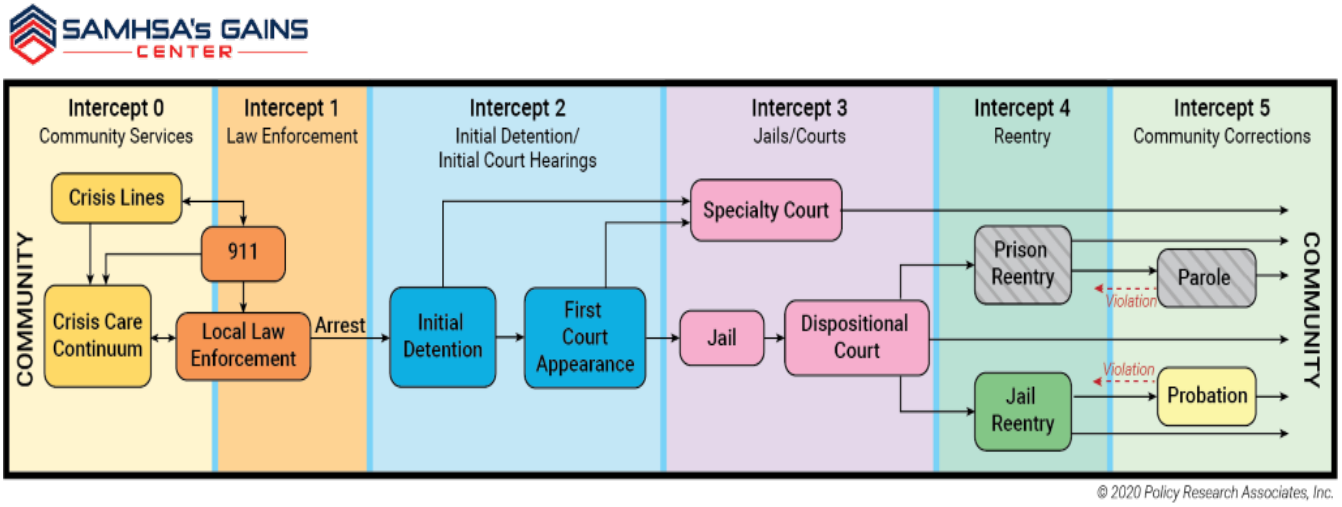
Texas Adult Sequential Intercept Model Mapping Best Practices

The Sequential Intercept Model (SIM) details how people with mental illness (MI), substance use disorders (SUD), and/or intellectual and developmental disabilities (IDD) encounter and move through the justice system.

SIM mapping workshops bring together community leaders across different agencies and systems to:

- Plot resources and gaps across the SIM;
- Identify local services to support diversion from the justice system;
- Introduce community system leaders and staff to evidence-based practices and emerging best practices related to each intercept;
- Enhance relationships across systems and agencies; and
- Create a customized local map and action plans to address gaps.



The Texas Behavioral Health and Justice Technical Assistance Center adapted SIM resources developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Policy Research Associates (PRA) to create this tool for Texas communities to use during SIM mapping workshops or as guidance for behavioral health and justice stakeholders to examine what programs and policies exist in their communities.

Best Practices Across Intercepts

There are five cornerstones that guide best practice recommendations across the justice system. All five cornerstones should be implemented at each intercept of the SIM.

- **Cross-systems collaboration and coordination of initiatives.** Coordinating bodies such as a behavioral health leadership team or behavioral advisory team can serve as a central infrastructure that supports accountability by fostering community buy-in, developing priorities and identifying funding streams.
- **Routine identification of people with MI and/or SUD.** People with MI and/or SUD should be identified through routine administration of validated, brief screenings and follow-up assessment as warranted.
- **Access to treatment for MI and/or SUD.** People with MI and SUD in the justice system should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.
- **Linkage to benefits to support treatment success, including Medicaid and Social Security.** People in the justice system routinely lack access to health care coverage. Practices such as Medicaid suspension while in jail (versus termination) and benefits specialists can reduce treatment gaps.
- **Information sharing and performance measurement among behavioral health, criminal justice and housing service providers.** Information sharing practices can assist communities in identifying frequent utilizers, providing an understanding of the population and its specific needs, and identifying gaps in the system.

Intercept 0: Community-Based Services

Best Practice Checklist

Intercept 0 highlights opportunities to divert people into local crisis care services and to connect people with behavioral health needs to treatment. Utilize this checklist to consider what exists in your community or what additional strategies you might pursue.

Someone to Call

- Local mental health authority (LMHA) or local behavioral health authority (LBHA) crisis hotline
- 988 Suicide & Crisis Lifeline
- Essential community services: 211
- Outreach, Screening and Assessment Referral (OSAR) line for SUD treatment
- 911 crisis call diversion to the LMHA/LBHA or local intellectual and developmental disability authority (LIDDA) crisis hotline

Someone to Respond

- Mobile crisis outreach teams (MCOT)
- Peer-operated crisis response teams
- Homeless outreach teams
- Assertive Community Treatment (ACT) providers

A Place to Go

- Crisis respite facilities and peer-led respite
- Extended observation units (EOU), crisis stabilization units (CSU) and crisis residential units (CRU)
- Intensive outpatient and partial hospitalization programs
- SUD treatment centers

Programs for Special Populations

- Frequent utilizer initiatives
- SUD-focused diversion
- Veteran-specific services
- LIDDA service coordinators
- Standardized mental health screenings

Data Collection and Information Sharing

- Establish essential data measures specific to Intercept 0.
- Information sharing across mental health crisis responders
- Dispatch coding of emergency mental health calls

Intercept 0: Best Practice Descriptions

Below is more information and descriptions for select best practices identified at Intercept 0. Note: The checklist is not an exhaustive list of items.

Someone to Call

Best Practice	Description
Crisis hotlines	24/7 call, text or chat offer crisis support through screening, intervention and community referrals for people experiencing a behavioral health crisis. These hotlines provide alternatives to 911. See the Texas Health and Human Services Commission (HHSC) Mental Health Crisis Services page, the HHSC 988 Suicide and Crisis Lifeline page or the 988 Lifeline website.
911 mental health crisis call protocol	911 crisis call protocols differ by community. Some jurisdictions include embedded behavioral health clinicians in dispatch to assess crises and send non-law enforcement responders directly. Others transfer calls to mental health crisis hotlines.

Someone to Respond

Best Practice	Description
MCOT	MCOTs deploy qualified mental health professionals to behavioral health crises occurring in the community, including jails, hospitals and homes. These providers coordinate with law enforcement, hospitals and jails to assess, stabilize and connect people to behavioral health services, sometimes working alongside law enforcement in public safety situations. See the HHSC MCOT page.

A Place to Go

Best Practice	Description
Crisis facilities accessible without law enforcement	**Crisis respite facilities** offer short-term community-based crisis care for those needing supervision but not hospitalization, posing low risk to themselves or others. This is the least intensive facility-based crisis option. Lengths of stays range from a few hours to 10 days, with professional staff providing counseling and medication. These centers are often operated by the LMHA or LBHA. See the HHSC Crisis Services Guide. **Peer-led** respite services, implemented by peer-based organizations or larger mental health providers, offer psychosocial support with varying levels of clinical treatment, typically delivered in a "living room" model. **IDD crisis respite centers** offer short-term crisis care for people with IDD experiencing or at risk of a mental health crisis, providing temporary relief for caregivers with the goal of returning the person to their home. **CRUs** provide short-term crisis services in a home-like environment for people who might harm themselves or others. The length of stay may vary depending on the clinical needs of the person with the average length of stay being between 6-10 days. **EOUs** offer 24/7 emergency psychiatric care for adults, and sometimes children and adolescents, on a voluntary or involuntary basis. They provide up to 48 hours of crisis stabilization before determining if further hospitalization is needed. **CSUs** offer up to 14 days of 24/7 short-term residential treatment for adult, children and adolescents (depending on the CSU), focusing on reducing acute mental health symptoms in a secure, clinically-staffed setting. While less intensive than full psychiatric hospitalization, CSUs are among the highest levels of facility-based crisis care and are the only crisis facilities requiring licensure under the Texas Administrative Code.

Programs for Special Populations

Best Practice	Description
Frequent utilizer initiatives	Frequent utilizer initiatives use data-driven strategies to help first responders divert people from arrest and emergency services, instead connecting them to treatment and community support.

Best Practice	Description
SUD-focused diversion	SUD-focused diversion includes self-referral, outreach and opioid response teams to prevent overdoses and fatalities. These programs rely on cross-sector collaboration, with mobile treatment as a best practice for opioid users. See the Bureau of Justice Assistance Mobile Treatment for Opioid Use Disorder article .

Data Collection and Information Sharing

Best Practice	Description
Establish essential data measures specific to this intercept.	Establishing essential aggregate data measures is important to gaining a clear vision of how people living with MI and SUD are encountered at each intercept and can help to identify where gaps exist in your local continuum. Examples of data to gather for Intercept 0: • How many mental health calls are placed to either 911 or dedicated crisis hotlines? • How many callers to local resource lines such as 211, also identify as having MI or SUD? • How many calls does OSAR receive? • How many callers are enrolled in local peer support services? See Data Collection Across the Sequential Intercept Model: Essential Measures.

Intercept 1: Law Enforcement and Emergency Health Services

Best Practice Checklist

Intercept 1 highlights opportunities for law enforcement and other first responders to divert people with MI, SUD and/or IDD into treatment as an alternative to being arrested or booked into jail. Utilize this checklist to consider what exists in your community or what additional strategies you might pursue.

Tailored Dispatch and Law Enforcement Behavioral Health Trainings

- Crisis Intervention Team (CIT) training
- Mental Health First Aid (MHFA) training
- Suicide prevention trainings:
  - Applied Suicide Intervention Skills Training (ASIST)
  - Assess Support Know: Suicide Training (AS+K)
  - Counseling on Access to Lethal Means Training (CALM)
- Training for 911 call takers on indications of mental health crisis and mental health crisis response

Law Enforcement and Emergency Medical Services (EMS) Initiated Crisis Facilities

- Diversion centers
- Sobering centers

Specialized Responses

- 911 crisis call diversion
- Multi-disciplinary response teams (MDRT)
- Law enforcement and mental health co-responder teams
- Community paramedics
- Remote co-responder programs

Data Collection and Information Sharing

- Data and information sharing between law enforcement and behavioral health providers
- Dispatch and police coding of mental health calls.
- Establish essential data measures specific to Intercept 1.
- Data-matching strategies

Intercept 1: Best Practice Descriptions

Below is more information and descriptions for select best practices identified at Intercept 1. Note: The checklist is not an exhaustive list.

Tailored Dispatch and Law Enforcement Behavioral Health Trainings

Best Practice	Description
Specialized dispatch and law enforcement trainings	Trainings that teach dispatchers and law enforcement officers how to identify the signs and symptoms of mental health disorders and de-escalate crises. Examples include: • CIT • MHFA • Suicide prevention trainings: ASIST, AS+K, CALM

Law Enforcement and EMS Initiated Crisis Facilities

Best Practice	Description
Sobering centers	Sobering centers provide short term (4-12 hour) recovery and recuperation from the effects of acute alcohol or drug intoxication. This model aims to offer an alternative to incarceration and relieve overuse of emergency services while assisting people with substance use related issues. Search Texas sobering centers to learn what communities in Texas are doing.
Diversion centers	Diversion centers are centralized facilities for law enforcement to "drop off" people with MI who are in crisis and at risk of arrest. See Implementing a Mental Health Diversion Program Guide and Planning for Diversion: A Texas Diversion Center Workbook.

Specialized Responses

Best Practice	Description
Crisis call diversion	Crisis call diversion programs embed mental health clinicians in emergency operations centers to provide intervention, de-escalation and treatment coordination to people in crisis. See The Council of State Government's Tips for Successfully Implementing a 911 Dispatch Diversion program.

Best Practice	Description
Specialized law enforcement responses	Specialized law enforcement responses include training for law enforcement on responding to mental health calls and empowering law enforcement to appropriately divert people away from the criminal justice system and into treatment through options like police referral to treatment. In Texas, the mental health deputy are an in-house mental health resource for their departments. See HHSC's Jail Diversion Services page.
MDRT	The model brings together paramedics, licensed mental health professionals and specialized law enforcement officers as an integrated team to respond to mental health emergencies.
Remote co-response	Remote co-response programs equip law enforcement officers with remote technologies (e.g., iPads) to conduct assessments and connect people in crisis to mental health clinicians via telehealth software if needed. See Harris County's Telehealth Implementation Guide.

Data Collection and Information Sharing

Best Practice	Description
Data sharing and data matching	Law enforcement agencies, crisis services and hospitals can use data to systematically identify familiar faces and coordinate appropriate follow-up after a crisis. For example, law enforcement in some communities share arrest information with behavioral health providers to notify providers when a client is arrested. See the Police-Mental Health Collaboration (PMHC) Toolkit.
Dispatch and police coding of mental health calls	Many communities have maximized dispatch call center efficiency by developing strategies to recognize, code and send the appropriate responders to people experiencing a mental health crisis more clearly.

Best Practice	Description
Establish essential data measures specific to this intercept.	Establishing essential aggregate data measures is an important part of gaining a clear vision of how people living with MI and SUD are encountered at each intercept and can help to illuminate where gaps or insufficiencies exist in the continuum as it exists in your community or county. Examples of data to gather for Intercept 1: • What proportion of 911 calls are related to either mental illness or SUD concerns? • What locations generate the most calls? Are these the same areas requesting and in need of mental illness and SUD services? • How often are CIT officers and co-responders called out on mental health calls? How many of those calls are high utilizers or repeat callers, i.e., week-to-week or month-to-month? See Data Collection Across the Sequential Intercept Model: Essential Measures.

Intercept 2: Booking and Initial Detention

Best Practice Checklist

Intercept 2 highlights opportunities for diversion to community-based treatment by jail clinicians, social workers or court officials during jail intake, booking or initial hearing. Utilize this checklist to consider what exists in your community or what additional strategies you might pursue.

Enhanced Jail Screening, Identification and Treatment

- Validated jail mental health and SUD screenings
- Jail contracts with the LMHA or LBHA to support jail-based mental health services and continuity of care
- Mental health jail liaisons and jail navigators
- 24/7 access to telepsychiatry
- Provision of prescription psychiatric medications

Court Diversion and Prevention Programs

- Risk assessments to inform court recommendations
- Mental health bonds
- Magistrate- and prosecutor-led diversion
- Deferred prosecution

Special Population Treatment Supports

- Veteran justice outreach specialists and community diversion coordinators
- Jail-based SUD assessments and detox protocol
- Medication-Assisted Treatment (MAT) for opioid use disorder (OUD)
- Recovery coaches
- Jail-based 12-step programs

Justice Stakeholder Collaboration

- Regular jail meetings
- Integrated systems to identify people involved with public mental health system (Texas Law Enforcement Telecommunications System (TLETS) continuity of care query)
- Regular information sharing and data analysis
- Consistent use of Texas Code of Criminal Procedure (CCP) Article 16.22 reports

Data Collection and Information Sharing

- Establish essential data measures specific to Intercept 2.
- Data-matching strategies

Intercept 2: Best Practice Descriptions

Below is more information and descriptions for select best practices identified at Intercept 2. Note: This checklist is not an exhaustive list.

Enhancing Jail Screening, Identification and Treatment

Best Practice	Description
Validated jail mental health and SUD screenings	Routine mental health screenings at jail entry help identify those with MI or SUD, guiding appropriate care. Non-clinical staff can conduct screenings at arrest, booking or before court proceedings. Tools should be locally validated for accuracy and reliability. See SAMHSA's Screening and Assessment of Co-occurring Disorders in the Justice System report and the PRA's Brief Jail Mental Health Screen.
Access to 24/7 telepsychiatry	Telepsychiatry services allow the potential for people to be assessed and referred to treatment around the clock, providing access to expert care when an in-person provider may not be available. Often, this may be the only way incarcerated people are able to see a psychiatrist, especially in more rural areas where psychiatric providers are not always consistently available for in-person appointments.
Mental health jail liaisons	Mental health jail liaisons are jail-based mental health coordinators, forensic social workers or trained jail staff available to screen, assess and connect people with mental health needs to treatment in the community.
Jail contracts with LMHAs or LBHAs to support jail-based mental health services	When jails partner with the LMHA or LBHA in their county, they can increase the number of treatments and services that people can access during their detention. These "in-reach" services can also help identify people with MI and SUD who may be better placed in community-based or inpatient treatment. .

Court Diversion and Prevention Programs

Best Practice	Description
Prosecutor-led diversion	Prosecutor-led diversion programs give district attorneys the option to refer people for treatment before and after filing charges.
Pretrial supervision	Pretrial services with specialized mental health services help reduce detention for people with mental health needs. These teams can make sure people with mental health needs are connected to services in a timely manner and avoid getting worse while waiting for their case to be resolved.
Risk assessments	Risk assessments help identify people who would be eligible and appropriate for diversion and bond. See the PRA Risk, Need and Responsivity in the Criminal Justice System guide.

Best Practice	Description
CCP Article 16.22 reports	CCP Article 16.22 mandates early identification of persons with MI or IDD in the criminal justice system. Magistrates must order a 16.22 Collection and Information Form within 72 hours if reasonable cause exists. See the Texas Judicial Commission on Mental Health Texas CCP Article 16.22 Guide .

Special Population Treatment Supports

Best Practice	Description
MAT for OUD	MAT, utilizing the medications methadone, buprenorphine or naltrexone, is considered a central component of the contemporary standard of care for the treatment of people with OUD. Search Jail-Based Medication Assisted Treatment Guide from National Sheriffs' Association and National Commission on Correctional Health Care.

Justice Stakeholder Collaboration

Best Practice	Description
Regular jail meetings	Regular jail meetings foster collaboration between correctional and clinical staff to coordinate placement, services and release planning, preventing crises and improving outcomes for incarcerated people.
TLETS continuity of care query	The TLETS continuity of care query identifies people at jail booking who, within the past three years, received state-funded psychiatric care or community mental health services. See HHSC's Information Item T-Jail Match Report and Jail Diversion Standards .

Data collection and Information Sharing

Best Practice	Description
Establish essential data measures specific to this intercept.	Establishing essential aggregate data measures is an important part of gaining a clear vision of how people living with MI and SUD are encountered at each intercept and can help to illuminate where gaps exist in the local continuum. Examples of data to gather for this intercept: • How many people booked were flagged for MI or SUD by jail mental health screening? • What is the average length of stay for people with a mental health flag? • Number of connections and referrals to treatment and services made by jail in-reach or jail staff for those flagged by the jail mental health screening. • What are the recidivism rates for people with MI or SUD once released into the community? See Data Collection Across the Sequential Intercept Model: Essential Measures.

Intercept 3: Jails and Courts

Best Practice Checklist

Intercept 3 highlights court-, jail- and community-based programs that support people with behavioral health needs after being booked into jail. Utilize this checklist to consider what exists in your community or what additional strategies you might pursue.

Specialized Court Interventions

- Treatment courts
- Mental health public defender programs
- Mental health diversion coordinators

Community-based Alternatives to Incarceration

- Specialized pretrial supervision
- Forensic assertive community treatment (FACT) teams
- Assisted outpatient treatment (AOT)

Court Stakeholder Education and Training

- Trauma-informed training
- Education on alternatives to inpatient competency restoration

Competency Restoration

- Regular county forensic team meetings
- Active waitlist monitoring
- Alternatives to inpatient competency restoration:
  - Outpatient competency restoration (OCR)
  - Jail-based competency restoration (JBCR)
  - Court-ordered medications
  - Competency reassessments and re-evaluations

Data Collection and Information Sharing

- Establish essential data measures specific to this intercept

Intercept 3: Best Practice Descriptions

Below is more information and descriptions for select best practices identified at Intercept 3. Note: The checklist is not an exhaustive list of items.

Specialized Court Interventions

Best Practice	Description
Treatment and specialty courts	Judges can use treatment courts to connect people with appropriate treatment, community resources and ongoing judicial monitoring. These programs provide services through a pre-plea or post-plea process. They may include specialty courts such as drug courts, mental health courts or veterans' courts. See JCMH's Mental Health Courts Mental Health Court Program 10-step guide, or the Texas Association of Specialty Courts.
Mental health public defender programs	Mental Health Defender Programs use specially trained lawyers to represent defendants with mental illness and link them with treatment and resources. These programs can generate cost savings through jail diversion and reductions in recidivism. See Texas Indigent Defense Commissions Texas Mental Health Defender Programs.

Community-Based Alternatives to Incarceration

Best Practice	Description
Risk assessments	Risk assessments help identify people who would be eligible and appropriate for diversion and bond. See Office of Court Administration's Pretrial Risk Assessment Information System Texas (PRAISTX).
AOT	AOT provides court-ordered, community-based mental health care to help adults with treatment adherence. It can be used pre- or post-arrest, pre- or post-booking, and for those unlikely to regain competency, serving as a diversion option before or after charges are dismissed. See the Treatment Advocacy Center's Texas Assisted Outpatient Treatment Practitioner's Guide.
FACT	FACT mirrors standard ACT but is focused on people with current or past criminal justice system involvement. In addition to all of the components of ACT, FACT treatment plans include assessing and treating criminogenic risk factors. See SAMHSA's Forensic Assertive Community Treatment (FACT) Overview and the U.S. Department of Health and Human Services ACT Program.

Jail-Based Mental Health and Crisis Services

Best Practice	Description
Jail-based programming and health care services	Jails must provide medical and behavioral health care for people detained. Trauma-informed, evidence-based programs help prevent worsening conditions, while suicide prevention plans protect those with and without known mental health concerns. See TDCJ's Inmate Health Services Plan, starting on page19,.
Partnerships with community-based providers of MI and SUD treatment	Jail partnerships with community providers expand access to treatment during detention and foster continuity of care post-release. "In-reach" services also help identify those who may benefit from community-based or inpatient treatment.

Competency Restoration

Best Practice	Description
County forensic teams	County forensic teams help monitor people found incompetent to stand trial. These teams should include key mental health and justice stakeholders, such as judges, prosecutors, defense attorneys, LMHAs or LBHAs, jail administrators and medical providers. See HHSC's Six Steps to Establishing a Jail In-Reach Program for resources on establishing a county forensic team.
Alternatives to inpatient competency restoration options	OCR programs provide community-based competency restoration services, which include mental health and substance use treatment services, as well as legal education for people found incompetent to stand trial. JBCR provides services to people with mental health or co-occurring psychiatric and SUD in jail. Services include mental health treatment services and competency education for people found incompetent to stand trial, consistent with other competency restoration services. For tools to support planning, see The Texas Competency Restoration Guide; The Eliminate The Wait Toolkit and The Diversion and Competency Workflow.
Court-ordered medication	Obtaining a court order for psychoactive medications for a person determined incompetent to stand trial may not only reduce the person's psychiatric symptomatology but may result in the defendant being restored to competency without the significant wait for a state hospital bed.

Data Collection and Information Sharing

Best Practice	Description
Establish essential data measures specific to this intercept.	Establishing essential aggregate data measures is an important part of gaining a clear vision of how people living with MI and SUD are encountered at each intercept and can help to illuminate where gaps exist in the local continuum. Examples of data to gather for Intercept 3: • How many referrals are made to each treatment court per year? • What percentage of those referrals are accepted into each court? • What is the current capacity of each specialty court? • What is the rate of successful program completion ("graduation") of each court? • How many recidivate after graduating from a specialty court? See Data Collection Across the Sequential Intercept Model: Essential Measures.

Intercept 4: Reentry

Best Practice Checklist

Intercept 4 highlights strategies to support people reentering their communities after a period of incarceration in a jail or prison to reduce further justice involvement. Utilize this checklist to consider what exists in your community or what additional strategies you might pursue.

Transition Planning

- Use of jail in-reach providers to coordinate reentry planning
- Needs assessments prior to release. Consider:
  - Housing
  - Transportation
  - Mental and primary health care
  - Psychological/vocational rehabilitation
  - Collaborative comprehensive case plans
  - Peer reentry specialists
  - Shared language across corrections and service providers
  - Medicaid suspension and benefits reinstatement
  - Referral to Projects for Assistance in Transition from Homelessness Program

Release

- Release times during business hours
- Transportation arranged prior to the release
- Release with medications and prescription access
- Jail release with pre-set community mental health appointments

Data Collection and Information Sharing

- Reentry coalitions
- Memorandums of understanding (MOUs) between jail and community treatment providers
- Standardized assessments and data management
- Establish essential data measures for Intercept 4.

Intercept 4: Best Practice Descriptions

Below is more information and descriptions for select best practices identified at Intercept 4. Note: This checklist is not an exhaustive list.

Transition Planning

Best Practice	Description
Transition planning by jail in-reach providers	Reentry planning should start at intake and continue through incarceration. Jail in-reach providers help ensure continuity of care, with transition planning involving needs assessment and coordination across jail, corrections and behavioral health providers. See The Council of State Government's Preparing People for Reentry Checklist.
Needs assessments	People returning to the community receive a comprehensive needs assessment. The assessment is used to determine services most likely to prevent recidivism and rearrests.
Pre-release reentry in-reach	Reentry partners make contact with the person prior to release. Service providers introduce themselves, initiate case planning and build rapport with the person incarcerated.
Collaborative Comprehensive Case Plans	A Collaborative Comprehensive Case Plan (CCCP) is a shared reentry strategy where agencies work together to address both behavioral health needs and criminogenic risks. By integrating input from corrections, behavioral health, housing and social service providers, CCCPs ensure coordinated support for successful reintegration.
Peer reentry specialists	Peer reentry specialists—professionals with lived experience—help those leaving jail or prison navigate reentry challenges like transportation and relapse triggers. Employed by jails or in-reach providers, they support transition planning and successful reintegration. See the HHSC Peer Support Services highlight and the Via Hope Peer Services Program highlight.
Medicaid suspension and disability benefits reinstatement	Jails can help people stay connected to care by suspending Medicaid instead of ending it when someone is incarcerated for more than 30 days. They can also support automatic reactivation of Medicaid when the person is released. LMHA or LBHA case workers can help with the application process. See the Social Security Administration's Re-entering the Community After Incarceration guide.

Release

Best Practice	Description
Release with medications and prescription access	Upon release, people should have enough medication to prevent relapse and maintain stability until they can see a community provider. Depending on enrollment in mental health services, they may need a supply ranging from one week to one month. Many jails collaborate with LMHAs, LBHAs and community providers to ensure a smooth transition.

Best Practice	Description
Transportation	Ensure that people being released from jail or prison have an identified person, provider or access to public transportation (i.e., a bus pass) to provide transportation upon release. SAMHSA indicates that people who are picked up directly and taken to services often see more ideal outcomes.
Reentry coalitions	Reentry coalitions, often led by community members and those with lived experience, help people transition from jail or prison. They coordinate resources across criminal justice, behavioral health, housing and workforce services to improve reintegration and reduce recidivism.
MOUs	Establish pathways for communication and effective information sharing before the community referral. Established MOUs with community service providers can ensure community supervision and community service providers are on the same page and effectively addressing the person's needs.

Data Collection and Information Sharing

Best Practice	Description
Establish essential data measures specific to this intercept.	Establishing essential aggregate data measures is an essential part of gaining a clear vision of how people living with MI and SUD are encountered at each intercept and can help to illuminate where gaps or insufficiencies exist in the continuum as it exists in your community or county. Examples of data to gather for Intercept 4: • How many people are receiving assessments after being released from jail? • How many people with MI and SUD are released annually? • How many days of psychotropic medications or prescriptions are given to those with MI upon their release? • What is the average number of days between release and contact with a community-based prescribing treatment provider? • Are people released being given information or contacts (including warm handoffs) to resources in the community? See Data Collection Across the Sequential Intercept Model: Essential Measures.

Intercept 5: Community Corrections

Best Practice Checklist

Intercept 5 highlights support to prevent recidivism for people with MI and SUD across community supervision and corrections. Utilize this checklist to consider what exists in your community or what additional strategies you might pursue.

Training and Specialization

- Specialized probation caseloads:
  - MI
  - SUD
  - Veterans
- Universal community supervision and corrections department (CSCD) training and education
- CIT
- MHFA
- Risk-needs responsivity model training
- Specialized psychotherapy tailored to reducing criminogenic risk

Partnerships and Collaboration

- Open communication between community corrections and behavioral health providers
- Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) data sharing
- Strong relationships between community corrections and social security offices, hospital records departments, U.S. Department of Housing and Urban Development case managers, and the Texas Department of Motor Vehicles

Recovery Supports

- Access to recovery supports; consider: photo/government ID assistance
- Benefits applications, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or Supplemental Nutrition Assistance Program (SNAP)
  - Legal services
  - Employment
  - Housing navigation and support
- Community-based support, e.g., mental health or addiction support groups
- Incorporate family support whenever possible

Data Collection and Information Sharing

- Establish essential data measures for Intercept

Intercept 5: Best Practice Descriptions

Below is more information and descriptions for select best practices identified at Intercept 5. Note: This checklist not an exhaustive list.

Training and Specialization

Best Practice	Description
Universal CSCD training and education	Officers with specialized caseloads should receive additional, more in-depth training to learn about the specific needs of the people under their supervision. See Mental Health First Aid.
Specialized case loads	The use of smaller and specialized mental health or substance use caseloads shows promising results for people on probation and parole. Specialized caseloads allow community corrections officers to provide support that keeps their clients on the path to recovery, increases connections to services and appointments, and reduces the chance of violations and jail stays. See the National Institute of Justice Program Profile: Specialty Mental Health Probation.
Specialized psychotherapy to reduce criminogenic risk	Tailored mental health treatment for people with high mental health needs and criminogenic risk tailored to reduce rates of recidivism and decrease criminogenic risk factors. See National Institute of Corrections Thinking for a Change.

Partnership and Collaboration

Best Practice	Description
Open communication between community corrections and mental health providers	Community corrections officers such as those in probation or parole can work with mental health providers and community stakeholders to make sure their clients have the support they need to remain independent, continue recovering and avoid going back to the criminal justice system. See Forensic Assertive Community Treatment (FACT).

Recovery Supports

Best Practice	Description
Access to recovery supports	Community corrections officers and case managers can help support reentry by helping their clients acquire government-issued photo identification, apply for or reinstate health care coverage or SSI and SSDI benefits, connect to job training, skills development and employment opportunities, and access to legal support like criminal records expungement.

Best Practice	Description
Housing navigation and supports	Housing navigators coordinate with community housing providers to identify available housing resources and support reentry planning prior to release. Navigators may work with both formal housing systems and other community-based housing options to help people secure stable housing as they transition back into the community. See The Council of State Government's Building Connections to Housing During Reentry report and HHSC Permanent Supportive Housing.

Data Collection and Information Sharing

Best Practice	Description
Establish essential data measures specific to this intercept.	Establishing essential aggregate data measures is an essential part of gaining a clear vision of how people living with MI and SUD are encountered at each intercept and can help to illuminate where gaps or insufficiencies exist in the continuum as it exists in your community or county. Examples of data to gather for Intercept 5: • How many people with identified MI or SUD are being served by community corrections? • How many hours of mental health and substance use training are community corrections officers (both with and without specialized caseloads) required to have? • What is the probation revocation rate of all probationers? • What is the probation revocation rate of all probationers with MI? • How many people does TCOOMMI carry on their monthly caseload? See Data Collection Across the Sequential Intercept Model: Essential Measures.