) greater individualization.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Promising Programs for Substance Abuse and Dependence					
12-Step or Other Mutual Aid Groups	Groups of non-professionals who share a problem and support one another through the recovery process.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Peer-Based Recovery Support Programs[19]	Justice-involved clients who are in recovery providing support to other clients who are also involved, or at risk of becoming involved, in the criminal justice system.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Evidence-Based Practices for Substance Abuse and Dependence					
Cognitive Behavioral Therapy (CBT)[20]	A therapeutic approach that helps clients address problematic behaviors and develop effective coping strategies to stop substance use and address other synchronous issues.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Motivational Enhancement Therapy (e.g., Motivational Interviewing)[13]	A consumer-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Contingency Management (CM) Interventions[21]	The objective of CM interventions is to reinforce a client's commitment to abstinence and to reduce his/her drug use using positive (e.g., vouchers) and negative (e.g., increased supervision) reinforcers in response to desired and undesired behaviors.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)

[17] The precise combination of treatment and services provided for one person must be guided by thoughtful assessment of his or her needs

[18] For more information on Modified Therapeutic Communities, visit http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=144

[19] For more information on Peer-Based Recovery Support Programs, visit http://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf

[20] For more information on Cognitive Behavioral Therapy, visit https://www.ncjrs.gov/pdffiles1/nij/229888.pdf

[21] For more information on Contingency Management, visit page 49 in http://static.nicic.gov/Library/023362.pdf

Domains[22]	Description	Implementation and Access Status *Fully (F), Partially (P), Not at all (N)*			Agency Capacity to Implement EBP
Evidence-Based Practices for Substance Abuse and Dependence, Continued					
Pharmacotherapy (i.e., Medication Assisted Treatments)[23]	Treatment that uses one or more medications as part of a comprehensive plan to reduce symptoms associated with dependence on drugs and/or alcohol.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Relapse Prevention Therapy [24]	A systematic treatment method of teaching recovering clients to recognize and manage relapse warning signs.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Behavioral Couples Therapy (BCT)[25]	A family treatment approach for couples that uses a "recovery contract" and behavioral principles to engage both people in treatment, achieve abstinence, enhance communication, and improve the relationship.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)
Promising Practices for Substance Abuse and Dependence					
Case Management[26]	An intervention that involves the coordination and/or direct delivery of services to meet the complex needs of justice-involved clients with substance use disorders.	F	P	N	Within your agency? Yes No Within partnering agencies? Yes No (if yes, list)

[22] The precise combination of treatment and services provided for one person must be guided by thoughtful assessment of his or her needs

[23] For more information on Pharmacotherapy, visit http://store.samhsa.gov/product/Medication-Assisted-Treatment-for-the-21st-Century/F038

[24] For more information on Relapse Prevention, visit http://kap.samhsa.gov/products/manuals/taps/19.htm

[25] For more information on Behavioral Couples Therapy, visit page 59 in http://static.nicic.gov/Library/023362.pdf

[26] For more information on Case Management for substance abuse and dependence in criminal justice settings, visit http://www.ncbi.nlm.nih.gov/books/n/tip27/A50228/#A50259

[i] Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2006). Prevalence of Serious Mental Illness Among Jail Inmates. *Psychiatric Services, 60*(6): 761-765.

[ii] For jail admissions, see Minton, T. D. (2011). Jail inmates at midyear 2010. (U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, DOJ Publication No. NCJ 174463). Washington, D.C. Retrieved from http://bjs.gov/content/pub/pdf/jim10st.pdf

[iii] Abram, K. M., & Teplin, L.A. (1991). Co-occurring disorders among mentally ill jail detainees, *American Psychologist, 46*(10): 1036–1045.

[iv] Ditton, P. (1999). *Mental Health and Treatment of Inmates and Probationers.* Washington, D.C.: Bureau of Justice Statistics. Retrieved June 3, 2012, from http://bjs.ojp.usdoj.gov/content/pub/pdf/mhtip.pdf

[v] Substance Abuse and Mental Health Services Administration. (2011). *The TEDS Report: Characteristics of Probation and Parole Admissions Aged 18 or Older (Center for Behavioral Health Statistics and Quality).* Rockville, MD. Retrieved from http://www.samhsa.gov/data/2k10/231Parole2k11Web/231Parole2k11.htm

[vi] Council of State Governments Justice Center (2005). *Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community.* New York, NY: Council of State Governments. Retrieved from http://reentrypolicy.org/Report/About

[vii] Drake, R. E., Essock, S.M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness, *Psychiatric Services, 52*(4): 469–476.

[viii] Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD. Retrieved from http://www.samhsa.gov/data/nsduh/2k8nsduh/2k8Results.htm