

Evaluation of the Sequential Intercept Model Mapping Workshop Across Texas Counties

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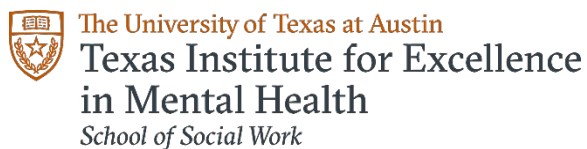


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Executive Summary

Background

The Sequential Intercept Model (SIM) outlines how people with mental illness (MI), substance use disorder (SUD), and intellectual and developmental disabilities (IDD) move through and can be diverted from the criminal justice system across six intercepts. This model has been operationalized into a day-and-a-half workshop in which community stakeholders convene to identify resources and gaps in behavioral health and justice services at each intercept and develop local strategic plans.

The SIM mapping workshop is a nationally recognized and widely recommended cross-sector planning tool. This evaluation used a mixed-methods approach and the Consolidated Framework for Implementation Research (CFIR) to understand the workshop's impact in Texas through outcomes such as:

- Progress on priorities identified during the SIM mapping workshop;
- Adoption of new policies or practices to support priority implementation; and
- Changes in collaboration among various systems and agencies involved.

Evaluators interpreted findings through implementation barriers and facilitators, leadership dynamics, and perceived utility of the SIM mapping workshop.

The evaluation examined SIM mapping workshops conducted across multiple Texas counties between March 2022 and July 2023. Evaluators obtained data from surveys and interviews across nearly all targeted sites, indicating broad engagement with the evaluation process. Responses primarily reflect the perspectives of mid- to senior-level leaders from law enforcement, behavioral health, and judicial systems. These responses provide insight into cross-system implementation experiences and collaboration following the SIM mapping workshops.

Key Findings

Priority Progress and Collaboration

Stakeholders reported moderate progress on priorities identified through the SIM mapping workshops, with some areas advancing more consistently than others. Priorities related to community-based programming and service coordination showed stronger momentum, while transportation remained a persistent challenge across sites. Overall progress did not differ meaningfully by county, context, or time since the workshops, which suggested sustained implementation depends on factors beyond time alone.

Stakeholders also described moderate collaboration across systems which closely linked to priority progress. Sites reporting stronger collaboration demonstrated greater advancement on identified priorities. Although internal collaboration within law enforcement, behavioral health, and judicial systems was generally strong, coordination *across* these systems varied more. Gaps in collaboration between major systems emerged as a recurring challenge, underscoring the importance of cross-system relationship development and alignment for successful implementation.

Role of the SIM Mapping Workshop

The SIM mapping workshop functioned as a critical strategic planning tool, providing communities with a shared structure to identify priorities, align stakeholders, and coordinate action across systems. Participants described the workshop as influencing what priorities were pursued and how stakeholders worked together, particularly through improved collaboration among county partners and engagement with the Texas Health and Human Services Commission (HHSC) as a credible, objective facilitator. Stakeholders valued the workshop's flexible, community-driven approach, noting it allowed local priorities to guide implementation rather than impose a one-size-fits-all model. At the same time, participants acknowledged SIM mapping workshops require substantial time and effort, particularly in planning and post-workshop follow-through. This commitment underscores the importance of sustained support to translate priorities into action.

Strategies

Continued Implementation Support:

- Offer follow-up activities, such as SIM Refresh or youth SIM workshops, to support ongoing priority review, adaptation, and sustained engagement over time.
- Continue promoting SIM mapping workshops as tools to strengthen leadership coordination and shared understanding across systems.
- Provide targeted technical assistance on data collection and information sharing to support coordination across systems and reduce communication breakdowns during implementation.

Improvements within the Inner Setting:

- Emphasize leadership buy-in and shared ownership across law enforcement, judicial, and behavioral health systems, prioritizing engagement from stakeholders with the authority to advance implementation.
- Incorporate missing frontline and community voices in SIM-related planning, including schools, housing, emergency medical services, community-based organizations, and youth services, as they are essential to effective implementation.
- Support regular, structured cross-sector meetings to improve collaboration, trust, and accountability, particularly in regions coordinating across multiple counties and between law enforcement and judicial system stakeholders.

Governance and Collaboration Infrastructure:

- Establish and fund a formal SIM coordinator role to maintain stakeholder connections, track deliverables and deadlines, and facilitate consistent participation across systems.
- Strengthen meeting structure and accountability by supporting clear agendas, respect for participants' time, and action-oriented workgroups under a coordinating body, such as a behavioral health leadership team, to promote effective collaboration.

Introduction

The SIM is a framework developed to help behavioral health and justice stakeholders address the overrepresentation of people with behavioral health issues in the criminal justice system (Munetz & Griffin, 2006; Willison et al., 2018). The SIM details how people with MI, SUD, or IDD encounter and move through the justice system across six key timepoints or “intercepts” (Table 1). The SIM identifies opportunities for diversion at each intercept to reduce the overrepresentation of people with MI, SUD, IDD, or any combination thereof, in the criminal justice system (Munetz & Griffin, 2006).

Table 1. Definitions of the Six SIM Intercepts (Substance Abuse and Mental Health Services Administration, 2024; Texas Behavioral Health and Justice Technical Assistance Center, 2025; Willison et al., 2018)

Intercept	Definition
Intercept 0: Community-Based Services	Intercept 0 highlights opportunities to divert people into local crisis care services and to connect people with behavioral health needs to treatment. This intercept focuses on connecting people with treatment or services in the community before arrest or formal involvement with the justice system.
Intercept 1: Law Enforcement and Emergency Health Services	Intercept 1 highlights opportunities for law enforcement and other first responders to divert people with MI, SUD, or IDD into treatment as an alternative to being arrested or booked into jail. This intercept requires law enforcement and other emergency service providers to act as divergence agents when they respond to people in crisis.
Intercept 2: Booking and Initial Detention	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. Diversion at this intercept occurs post-arrest. This intercept avoids incarceration by funneling people to community-based treatment during jail intake, booking, or initial hearing.
Intercept 3: Jails and Courts	Intercept 3 highlights court-based, jail-based, and community-based programs that support people with behavioral health needs after being booked into jail. This intercept focuses on programs and services for those in pre-trial detention. Services at this intercept can be cost-effective by preventing deterioration of mental health during custody and reducing the financial burden of incarceration.

Intercept	Definition
Intercept 4: Reentry	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. Well-supported reentry back into the community after jail or prison can reduce recidivism. This intercept involves connecting people with community behavioral health providers, peer support staff, and mental health and substance use treatment services.
Intercept 5: Community Corrections	Intercept 5 highlights support to prevent recidivism for people with MI and SUD across community supervision and corrections. This intercept focuses on supporting people under community supervision by helping them avoid violations or new offenses and, when violations do occur, connecting them with alternatives to jail or prison.

Research across diverse areas shows that effective SIM implementation requires coordinated partnerships, strong local leadership, and shared data systems. Effective SIM implementation is strengthened by teamwork and interagency collaboration, where sustained communication and shared accountability across behavioral health, justice, and community partners drive coordination and long-term system change (Griffin et al., 2015; Substance Abuse and Mental Health Services Administration, 2019; Texas Behavioral Health and Justice Technical Assistance Center, 2025). For example, county-level studies show communities achieving the greatest reductions in length of stay and recidivism, also exhibit robust behavioral health infrastructure and regular interdisciplinary collaboration (Griffin et al., 2015; Swanson et al., 2023). Community-based behavioral health initiatives guided by SIM principles also demonstrate the value of strong interagency partnerships and shared goals in improving engagement and discharge outcomes (McNeish et al., 2019). Moreover, national examples from veterans justice programs and rural hospital systems confirm the SIM can be adapted to specific populations and contexts, with flexibility in how intercept points are operationalized (Blue-Howells et al., 2013; Griffin et al., 2015).

Adding to the utility of this model, the Policy Research Associates, Inc. (PRA) developed and began facilitating SIM mapping workshops in 2005 and has since conducted over 250 workshops across the United States (Systems Mapping and Training Center, 2025). Community stakeholders convene at these workshops to identify resources and gaps in behavioral health and justice services at each intercept and develop local strategic plans (Griffin et al., 2015; Substance Abuse and Mental Health Services Administration, 2024). These workshops bring together community leaders and officials from different agencies and systems to find ways to

help people with MI, SUD, and IDD receive treatment instead of being arrested or incarcerated.

At the systems level, SIM-informed strategic planning supports data-driven improvement and cross-system accountability. System-wide dissemination efforts demonstrate the scalability of SIM when supported through federal and state leadership initiatives, as reflected in multi-state training and mapping programs (Matteo et al., 2015). State dissemination efforts in Florida, Illinois, and Pennsylvania underscore the importance of leadership stability, local champions, and technical assistance in sustaining system change (Griffin et al., 2015). Emerging studies also highlight the need for common metrics across agencies to track behavioral health and justice outcomes (Substance Abuse and Mental Health Services Administration, 2019). However, persistent barriers include limited data integration and workforce capacity constraints that restrict one-on-one therapeutic engagement, particularly among people with cognitive or neurodevelopmental impairments. Later expansions of the SIM underscored its function as both a planning and evaluation tool that supports data-driven collaboration among behavioral health, law enforcement, and court systems (Heilbrun et al., 2015). These findings indicate that the potential of the SIM to reduce justice involvement depends on sustained interagency collaboration, clear data infrastructure, and resourcing that supports individualized engagement when required.

HHSC facilitates SIM mapping workshops across Texas counties for adults and youth populations. The HHSC-facilitated SIM mapping workshops reflect the landscape of Texas behavioral health, criminal justice, and juvenile justice systems. These workshops also adapt to meet the needs of each community by considering unique populations or issues. Workshop preparation includes developing a community resource map through an inventory scan of the current services available in the community at each intercept (Texas Behavioral Health and Justice Technical Assistance Center, 2024). In addition, the day-and-a-half HHSC-facilitated SIM mapping workshops introduce attendees to evidence-based best practices related to each intercept. Communities collaborate to plot resources and gaps across the SIM, identify local behavioral health services to support diversion from the justice system, and enhance relationships across systems and agencies. Participants leave with customized local resource maps and action plans to address identified gaps and priority areas (Texas Behavioral Health and Justice Technical Assistance Center, n.d.).

This report summarizes evaluation findings of SIM mapping workshops across Texas counties facilitated by HHSC. Research questions co-developed with HHSC focus on

whether communities acted on their SIM mapping workshop priorities, and what conditions supported or hindered priority progress. The research team selected the Consolidated Framework for Implementation Research (CFIR) to assess implementation success through a mixed-methods approach (Arora et al., 2017).

The CFIR strengthens insight into community-based and low-resource settings. Across applications, several facilitators and barriers emerge. Studies found that strong leadership, ongoing communication, and local adaptability facilitated implementation success, while funding instability, unclear roles, and workforce turnover acted as significant barriers (Breimaier et al., 2015). Similar studies found the CFIR to be a useful framework for mapping facilitators and barriers, emphasizing the need for capacity building and clear system alignment (Roshan et al., 2025). Subsequent work operationalized the CFIR's Inner Setting constructs, demonstrating the importance of reliable measurement of leadership engagement, learning climate, and available resources in predicting implementation success across health organizations (Fernandez et al., 2018). The combination of these findings supports the use of the CFIR as an evaluative tool.

Researchers selected the CFIR for this study because of its flexible and adaptable design. Relevant constructs of choice can capture both contextual barriers and facilitators that affect implementation outcomes across diverse service environments (Damschroder et al., 2009; Kirk et al., 2016). The CFIR is a useful framework to evaluate and improve the implementation of initiatives that span across systems and structural levels, while also producing actionable findings and recommendations for stakeholders. When applied within state-level behavioral health and justice evaluations, the CFIR provides a practical lens to understand how structural and interpersonal factors influence implementation and sustainability (Hanna et al., 2020).

The SIM mapping workshop is a nationally recognized and widely recommended cross-sector planning tool designed to address the overrepresentation of people with behavioral health needs in the justice system. This evaluation examines the degree to which multiple counties across Texas acted on their SIM action plans following SIM mapping workshops conducted by HHSC. This report is the first effort to apply the CFIR to SIM mapping workshops and explains the conditions under which system-level programs like the SIM mapping workshop and related priorities are most likely to sustain change.

Methods

Site Selection and Outreach

The evaluation covered HHSC-facilitated workshops carried out between March 2022 and July 2023. During this period, a total of 22 counties (18 rural and four urban) participated in 14 SIM mapping workshops across eight local mental health authorities (LMHAs). All of these were included in this study. Three of the 14 workshops were conducted regionally, meaning stakeholders from multiple counties came together for one workshop. All counties that participated in a regional workshop fell under the same LMHA's service area. Regional mapping sites were as follows:

- Potter and Randall Counties
- Dallam, Hartley, and Moore Counties
- Bosque, Falls, Freestone, Hill, Limestone, and McLennan Counties

Regional mappings intend to benefit counties whose service participants and LMHAs often overlap. While three additional counties in the sample shared an LMHA, they opted for single-county mappings.

Researchers used purposive sampling to identify intentional selections of key stakeholders. For initial outreach, HHSC provided a contact list of key county stakeholders that had coordinated and planned the SIM mapping workshops. Information collected from these contacts helped identify local workgroup structures and informed the development of interview and survey questions.

This evaluation utilized a mixed-method approach employing qualitative interview data and quantitative survey data to inform the outlined outcomes. For the quantitative survey, researchers employed a snowball sampling approach after making initial contact. All initial SIM contacts were invited to complete the survey as well as encouraged to forward the survey to additional stakeholders. Eligible survey takers included anyone who attended the SIM mapping workshop, anyone who had worked on the priorities since the workshop, anyone currently working on them, or any combination thereof. Research on the CFIR framework finds input from people with influence or authority gives the most accurate representation of measured implementation success (Damschroder et al., 2022a). Therefore, evaluators determined it would be most appropriate to select and interview one to

two key stakeholders from each site who held a leadership role during or after the workshop.

Interviews

Evaluators, in collaboration with HHSC, developed a semi-structured qualitative interview guide based on the research questions. Evaluators then invited participants using an email template, with the goal of engaging at least two high-level leaders from each site. Additionally, evaluators conducted, recorded, and transcribed interviews via Microsoft Teams. Each interview lasted approximately 40 – 60 minutes and participants provided verbal consent prior to recording. Questions focused on:

- Progress toward identified priorities;
- Barriers and facilitators to implementation;
- Behavioral health leadership team dynamics and roles; and
- Reflections on the utility of the SIM workshop.

Survey Design

Items included stakeholder type, county, urban or rural status, and role in the behavioral health leadership teams. Evaluators administered the survey through Qualtrics and distributed the survey to participants through email outreach. Prior to administering the survey, evaluators defined SIM-related work and priorities as any activities and opportunities identified during the adult SIM mapping workshop.

Implementation Measures

Drawing from implementation science literature, evaluators identified three CFIR domains and 14 associated constructs as key drivers of change and implementation success (Damschroder et al., 2022b; Labbé et al., 2024). Evaluators selected three domains based on their relevance to system-level collaboration and leadership engagement observed in SIM mapping workshops: Inner Setting, Outer Setting, and Implementation Process. Evaluators then adapted constructs across these domains to the SIM context (Table 2) and used the constructs to develop 25 Likert-scale survey items and codebook codes.

Table 2. CFIR Domain and Construct Conceptualizations Used to Develop Survey Items for this Study

Domains	Constructs
<p>Implementation Process: The Implementation Process domain summarizes the mechanisms by which implementation is accomplished.</p>	<ul style="list-style-type: none"> • Doing: Carrying out or accomplishing the implementation steps according to plan • Reflecting and Evaluating: Quantitative and qualitative feedback and debriefing about progress, experience and quality of implementation • Planning: The degree to which a method for implementing SIM priorities is developed • Teaming: The active collaboration and coordination required to implement tasks related to SIM priorities • Access to Knowledge and Information: Ease of access to information and knowledge about implementing SIM priorities
<p>Inner Setting: The Inner Setting domain represents the local context or the county or counties that did the SIM mapping workshop.</p>	<ul style="list-style-type: none"> • Access to Knowledge and Information: Ease of access to information and knowledge about implementing SIM priorities • Available Resources and Access to Funding: The level of monetary resources dedicated to implementing SIM priorities available within the Inner Setting • Communications: High-quality formal and informal information sharing practices within and across the Inner Setting • Incentive Systems: Tangible or intangible rewards supporting priority achievement • Implementation Leads: People who lead efforts to implement the innovation (champions) • Relative Priority: People shared perceptions of the importance of the SIM priorities within the county • Work Infrastructure: Teams and general staffing levels that support functional performance of the Inner Setting
<p>Outer Setting: The Outer Setting domain encompasses the state-level, federal-level and other external resources that supported implementation of the SIM mapping workshop priorities.</p>	<ul style="list-style-type: none"> • Financing: Funding from external (federal, state, non-county) entities is available to implement or deliver the innovation • Other Implementation Support: People who support the organizations, within the SIM mapping sites to implement the SIM priorities • Partnerships and Connections: External entities that the Inner Setting is networked with, including referral networks, academic affiliations, and professional organizational networks

Outcome Measures

For this study, evaluators defined implementation success as the extent to which counties did the following:

- Established a behavioral health leadership team to govern behavioral health and justice initiatives;
- Actively worked on their identified priorities;
- Utilized the SIM workshop map to guide diversion planning efforts; and
- Fostered cross-system communication and collaboration (Bonfine & Nadler, 2019).

Evaluators translated implementation success into three key measurable outcomes based on the above definitions (Table 3).

Table 3. Outcome Conceptual Definitions and Corresponding Survey Items

Outcome Conceptualization	Survey Item
Priority Implementation Progress: Assess the extent to which the priorities identified during the SIM mapping workshop have been successfully implemented within the community.	On a scale of 1 to 10: "Rate the progress made related to this priority, with 1 indicating no progress has been made and 10 indicating the priority has been successfully completed."
Policy and Practice Changes: Evaluate the adoption of new policies, procedures, or practices within organizations or systems to support the implementation of priorities.	On a 5-point frequency Likert scale: "Since the SIM mapping workshop, the county made changes to policies and procedures related to behavioral health and justice initiatives."
Cross-System Collaboration: Measure the degree of collaboration and coordination among various systems and agencies involved in addressing the priorities identified during the SIM mapping workshop.	On a scale of 1 to 10: "Since the SIM mapping workshop, rate the collaboration of the following stakeholders on behavioral health and justice initiatives in your community. These collaborations can be formal (e.g., strategic planning meetings) or informal (e.g., phone calls, in person conversations)."

Based on HHSC SIM reports, each SIM mapping workshop site identified an average of four priorities, ranging from two to six priorities. To standardize scores across

sites, participants rated progress on only their county's top two priorities, using the order in which priorities appear in county reports. Participants also had the opportunity to mention a third priority using an open-ended response and to rate the progress made on this priority. This response option allowed the research team to capture the community's emerging needs and not penalize the community's progress scores if momentum shifted towards other behavioral health and justice priorities.

Ethical Considerations

The University of Texas at Austin Institutional Review Board (IRB) determined the proposed evaluation is not human subject research as defined by U.S. Department of Health and Human Services (DHHS) and U.S. Food and Drug Administration (FDA) regulations but meant as a quality improvement or program evaluation.

Analysis

Priority Areas Across SIM Mapping Sites

The evaluation team reviewed HHSC’s post-SIM workshop reports for each site in the sample to analyze and categorize the priority areas. For regional SIM workshops, all participating counties shared a single report and adopted the same set of priorities. The evaluation team grouped the priorities into two main categories and 11 subcategories to allow for cross-site comparisons (Tables 4a and 4b). Priorities under *Direct Services and Programmatic Interventions* encompass initiatives such as diversion centers, jail-based competency restoration, case management, and other initiatives. Priorities under *System Infrastructure and Capacity Building* refer to those that create supportive and enabling conditions for future behavioral health and justice efforts. The evaluation team cross-coded priorities spanning across two or more categories.

Table 4a. Priorities Identified from HHSC SIM Reports by Categories, Subcategory, and Frequency of Mention

Priority Category and Subcategory from HHSC SIM Reports: <i>Direct Services and Programmatic Interventions</i>	<i>n</i>
Diversion centers or services	16
Service coordination	10
Housing supports	6
Community-based programming	5
Reentry programs	3
Jail-based services	2
Mental health or specialty court	2
Transportation access	2

Table 4b. Priorities Identified from HHSC SIM Reports by Categories, Subcategory, and Frequency of Mention

Priority Category and Subcategory from HHSC SIM Reports: <i>System Infrastructure and Capacity Building</i>	<i>n</i>
Behavioral health leadership team	8
Data collection and information-sharing processes	7
Education and training	5

Quantitative Analysis

During data cleaning, the evaluation team excluded responses with more than 50 percent missing data across implementation and outcome variables to ensure analytic integrity. Descriptive statistics were computed for each CFIR domain (Outer Setting, Inner Setting, and Process), as well as for outcome measures (Priority Progress, Collaboration, and Policy Change). The evaluation team reported single-item construct scores as medians and multi-item construct scores as means. The open-ended responses for the third priority were categorized according to the priority areas listed in Table 4. The evaluation team also disaggregated priority progress scores by these categories and summarized the scores using descriptive statistics. Priority progress scores for the third optional priority item had nearly 48 percent missing data, resulting in only the scores being used in aggregated priority means, where available.

Researchers used non-parametric statistical tests due to small sample size and data distribution considerations to examine relationships between CFIR implementation domain scores and outcome variables. Kendall's tau-b (τ_b) correlation to assessed associations between priority progress scores and CFIR domains where monotonicity assumptions were met (Inner Setting and Implementation Process). For collaboration scores, correlations analysis only tested Inner Setting, as other domains did not meet monotonicity requirements. Scatterplots assessed assumptions of monotonicity and examined relationships between time since mapping and outcome variables.

Researchers categorized stakeholders as urban or rural counties where possible, and as regional when their organizational purview extended across multiple counties. For this analysis, rural is defined as a Texas county with a population of 250,000 or less. Wilcoxon rank-sum tests compared Priority Progress and Collaboration scores between urban and rural respondents, and between regional versus county-specific SIM mapping sites. These exploratory hypothesis tests intended to identify potential patterns rather than support generalizable conclusions. The results report only descriptive statistics for the policy change item, measured on a 5-point Likert scale.

Qualitative Analysis

A hybrid inductive–deductive coding approach allowed for interview transcripts to be analyzed thematically. Research questions, the CFIR framework, and the identified priority areas inductively informed the development of a preliminary

codebook. The evaluation team generated additional codes as patterns emerged from the data. Qualitative analysis used Microsoft Excel for data management and reduction, and NVivo 15 for coding transcripts.

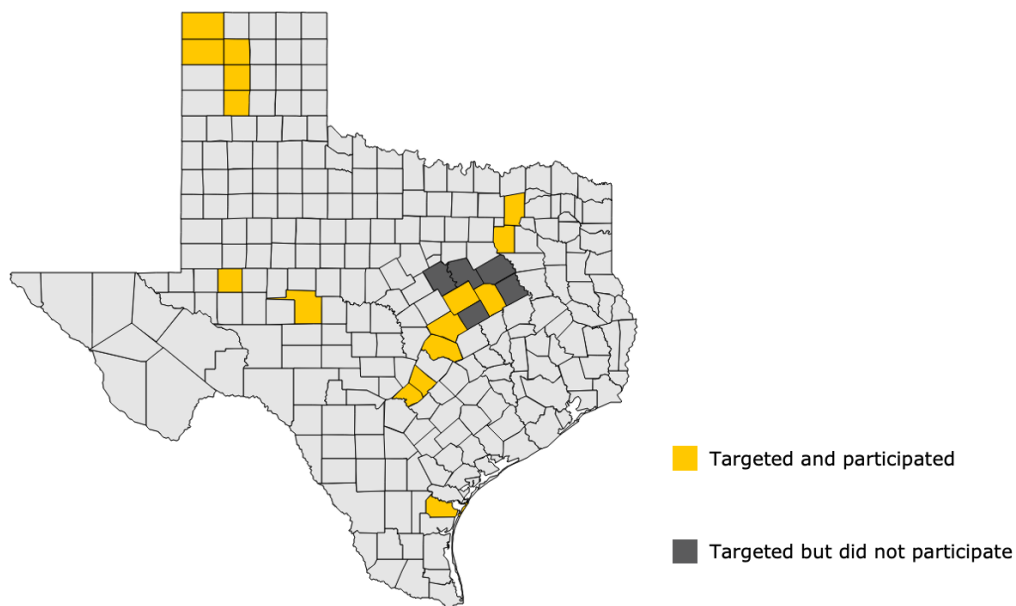
The primary researcher coded 25 percent of the data (i.e., five interviews), and a second analyst subsequently reviewed the data to ensure coding definitions were reliably applied. Revisions involved removing unused codes, employing structurally similar coding levels for priority area codes, and clarifying code definitions to enhance conceptual coherence. Researchers documented recoding decisions, structural changes, and coder reflections to ensure transparency and traceability. Researchers also recorded all adjudication decisions and preserved coder memos to capture analytic rationale and insights. To provide a comprehensive understanding of implementation dynamics across mapping sites, researchers integrated findings from qualitative interviews with quantitative results.

Results

Survey Respondents

After data cleaning, the final sample consisted of 46 survey responses. Responses represented 13 of the 14 targeted SIM mapping sites and 17 of the 22 counties (Figure 1), indicating broad engagement across the intended sample. The sample included 29 respondents from rural counties and 17 from urban counties, allowing for rural-urban comparisons in implementation experiences. Additionally, 26 respondents were from counties that participated in regional mappings and 20 respondents were from counties that had individual mappings. On average, it had been two years since respondents' county's SIM workshop. At time of data collection, the earliest workshop had occurred 33 months prior, and the most recent one had occurred 10 months prior.

Figure 1. Targeted and Participating Counties



The sites with the highest representation included (Figure 2):

- Dallam, Hartley, and Moore Counties ($n = 11$)
 - ▶ Although this a regionally mapped site, most responses (six of 11) came from Moore County and the remaining from stakeholders working across all three counties.

- Williamson County ($n = 11$)
- Potter and Randall Counties ($n = 7$)

The following three stakeholder types represented 65 percent of the respondents:

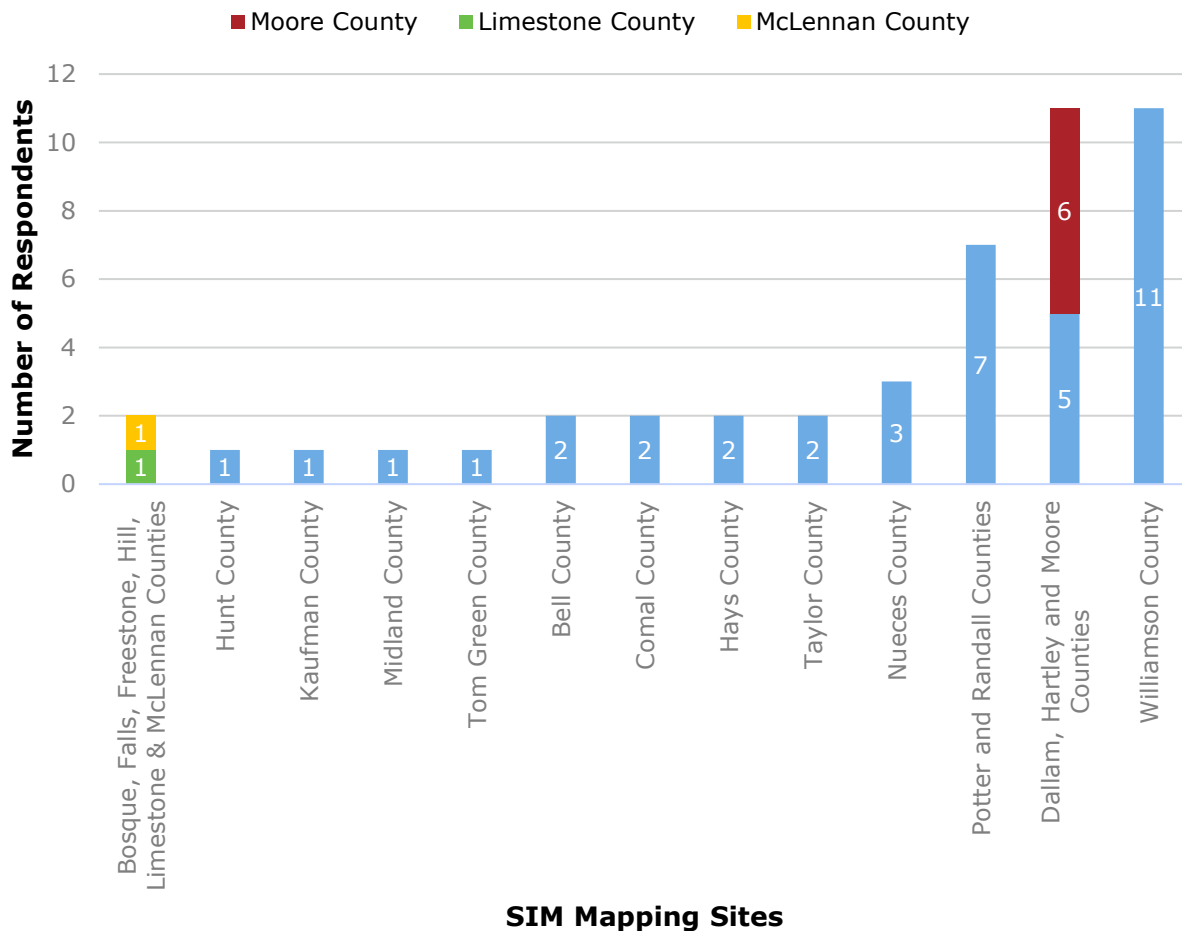
- Law Enforcement ($n = 13$)
- LMHA ($n = 10$)
- Judicial System and Court Services ($n = 8$)

The remaining respondents included stakeholders from behavioral health coordinating and community organizations, reentry and housing coalitions, public health and safety, adult probation, parole, hospital systems, or any combination thereof.

To better understand the perspectives captured through the survey, researchers analyzed respondents' involvement in SIM-related work and behavioral health leadership teams. Of these responses, 89 percent ($n = 41$) reported ongoing involvement in SIM-related work and the behavioral health leadership team. Out of these, 35 were involved from the start, having attended the SIM workshop. Conversely, five respondents attended the SIM workshop but were no longer involved in priority implementation efforts. Notably, three of these five remained on the behavioral health leadership teams, suggesting they may still have broader oversight.

The survey results represented a small number of frontline or "boots on the ground" voices, as only three respondents currently doing SIM-related work reported they are not part of the behavioral health leadership teams. These responses indicate that survey results primarily captured voices of mid- to high-level leaders who were engaged in the initial SIM workshop and had the opportunity for implementing change within their communities.

Figure 2. Survey Respondents by County



Interview Respondents

Researchers conducted 19 interviews with 21 participants, achieving the target of interviewing two participants per mapping site for most cases (Tables 5a, 5b, and 5c). Researchers conducted single interviews in two communities and conducted both an individual interview and a paired interview at one site, resulting in three participants from that site.

Out of the 14 targeted mapping sites, 11 participated (four urban, seven rural) in the interviews. The strategy of targeting those in leadership roles was largely successful, as 16 out of the 21 interviewees corresponded with champions identified by county members in the survey. This strategy ensured accurate insights into community progress following the SIM mapping workshop.

The largest proportion of interviewees represented LMHAs, reflecting their central role in coordinating behavioral health and justice initiatives. However, other key players are represented, such as law enforcement, who remain critical to SIM implementation (Table 5a).

Table 5a. Interviewee Demographics (Stakeholder Type; *n* = 21)

Stakeholder Type	<i>n</i>
Local Mental Health Authority (LMHA)	9
Law Enforcement	5
Judicial System	3
Behavioral Health Coalition	2
Hospital System	1
County Leadership	1

Table 5b. Interviewee Demographics (Urban vs. Rural Counties; *n* = 21)

Urban vs. Rural Counties	<i>n</i>
Urban	8
Rural	13

Table 5c. Interviewee Demographics (Regional vs. County-specific Mappings; *n* = 21)

Regional vs. County-specific Mappings	<i>n</i>
Regional	5
County-specific	16

Outcomes

Priority Progress and Policy Change

The SIM mapping workshops asked attendees to collaboratively identify and prioritize community issues they believe are most critical to address. Workshop facilitators condensed and organized these issues into priority items and attendees then voted on the issues. After voting, workshop facilitators selected priority items with the most votes for action planning, workgroup formation, and implementation.

The survey asked participants to report progress on their top two priorities, as identified from the reports. A total of 35 out of 46 respondents provided valid progress ratings. On a 1 to 10 scale, respondents had a mean priority progress score of 6.22 ($SD = 1.85$), indicating moderate advancement on the implementation of priorities identified during SIM workshops.

Data analysis revealed similar priority progress scores across different contexts in the sample (Appendix Table A1). The urban group has median priority score of 6.5 compared to 6.0 in the rural group. While urban SIM mapping sites had a higher median score compared to rural sites, a Wilcoxon rank-sum test showed no significant difference between the two scores ($W = 107, p\text{-value} = 0.382$). Respondents from regional mapping settings displayed a similar pattern, where non-regional priority medians (6.5) were higher than regional ones (6.0), but these differences were not meaningfully significant ($W = 171.5, p\text{-value} = 0.527$). Overall, county context did not change priority progress scores.

To further gauge implementation of SIM-related work, the survey asked respondents to report on a 5-point Likert scale how frequently their communities had changed policies or procedures related to behavioral health and justice initiatives. These responses reflected high advancement towards broader behavioral health and justice efforts, with nearly half of the respondents ($n = 22$) selecting "Frequently," or "Very Frequently."

To understand variation in implementation success across initiatives, evaluators disaggregated priority progress scores by previously established categories (Tables 6a and 6b). The most frequently reported categories are "diversion center or services" ($n = 21$), "community-based programming" ($n = 12$), "transportation" ($n = 12$), and "data collection and information sharing" ($n = 12$). When asked to rate their level of involvement in each of the priorities, over 65 percent of respondents reported "Frequent" or "Very Frequent" involvement (Figures 3a and 3b). This result serves as a proxy for understanding whether respondents had opportunities to advance SIM-related goals.

"Community-based programming" had the highest mean score ($M = 7.6$) and included efforts such as developing Assertive Community Treatment (ACT) programs for frequent utilizers, expanding juvenile justice and early intervention services, and enhancing community-based SUD treatment capacity. "Service coordination" and "data collection and information sharing" followed closely with a mean score of 7.5 and 7.0, respectively.

In addition, several interviewees described increased progress in implementing SIM priorities. Eight stakeholders shared examples of enhanced “service coordination” mechanisms, including initiatives that leveraged data to identify frequent utilizers, embedded jail navigators to support transitions out of incarceration, and convened cross-system staffing meetings to coordinate mental health caseloads and discharge planning from jail settings. New “education and training” initiatives included mental health training for frontline staff such as dispatchers, crisis line staff, and first responders in two communities. Public awareness campaigns in another two communities included a 988 promotional billboard. Another community reported leveraging cross-sector partnerships with a local university to educate providers and improve their competency to serve people with IDD.

Table 6a. Descriptive Statistics for Priority Scores by Categories (Direct Services and Programmatic Interventions)

Priority Category	Min	Max	Median	Mean (SD)	<i>n</i>
Transportation	1	9	6	5.6 (2.54)	12
Jail-Based Services	2	9	5.5	5.7 (2.34)	6
Diversion Center or Services	2	10	6	6.0 (2.62)	21
Housing	3	8	7	6.2 (1.92)	5
Reentry	0	10	7	6.7 (3.5)	6
Service Coordination	6	10	7	7.5 (1.51)	10
Community-Based Programming	2	10	8	7.6 (2.19)	12

Table 6b. Descriptive Statistics for Priority Scores by Categories (System Infrastructure and Capacity Building)

Priority Category	Min	Max	Median	Mean (SD)	<i>n</i>
Education and Training	2	8	7	6.2 (2.04)	10
Behavioral Health Leadership Team	1	10	7.5	7 (2.58)	10
Data Collection and Information-Sharing Processes	3	10	7	7 (2.09)	12

Despite mention of “mental health or specialty courts” in the SIM mapping reports, zero respondents from counties who identified this as a top-two priority submitted responses. Respondents also did not mention “mental health or specialty courts” as a third priority in the open-ended question. However, qualitative data showed some counties (*n* = 4) are actively implementing, or in the process of planning, mental

health or specialty courts. While other counties recognized a need, this priority demonstrates how Inner Setting barriers, such as limited funding, lack of commitment from judicial decision-makers, and court capacity, hinder progress. One participant noted, “[There] hasn't ever been a real strong will for specialty courts in our community. And then I think some of that is just based on the fact that, you know, we don't have a real best court system to begin with.”

One participant captured the diversity of implementation experiences across multiple priorities, noting, “Some of the priorities had no trouble maintaining their energy and momentum,” while “scope creep” hindered others. Reflecting on one such case, they noted, “One of our priorities was the diversion center. So obviously that had to be the LMHA that led it. So, trying to be mindful about not stepping on toes.”

Lastly, a scatterplot showed no evidence of a relationship between time since SIM mapping workshop completion and priority progress scores. The relationship appeared flat with no consistent upward or downward trend, despite variation in the time since each county’s SIM mapping workshop (ranging from 10 to 33 months). Respondents whose workshops occurred earlier did not report greater progress, and vice versa.

Figure 3a. Priority Involvement by Categories and Priority Area (Direct Services and Programmatic Interventions)

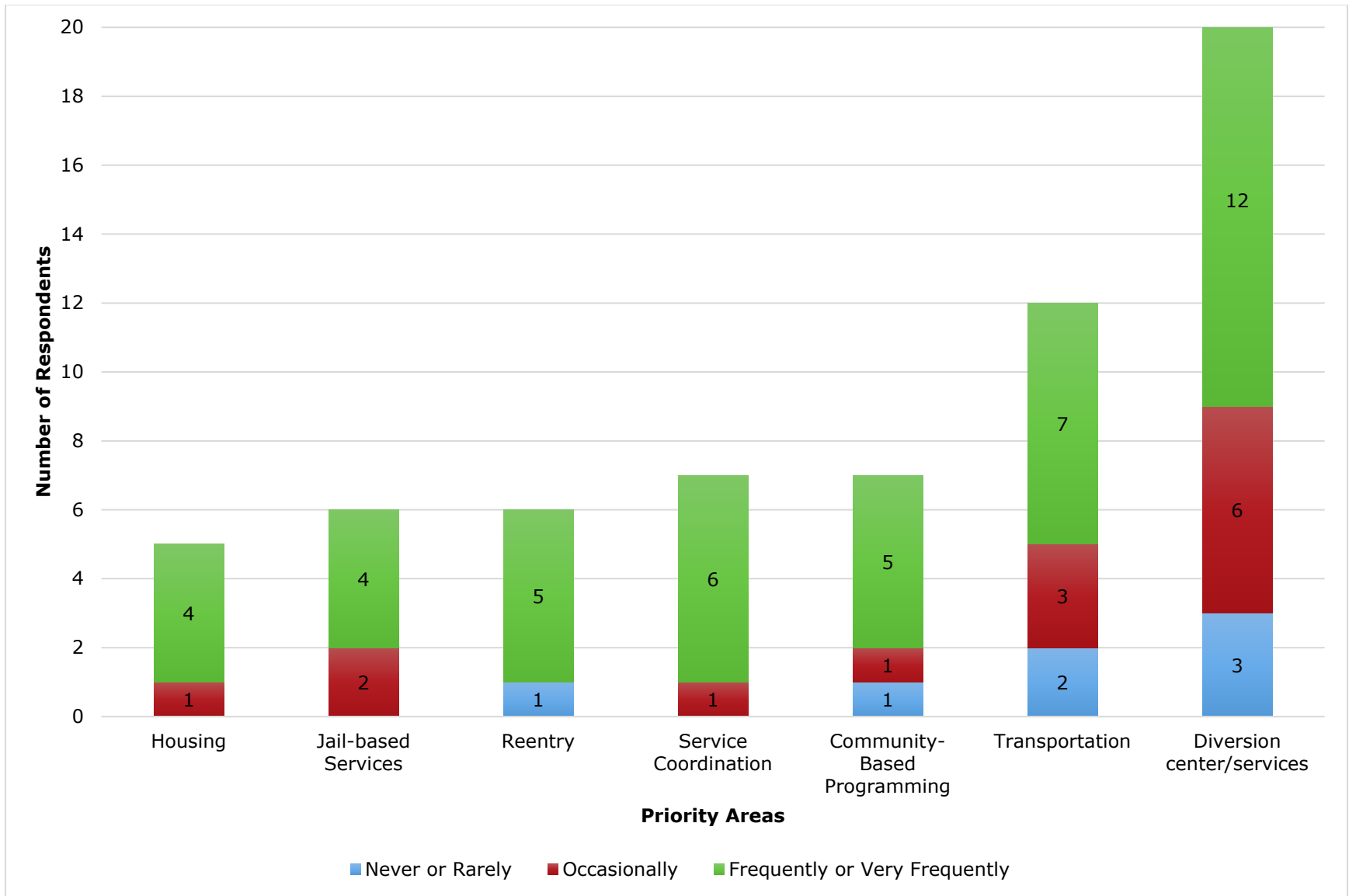
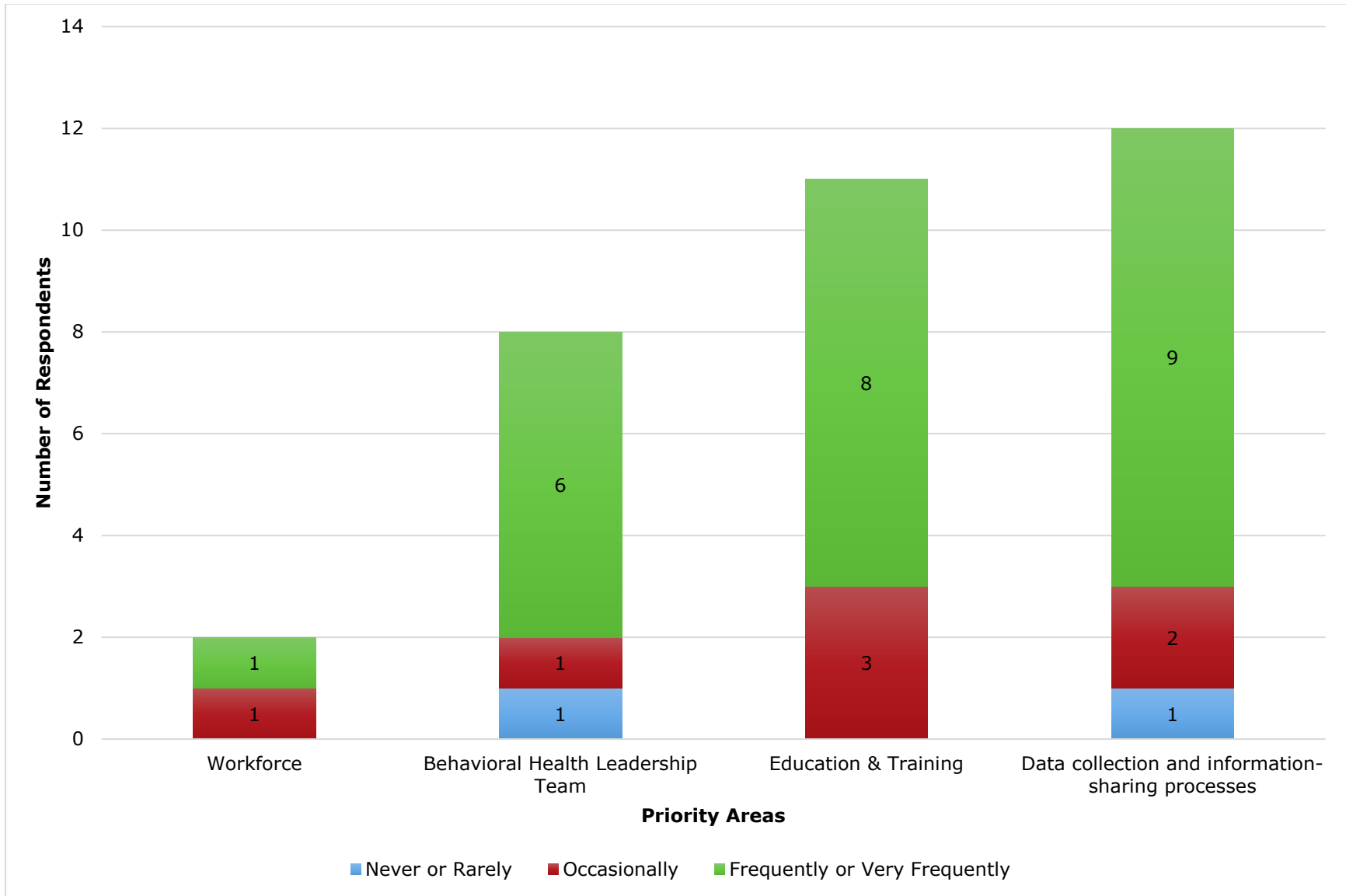


Figure 3b. Priority Involvement by Categories and Priority Area (System Infrastructure and Capacity Building)



Collaboration

Respondents rated the quality of collaboration since the SIM mapping workshop on behavioral health initiatives among 11 specific collaborator types from their community. The aggregated collaboration score ($M = 6.3$, $SD = 1.47$) on a scale from 1 to 10 shows moderate collaboration overall, suggesting generally positive perceptions of cross-system coordination.

A Wilcoxon rank-sum test showed no significant difference in overall collaboration scores between urban and rural groups ($W = 87$, $p = 0.12$). The urban group had a median collaboration score of 6.82 compared with 6.14 for the rural group. However, there was a significant difference in collaboration scores between regional and county-specific groups ($W = 193$, $p = 0.01$). The regionally mapped group had a median collaboration score of 5.55 compared with 7.09 for the county-specific group.

Researchers also explored whether collaborative momentum generated by the SIM mapping workshop declined over time. To do this, researchers used a scatterplot to assess the relationship between time since the workshop and the reported collaboration scores. The sample showed no clear trend indicating higher instances of collaboration among those who more recently completed SIM workshops compared to those whose workshops occurred much earlier.

Analysis of collaboration ratings by collaborator type revealed that law enforcement, behavioral health providers, and judicial system entities were consistently viewed as the most collaborative ($M > 6.9$) (Appendix Table A3). To understand how different stakeholders rated each other, evaluators reviewed collaborator types with the three highest scores and analyzed the scores by respondents' stakeholder type. Due to limited sample size, evaluators divided respondents' stakeholder type into four groups: Law Enforcement ($n = 13$), LMHA ($n = 10$), Judicial System and Court Services ($n = 8$), and "Other" ($n = 15$).

These findings demonstrated strong internal collaboration and an increased need for improvement in cross-agency connections. For example, Law Enforcement respondents rated their own group the highest ($M = 8.00$, $SD = 1.41$), while Judicial System and Court Services respondents rated law enforcement collaboration lower ($M = 6.13$, $SD = 1.89$). Similarly, Judicial System and Court Services stakeholders rated judicial system actors the highest ($M = 7.38$, $SD = 0.70$), while Law Enforcement rated judicial system actors the lowest ($M = 6.08$, $SD = 2.31$). These results suggest a gap in coordination across two major players in

SIM priority implementation. Similarly, stakeholders in the Judicial System and Court Services category rated judicial system actors the highest ($M = 7.38$, $SD = 0.70$) while those in the Law Enforcement group ($M = 6.08$, $SD = 2.31$) rated them the lowest.

Nevertheless, collaboration scores showed moderate cross-system relationships which may have improved due to the SIM mapping workshop. One law enforcement stakeholder reflected in the interview:

“So having those people in there, the attorneys that prosecuted, the judges that hear those cases, the JPS [justices of the peace] that have something to say with, you know, the EDO [emergency detention orders] orders, having them in the room and having them have a little bit of buy-in was refreshing to me. Because in the past they have not even wanted to deal with it. ‘You know, hey, if it’s mental health, then the LMHA needs to deal with it. It’s not a court issue.’”

Similarly, LMHA stakeholders highly rated behavioral health collaboration ($M = 7.6$, $SD = 1.17$), as did Law Enforcement ($M = 7.46$, $SD = 2.18$). Through the qualitative data, respondents reflected law enforcement and behavioral health coordination as a crucial need and a strength. For three communities, stakeholders described established practices such as LMHA- or contract provider-embedded positions (e.g., jail navigators, case managers, or qualified mental health professionals conducting ride-alongs). In three additional communities, efforts are underway to expand similar partnerships. One participant noted, “One of the things we’re looking at with that grant [is] hopefully having mental health providers and social workers in the jail and with the mental health providers being people who actually do the 1622 assessments, to make sure that those are accurately done.”

Importantly, all “Other” stakeholders gave judicial stakeholders relatively high ratings ($M = 7.36$, $SD = 2.02$), and behavioral health stakeholders lower ratings ($M = 6.2$, $SD = 1.6$). These results indicate opportunities for stronger outreach and engagement by LMHAs.

While evaluators assessed collaboration as an outcome of the SIM mapping workshop, the collaboration outcome also reflects the degree of Inner Setting connectedness (*Relational Connections*). Unsurprisingly, analysis revealed a moderate positive correlation between Inner Setting scores and collaboration scores (Kendall’s tau-b $\tau_b = 0.422$, $p = 0.002$). Collaboration appears to influence priority

progress as well. When tested with priority scores, collaboration scores revealed a positive correlation ($r_b = 0.457, p = 0.001$).

Innovation Domain

The Innovation domain refers to the specific innovation being implemented, which, in this project, is conceptualized as the SIM mapping workshop and its resulting priorities.

Innovation Source

In this study, the Innovation Source is HHSC, which facilitated the SIM mapping workshops. Participants valued HHSC as an objective, outside entity who is not an LMHA or local agency with competing interests. This perspective gave priorities credibility and contributed to alignment and collaboration, both important considerations for implementation success (Damschroder, 2022; Aron et al., 2009). Participants also noted HHSC's cross-county expertise in behavioral health and justice across Texas, which allowed the agency to share examples of innovative solutions or challenges from other counties of similar sizes and contexts. While participants viewed HHSC as the source of the innovation, it is clear participants felt their own input and involvement was necessary for success.

“But it's hard to wrap your head around what is happening in Texas. So I wanted some individuals from Austin with Health and Human Services Commission who see the greater landscape to come in and to say, ‘Hey, this is kind of things that we see that would help your area that you don't have,’ which is largely what we, you know ended up with from our SIM mapping priorities.”

Relative Advantage

The primary goals of a SIM mapping workshop are to firstly, provide communities with direction to advance behavioral health and justice priorities and secondly, strengthen collaboration among stakeholders working toward those goals. While quantitative results showed moderate progress on both priority implementation and interagency collaboration, qualitative findings uplifted the SIM mapping workshop as a systems planning tool that clarified local priorities and reinforced accountability among partners.

Participants viewed priorities and action plans as a tangible way to hold partners accountable to collective goals over time. Communities prevented mission drift by returning to the SIM reports when competing initiatives threatened to divert focus. Participants also valued the workshop’s ability to help them visualize their community’s strengths, which prompted discussions about overlaps and unmet needs across agencies related to services, capacity, and funding.

“it allowed us, to acknowledge all of the different needs and resources and roles that our community has invested or needs to be invested in this but in addition to that acknowledgement, it was, ‘This is what we’re going to focus on’ and so I think it allowed us to really come out of that with action steps that were just, ‘Let’s get going.’”

Notably, 12 out of 21 stakeholders from seven different counties continue to use the reports and resource maps provided to strategize behavioral health and justice planning. One additional participant stated they used the resources in the first year after the workshop but no longer do so now. Five stakeholders reported direct impact of the workshop on priority achievement in the following areas:

- Community-Based Programming
- Diversion Center or Services
- Service Coordination
- Behavioral Health Leadership Team
- Education and Training

When asked if they would participate in a SIM mapping workshop again, responses were largely positive. Participants emphasized the benefits of having stakeholders come together to coordinate efforts. However, participants also raised thoughtful considerations around the cost, structure, and timing of future workshops. Rather than repeating the same workshop again, several stakeholders suggested a more advanced follow-up workshop focused on priority progress and reassessing needs. Importantly, stakeholders also expressed interest in, or having completed, a youth-focused SIM workshop. Some stakeholders overseeing multiple counties expressed they would like to see a SIM workshop replicated in the other counties in their jurisdiction. This reflects participants’ forward-thinking desire to further evolve SIM mapping workshops to meet their community’s needs.

Innovation Adaptability

Participants reflected that HHSC avoided a one-size-fits-all approach by allowing each community to define priorities organically. For example, one county had a program-specific SIM focused primarily on uplifting a diversion center. One regional site had a SIM Refresh, which reconvened local stakeholders to update the service map, discuss progress against initial mapping priorities, reassess gaps and opportunities, and develop new action plans. Another county had an intercept-specific mapping, focusing solely on Intercepts 0 and 1.

Desire for Formalized Coordination

Additional participants raised concerns about the substantial effort and time required for SIM mapping workshops, both in planning, execution, and post-workshop implementation. Planning committees must gather data and secure participant commitment to a day-and-a-half of attendance at the workshop, as well as dedicate time and resources for ongoing post-SIM workshop implementation efforts. This burden can challenge sustained engagement, especially when stakeholders balance other organizational priorities. Implementation leaders must have time, a key component under CFIR's "opportunity," and feel supported by the Inner Setting to make progress towards SIM priorities (Damschroder et al., 2009; Feldstein & Glasgow, 2008).

To address this concern, participants suggested establishing a formalized coordinator role or entity tasked with ensuring the sustainability of SIM mapping workshop outcomes. This role would focus on maintaining stakeholder connections, tracking deliverables and deadlines, and facilitating consistent participation across all involved stakeholders. Participants cautioned that, without a dedicated coordinator, collaboration could weaken over time. This absence would leave only a few highly engaged people to continue the work, while others gradually disengage due to competing demands. One participant with a similar role reflected, "There's been times that if I wasn't accountable because I wouldn't have a paid position, then I probably would have been like we're canceling this meeting because I'm busy or because my kid's sick." Formalizing this coordinator role, ideally with funding support, could be key to sustaining momentum and achieving SIM priorities long-term.

Implementation Process Domain

The CFIR's Implementation Process domain seeks to understand how activities and strategies are used to implement an innovation (Damschroder et al., 2009). Stakeholders made progress on many different priorities, and the following findings demonstrate factors of the Implementation Process that supported and hindered priority success.

Overall, participants rated elements of the Implementation Process moderately high, indicating supportive processes for teaming, planning, acting, and reflecting were in place. A Kendall's tau-b correlation analysis investigated the relationship between Implementation Process scores and priority progress, revealing a slightly positive but statistically significant correlation ($\tau_b = 0.307$, $p = 0.03$). This correlation indicates that people who reported higher levels of Implementation Process scores also report better progress on their priority.

Mean implementation scores were similar for both urban ($M = 3.92$, $SD = 0.62$) and rural sites ($M = 3.65$, $SD = 0.49$). Regionally mapped versus county-specific sites showed the same pattern (Appendix Table A4). However, the sample was too small to detect any statistically meaningful differences across county contexts.

Teaming

Survey items captured participants' perceptions of equal decision-making, sense of safety, effective coordination, and agreement, all factors that can address implementation barriers (Damschroder et al., 2022b; Song et al., 2015). Scores revealed moderately positive perceptions of teaming ($M = 3.86$, $SD = 0.67$).

Roughly half of the communities had an existing coordination body, some of which took on SIM priorities, while the remaining communities established new oversight teams. Some communities with existing behavioral health leadership teams considered earlier efforts to be uncoordinated, inconsistent, and without real impact. One participant explained, "...it was kind of like that was where people would go and everybody would kind of say the same things over and over again, and then we get back together and there wasn't a lot of action taken out of those larger meetings." However, participants reported promising results in current efforts to overcome historical mistrust or uneven collaboration.

After the SIM mapping workshop, all but one county had an established behavioral health leadership team. Establishing a behavioral health leadership team was also a

priority for eight counties and received a mean score of 7 out of 10 in the survey, demonstrating sufficient progress. Interview participants credited behavioral health leadership teams as a source for coordination and accountability. Interview findings revealed effective teaming strategies, including structuring meetings with clear agendas, respecting participants' time, and forming action-oriented working groups to maintain momentum.

Across multiple communities, stakeholders described forming cross-sector topic-specific workgroups overseen by behavioral health leadership teams (e.g., leadership bodies, steering committees, task forces, etc.) to implement SIM priorities. These workgroups took the form of formalized partnerships (e.g., law enforcement, hospitals, and LMHAs) and coalitions focused on topics such as housing or diversion planning. Meeting frequencies varied from monthly to semiannually, which provided opportunities for mutual updates, problem-solving, and informal case consultation. One stakeholder described, "We've found that having the smaller groups helps us to communicate and work on things that we need to do specifically for that group. But then we'll gather up again, you know, with the larger ones monthly as well so."

One common barrier to effective teaming is participants' struggle to separate individual or agency priorities from collective goals. Across communities, participants viewed aligning stakeholders from different agencies on funding as a consistent challenge. Questions around who receives the funding and how it is utilized challenged previously built cooperation. Another barrier hindering teaming was poor data-sharing infrastructure. Participants reflected limited data-sharing practices stalled the ability to collaborate on shared clients, leading to duplicated or fragmented efforts. At the same time, weak teaming also prevented data-sharing from advancing, subsequently limiting progress on priority goals.

Planning

All sites demonstrated strong planning through clear efforts to define roles, set goals, and coordinate implementation activities. Counties consistently identified who is responsible for advancing each priority and established coordinating bodies to hold teams accountable. Regular meetings and structured agendas operationalized planning. As one participant summarized, effective planning means "...making sure that the meetings start in time, end on time. You're respectful of their busy schedules, and it's meaningful. You have an agenda, you have a purpose for being there, but then also to make it fun."

As previously described in [Teaming](#), topic-specific workgroups reported back to a larger governing body such as a task force or a behavioral health leadership team. For some communities, this meant aligning pre-existing entities with post-SIM mapping workshop entities. One workgroup participant stated, "...the three working groups kind of came about from multiple things: the SIM, the youth SIM and then in addition to that, multiple times where we have attempted to get more planning and implementation for these justice-involved individuals." Another workgroup participant highlighted the value of smaller, focused subgroups, stating, "...there's multiple bodies. There's so many, though I think that there's not a lot of work that gets done in them, to be honest... But to create long term plans, I think it works better when it's in smaller groups."

LMHAs, judicial entities, and law enforcement held meetings of routine progress review. Planning activities focused on launching diversion centers, strengthening reentry coordination, and expanding in-jail mental health services. Participants emphasized aligning tasks to people with resources and influence ([Implementation Leads.](#))

While most sites reported clear roles and regular checkpoints, several sites noted formal data plans and performance measures are still being built, which impacted the degree of planning. Additionally, survey scores revealed moderately positive perceptions of planning ($M = 3.77$, $SD = 0.7$).

Doing

The 'Doing' construct reflects the degree to which participants took actionable steps related to SIM priorities. Qualitative insights revealed participants actively implemented priorities established from the SIM mapping workshop. Nearly all stakeholders reported at least one new effort from the *Direct Services and Programmatic Interventions* category, and all stakeholders referenced initiating some activity related to the *System Infrastructure and Capacity Building* category. A small number of sites reported engaging in iterative, trial-based approaches that are expected to lead to full-scale implementation. Across five rural communities, pilot programs (e.g., soft launch of a diversion center, trial of a co-responder model, jail-based competency restoration, jail continuity of care program) are also underway.

Survey results suggest stakeholders were modestly engaged in grant-seeking efforts, with participants applying for funding (*median* = 4) more often than

receiving it (*median* = 3). Similarly, eight interviewees explicitly mentioned applying for funding to support their SIM priorities.

Reflecting and Evaluating

Reflecting and evaluating the implementation of SIM priorities are ongoing processes, often overlapping with aspects of the *Teaming* and *Planning* constructs. Nearly all sites had monthly or semiannually structured reviews, indicating a high level of reflecting and evaluating. Similarly, reflection and evaluation received a mean score of 3.97 (*SD* = 0.66) in the survey. Partners met regularly to assess progress, identify improvements, and, where possible, use data as a core mechanism for evaluation. In several counties, reflecting and evaluation activities included developing progress reports, highlighting community needs, and tracking outcomes and advancement towards goals. One participant described the real-world impact of one of these reflective spaces with law enforcement agencies :

“So, it really takes a hard look at diversionary activities and then tries to understand how we can impact those, and this co-response model was one of those results.”

Inner Setting Domain

On average, respondents rated their Inner Setting moderately well. Inner Setting scores may not be exceptionally high in this sample, but their importance should not be overlooked. Evaluators ran a Kendall's tau-b correlation to determine the relationship between Inner Setting scores and priority progress ratings amongst 29 participants. There was a moderate and statistically significant positive correlation between Inner Setting scores and priority progress scores ($\tau_b = 0.470$, $p < 0.001$). This finding suggests stakeholders perceive their county's climate and culture as only slightly supportive, with lower scores reflecting the complexity of numerous, multi-level systems coming together to form the Inner Setting context.

Quantitative results also indicated similar Inner Setting experiences across county contexts. Mean scores across urban and rural respondents were 3.86 (*SD* = 0.63) and 3.69 (*SD* = 0.47), respectively. These scores indicate no clear directional trend by county region. Evaluators also observed a similar mean difference of 0.17 between Inner Setting scores of regionally mapped and county-specific sites (Appendix Table A7).

Relational Connections

Relational Connections are a construct of the Inner Setting and a key element of “Collaboration.” Participants reported positive collaboration and described growing opportunities for connecting with stakeholders across their communities. There is also a strong overlap between *Teaming* and *Relational Connections* as SIM priorities require collaboration across many organizations in the Inner Setting to form “teams.” Several participants noted repeated exposure through frequent meetings had begun to build familiarity and trust. As one participant noted, “...you know the more you meet someone, the more comfortable you are to talk to them, and you feel like you do have a relationship.”

Additionally, compared to previous efforts, the SIM mapping workshop greatly contributed to improvements within the Inner Setting. Participants cited strengthened collaboration and communication among stakeholders who rarely occupied the same room (*Innovation Domain*). Participants also identified the workshop as an opportunity to bring together representatives from the judicial system, law enforcement, LMHAs, hospitals, and community organizations to learn from one another and build new connections. One participant felt inspired by “a moment of victory” when they realized many agencies and people are already committed to improving behavioral health and justice outcomes. However, some gaps remain.

Some participants described lingering historical mistrust and power dynamics. In a few counties, participants described relationships between LMHAs and other partners as strained. Jurisdictional divides, such as those across several counties for the regionally mapped sites and county versus city, created barriers to cross-system collaboration. Several participants also expressed bringing missing voices to the table, including school administrators, additional judges, and more frontline staff.

Despite these gaps, participants recognized the urgency of addressing persistent fragmentation between agencies. As one judicial stakeholder emphasized, “...we definitely still need to have that multidisciplinary crisis response team pairing up clinicians and law enforcement, and I think that’s something that we wanna tackle sooner rather than later.”

Relative Priority

Behavioral health initiatives are important to the community overall, as 80 percent of the survey respondents reported prioritizing SIM initiatives “Very Frequently” or “Frequently.” However, across the multiple priority areas, importance of initiatives varied across stakeholders. For instance, department or county leadership preferences shaped which priorities received the most attention. One participant noted, “...specific departments are very fixated on the specific initiatives that pertain to their department only...” Limited resources could also change focus, with another participant explaining, “...if there's not a funding opportunity in front of us right now, then we need to focus on something else, you know, for a while.” Additional barriers included distractions due to day-to-day activities, other pressing local issues, and waning enthusiasm due to prolonged timelines.

Mission Alignment

Implementing and delivering an innovation that aligns with stakeholders’ sense of commitment, purpose, and community goals is a critical determinant of successful implementation (Damschroder et al., 2022). Six stakeholders described conditions reflecting community readiness for the SIM workshop. These stakeholders highlighted a shared sense of urgency around addressing isolated systems and a desire for more structured collaboration. Most importantly, stakeholders noted buy-in from law enforcement, judicial leaders, LMHAs, or a combination from the three initiated the process.

Other stakeholders mentioned identifying a need for alignment, using the SIM workshop as a solution. One stakeholder mentioned, “Everyone has their own priorities...and I think having that group helps us identify ‘OK, this is our shared priorities that we could really all work together to try to achieve.’” Furthermore, the SIM report outlining the priorities generated during the SIM mapping workshop act as a vehicle for mission alignment across multiple organizations in the Inner Setting.

“I think it prevented a lot of mission drift because as time goes on, those other priorities, they're like, ‘Oh no, this is what we really wanna do. This is what we really wanna do, you know’, and then we can go back to the SIM. Like. Nope, those things are important. And we're gonna get there. But this is what we agreed on.”

Since the workshop, a shared commitment to community well-being and a collective recognition that behavioral health needs across intercepts need to be addressed have driven alignment. As one participant reflected, “This is the first time I’ve really seen the whole community push forward toward the same initiatives.”

While alignment appeared to be largely present, participants shared examples of misalignment. In one community, their police department was described as “...not pro-mental health...” while in another, the local hospital was seen as actively avoiding involvement in behavioral health efforts. One stakeholder noted that although discussions about serving the unhoused population could be polarizing, these tensions did not derail progress. Another participant cautioned leadership in their community with “...a lot of ego-driven strategies...” hindered implementation progress.

Implementation Leads

The presence of local champions and implementation leads emerged as a critical driver of SIM-related progress across sites. When asked how often “Someone in my county acted as a specific champion of implementing SIM priorities,” participants reported high frequency with a mean score of 4.21 on a 5-point Likert scale ($SD = 0.7$). Across all sites, evaluators identified 44 stakeholders and two organizations as champions or specific facilitators of change in implementing SIM priorities, with an average of three stakeholders identified per mapping site.

Qualitative data also supports that roles of these champions were instrumental in keeping priorities on the forefront. One participant noted, “Honestly, the fact that I keep putting it in front of people. You know, at these different meetings, you know. Like, if I stop talking about it, some of these things might not move very far.”

While implementation leads were recognized and commended for their roles, participants expressed the importance of implementation leads being stakeholders with the opportunity (i.e., scope and power) to implement change. One participant expressed confidence in their community’s ability to navigate conflict because of a local champion, stating, “I mean, he is respected and he is a leader in that group, and I think he has shown the ability to kind of get things back on track. And so I kind of leave that up to him”. However, participants raised additional sustainability concerns about increased dependence on a small core group to bear most of the workload.

Although not captured in the survey data, several interview participants emphasized the critical role of mid-level and frontline staff as key agents of change. Participants viewed the perspectives and involvement of mid-level and frontline staff as essential to effective implementation and should be integrated into planning and strategy.

Work Infrastructure

Workforce development in the form of increasing staffing levels or improving turnover was not a priority across the SIM reports. However, respondents brought up workforce development as an emerging priority in nine interviews and two open-ended survey responses. These survey respondents rated progress on workforce development as low, with one respondent giving it a “1” and another respondent giving it a “5” on a 1 to 10 scale. Survey data indicated strong perceptions of having the “*right mix*” of collaborators ($M = 4.18, SD = 0.79$), but lower team stability ($M = 3.16, SD = 0.86$).

Similarly, qualitative data reflected staff turnover, limited time capacity, and low staffing levels. Across several stakeholders, people balancing multiple obligations and roles led SIM-related initiatives. Some respondents cited without dedicated mental health infrastructure, balancing responsibilities and aligning stakeholders is difficult. Even within SIM goals, competing demands related to grant writing and data analysis often pulled stakeholders away from direct implementation or team supervision. One participant recognized infrastructure must be purposeful, as multiple coalitions can be redundant and inefficient:

“...it's mainly people finding the time at the top levels or even if it is just having consistency and maybe having one behavioral health council that would be the most beneficial. Everyone has their own meeting, so we're trying to navigate that. I think that will be the ever-ending struggle is to get one huge body and the right people at the table.”

While two communities saw an uptick in case managers and counselors, the majority noted shortages across mental health, nonprofit, and jails that prevented collaboration and subsequent priority progress. Turnover in key roles, including among partners already at capacity and elected officials, further stalled SIM implementation efforts.

Communication

Survey responses indicated a high level of communication ($M = 4.25$; $SD = 0.72$). Mentions of regularly scheduled meetings, structured workgroups, and actively involved coordinating bodies in *Teaming* and *Planning* further supported this finding. Qualitative data also revealed opportunities for improvement.

Participants consistently identified data-sharing as a critical barrier to effective communication. While some counties reported strong local data collection and reporting practices, most communities lacked formal platforms or memorandums of understanding. Misunderstandings around data-sharing policies and community resources led to service disruption or duplication. As described in *Work Infrastructure*, staff turnover also disrupted communication continuity across agencies. Participants indicated engagement in some behavioral health leadership teams is limited to high-level decision-makers, which reduces the flow of information to and from frontline implementers.

Access to Knowledge and Information

While participants frequently praised *Implementation Leads* for their initiative and support, explicit references to formal guidance or training within the Inner Setting were limited. Instead, participants described meetings in which they could ask for support, troubleshoot, and share updates. One participant described a workgroup in their community that had both an LMHA leader and a community co-leader, with regular progress reports to a coordinating body. This example may indicate a two-way stream of knowledge sharing and access to implementation support. Similarly, 57 percent of survey respondents reported positive perceptions of accessing guidance or more information related to SIM priority implementation within the Inner Setting. This construct did not appear as a strong facilitator or barrier to implementation.

Available Funding

Survey data showed only 11 out of 41 respondents felt sufficient Inner Setting funding was “frequently” or “very frequently” available, while 17 selected “neutral,” indicating uncertainty or variability.

Across eight sites, participants described funding challenges tied to dependence on short-term grants, unstable county budgets, or one-time federal sources like the American Rescue Plan Act (ARPA). Participants also reported having to scale back

eligibility criteria for inpatient beds, losing partnerships due to insufficient funding, confusion about allocating and utilizing available funding, and varying commitment from county leadership on how to use funding. These limitations restricted participants' ability to implement core SIM priorities such as diversion centers, mental health courts, and housing infrastructure. Even when local buy-in existed, a lack of sustainable operational funding halted innovation.

“Funding is a major challenge...it was consistent fundings too, that's kind of just the Achilles heel sometimes of nonprofit work. But I think it can be very challenging because it limits our ability to really dream big, and grow. Because we're just so busy just trying to keep what we currently have going.”

Participants also cited the COVID-19 pandemic as a resource-draining shock that depleted staff and funding across systems, the effects of which the communities are still reeling from. One community mentioned how limited resources adds pressure on their local system, which already acts as a service hub for surrounding counties.

Incentive

While 22 survey respondents reported teams were “frequently,” or “very frequently” given incentives to work on SIM priorities, direct incentives (e.g., payment, recognition, continuing education credits) were not heavily emphasized in the qualitative data as key facilitators of change. Instead, law enforcement mentioned operational incentives, such as reducing the frequency of crisis calls, are more rewarding than continuing Texas Commission on Law Enforcement (TCOLE) education hours. Additionally, incentives appeared less important than leadership buy-in, with one participant stating:

“Law enforcement is going to get their hours regardless...You're just going to have to get your chief executives, your sheriffs and your chiefs to say this is a priority.”

Furthermore, some stakeholders indicated grant competitiveness as a subtle incentive. Interviewees believed communities who demonstrated cross-sector collaboration, stakeholder buy-in, and participation through the SIM workshop are viewed as better positioned to apply for and receive grant funding.

Outer Setting Domain

Building and strengthening coordination with entities outside of the Inner Setting is a facilitator for implementation success (Sarkies et al., 2020). Through this domain, evaluators captured the relationships between SIM priority implementers across the mapping sites (Inner Setting) with state, federal and other entities outside of the county. These relationships can be academic partnerships, learning collaboratives, or technical assistance organizations (Damschroder et al., 2009). Across all domains, Outer Setting received the lowest aggregate mean score of 2.82 ($SD = 0.73$) on a scale of one to five.

Respondents from the urban ($M = 3.13$, $SD = 0.52$) sites rated Outer Setting slightly higher than rural ($M = 2.61$, $SD = 0.78$) sites, indicating a better relationship with external entities. However, this did not have a major impact on outcomes. Respondents from county-specific ($M = 2.96$, $SD = 0.62$) mapping sites also rated Outer Setting higher than respondents from regional mapping sites ($M = 2.57$, $SD = 0.84$).

Financing

Participants were grateful for external grants that served as the primary mechanisms for funding SIM-related initiatives. These grants supported co-responder programs, mental health court services, and staff attendance at national conferences. Participants recognized state-level mental health funding has increased, particularly through legislative mechanisms such as Rider 52 (88th Texas Legislative Session, 2023) and Senate Bill 292 (85th Texas Legislative Session, 2017). Additionally, participants viewed external funding from entities such as HHSC, Substance Abuse and Mental Health Services Administration (SAMHSA), and Meadows Mental Health Policy Institute (MMHPI) as critical when counties were reluctant or unable to fund mental health initiatives directly. However, participants still felt a sense of scarcity.

One stakeholder reported HHSC grants often require a 100 percent match, something local governments and organizations cannot afford. They cited this as a key reason for underutilization of available state-level funds, which created a mismatch between available funding and local capacity to access it. Furthermore, even when grants were awarded, stakeholders described significant delays between approval and actual disbursement or implementation. Stakeholders reported this delay sometimes spans several months and creates bottlenecks in program rollouts or decreased motivation.

Partnerships and Connections

Participants cited support from HHSC, MMHPI, SAMHSA, Texas Judicial Commission on Mental Health, and other entities to implement SIM priorities. Access to technical assistance such as policy guidance, knowledge of funding opportunities, and grant preparation helped communities meet their SIM-related goals. Participants credited relationships with HHSC with providing encouragement, data access, and support that extended beyond the initial SIM mapping workshop. While one participant did not receive a grant they had applied for, they were still able to benefit from the relationship with the state. This participant stated, "HHSC reached out to us and said, 'Hey, we're starting a pilot program for jail continuity of care!', which is basically what I was asking for."

Additionally, six participants mentioned learning collaboratives initiated by HHSC, including those focused on reentry, zero suicide, and jail in-reach, as avenues for maintaining relationships, building expertise, and receiving targeted support. One participant highlighted the democratic style of the learning community as a perk, stating, "You know in a community where everybody's learning together and there's not 'one' you know. Something like the LMHA being the one leader, you know, everybody has the opportunity to lead together."

Participants also highlighted the benefits of learning from other counties. One example participants upheld is how site visits to observe potential jail services and diversion model programs are transformative experiences. These cross-county exchanges provided a blueprint for implementation, shifted mindsets, and resulted in new policies.

Implementation Support

Across both quantitative and qualitative results, participants positively perceived implementation support from HHSC. Participants praised the SIM facilitation team for being readily accessible, responsive to questions, and willing to connect stakeholders to tailored resources. One participant reported, "I did apply for grants that I probably wouldn't have applied for if I hadn't talked to [HHSC staff] and her team and understood what those grants were."

Stakeholders from six SIM mapping workshop sites participated in the SIM Community of Practice, yet only one participant reported the session as being helpful in the interviews. HHSC also provided a six-month follow-up to all but one mapping site, which can influence outcomes. Only one participant mentioned this

support as an important accountability mechanism. Additionally, one participant mentioned wanting more support from HHSC in identifying funding and training opportunities. While the overall tone toward HHSC support was positive, gaps remain. In addition to more proactive assistance in identifying funding and training opportunities, some stakeholders also expressed a desire for support in navigating Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), and similar data-integration barriers.

Discussion

The SIM mapping workshop is a long-standing strategic tool improving community-based responses for people with mental and substance use disorders involved in the criminal legal system (PRA, n.d.). The current study offers insight into how the following came together to shape SIM's implementation across local Texas contexts:

- Outer-setting factors such as external supports and resource alignment
- Inner-setting readiness and leadership engagement
- Process elements like teaming and planning

Both qualitative and quantitative data point to moderately strong implementation of infrastructure across communities. Statistically, a modest but significantly positive correlation between Implementation Process scores and priority progress scores suggest well-coordinated Implementation Processes are associated with better outcomes. *Planning* commonly included naming leads, formalizing governance, setting meetings, and establishing processes. Yet, several sites noted underdeveloped performance measures and limited formal data use, a best practice across the SIM model recommended by HHSC (Texas Behavioral Health and Justice Technical Assistance Center, 2025).

Findings revealed Inner Setting is positively associated with both collaboration and priority scores. *Relational connections, mission alignment, and implementation lead* emerged as strong facilitators of success, while resource limitations such as work infrastructure and available funding emerged as barriers. Importantly, the several involved systems in the Inner Setting make it difficult to determine what organizations are contributing to the results (Hanna et al., 2020). This study established a clear link between higher Inner Setting scores, higher collaboration scores, and priority progress scores in these communities. Specifically, evaluators determined higher collaboration scores are associated with higher priority progress scores.

Urban and county-specific sites rated Outer Setting factors more favorably, indicating stronger linkages with external partners. Participants noted strong technical assistance from entities like HHSC, SAMHSA, and the Texas Judicial Commission on Mental Health as a key facilitator of implementation success. Support from external change agents can be instrumental in achieving

implementation outcomes (Damschroder et al., 2009, 2022a; King et al., 2019), but implementation of SIM priorities suffer without predictable funding.

The SIM mapping workshop influences priority outcomes by improving aspects of the Process, Inner Setting, and Outer Setting domain. Not only does the workshop provide direction for communities to achieve their priorities, but the workshop also impacts how people work together towards those priorities. These impacts are achieved through increased collaboration amongst county stakeholders and external partners like HHSC. Additionally, SIM mapping workshops affect contextual factors like those related to teaming and leadership dynamics, which further explain outcomes of implementation. When the right conditions for teamwork, shared understanding, and supportive processes are in place, stakeholders' sense of cohesion and collective identity increase. In turn, this increase is associated with higher perceived team effectiveness or perceived greater achievement of shared priorities (Song et al., 2015).

Across counties, participants described robust planning structures that translated SIM mapping workshop priorities into organized action. One effective approach involved the formation of smaller, topic-specific workgroups operating under a coordinating body, such as a behavioral health leadership team. The SIM mapping workshop strongly indicates behavioral health leadership teams are operating effectively, with the related priority receiving the highest progress score. The SIM mapping workshop also created a shared environment, where efforts could emerge from silos and align with one another. However, opportunities for improving uneven collaboration across all sites are still available.

Stakeholders consistently described law enforcement, behavioral health providers, and the judiciary as the most active participants in SIM efforts. However, several stakeholders emphasized SIM implementation is most effective when other sectors, such as housing, emergency medical services, education, and community-based organizations, are also meaningfully engaged. Additionally, collaboration patterns suggest while collaboration within sectors is perceived positively, cross-sector collaboration may vary significantly, especially for those who coordinate across county lines. For example, quantitative data revealed a notable difference in collaboration scores between county-specific and regionally mapped sites, suggesting some regional entities may suffer from lower engagement or buy-in. Not all counties from the regional mapping sites are represented in the data collection, which could further support the finding that regional sites had lower average collaboration scores. Despite these gaps, there is an undercurrent of progressively improving collaboration and relationships.

Several participants suggested adaptations to the SIM mapping workshop, including follow-up workshops and youth-focused mapping sessions. These adaptations align closely with existing offerings from HHSC, such as the SIM Refresh and youth SIM, as well as ongoing efforts to expand participation across counties. Promoting awareness of these state-supported options can help communities sustain momentum, revisit priorities, and tailor SIM activities to emerging needs.

Investing in a dedicated SIM coordinator for each site can also significantly enhance implementation outcomes. These coordinators would serve as a consistent point of contact to manage cross-sector communication, track progress on priorities, and ensure sustained engagement across partners. Another key function of the coordinator position would be to translate SIM mapping workshop materials and concepts into more digestible, actionable formats tailored to frontline staff. For most communities, the behavioral health leadership team often takes on these responsibilities, and champions can increase perceptions of team effectiveness (Shortell et al., 2004). However, when there is investment in a formal paid and dedicated position, there is accountability and focus. In several counties, elected officials serve as the visible drivers of SIM work but are prone to turnover. Additionally, other findings cautioned against relying too heavily on one person or entity serving in this capacity (Bonfine & Nadler, 2019).

Scatterplot trends appeared relatively flat for priority progress and collaboration over time. Counties whose workshops occurred over two years ago reported similar levels of progress and collaboration as those with more recent workshops. This suggests the passage of time alone may not explain progress and the level of collaboration may not wane over time, and other factors may be more impactful. Additionally, the wide variation in priorities across counties suggests various initiatives are implemented differentially across time.

Early SIM development emphasized community-based alternatives and the cost-effectiveness of diversion, relative to traditional incarceration models. This emphasis demonstrates even modest investment in treatment capacity can yield substantial savings and social benefits (Substance Abuse and Mental Health Services Administration, 2019). Respondents reported “diversion centers and services” as the most reported priority area, indicating a strong emphasis on acting at the early intercepts. Diversion centers are a tangible, high-impact intervention for addressing behavioral health needs, outside of the traditional criminal justice system (Menefee & Lovins, 2022; Steadman et al., 2001).

To understand reported barriers and facilitators, future studies can employ the CFIR application to the SIM at both the workshop-level and the priority-level (Zielinski et al., 2020). The CFIR can guide evaluation of the SIM mapping workshop by assessing planning quality, stakeholder engagement, and knowledge-change in real time. At a deeper level, specific initiatives, such as establishing a diversion center, can be analyzed using CFIR constructs focused on the Inner Setting (e.g., organizational culture, leadership engagement) of directly involved agencies. Comparing CFIR-informed determinants across counties working on the same initiative may also uncover structural and contextual differences that can tailor technical assistance and resources more effectively.

Limitations

Several limitations should be considered when interpreting the findings of this study. First, although counties that participated in regional SIM mapping workshops shared common priorities, representation across those counties was uneven. Stakeholders from all counties within regionally mapped sites were not equally represented in survey or interview data. Furthermore, some target counties were absent entirely, suggesting findings from this study may not fully reflect implementation experiences across all participating sites. Additionally, this study's design and small sample size are not structured to assess effectiveness. While this study used an evaluative design to understand whether the SIM mapping workshop is a useful tool for achieving SIM outcomes, full-scale effectiveness studies are still needed.

This study also did not assess downstream system-level impact such as jail diversion rates, recidivism, emergency department utilization, or average length of stay in jail or state hospitals. Given the SIM model's intended long-term impact on these outcomes, future research is needed to incorporate administrative data to evaluate whether implementation of SIM priorities translates into measurable system-level improvements (Swanson et al., 2023). Lastly, it is possible this study did not capture all determinants essential to implementation.

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Appendix

Outcomes Tables

Table A1. Descriptive Statistics for Priority Scores Overall, by Respondent Location Type (Urban vs. Rural) and by Mapping Type (Regionally Mapped vs. County-Specific Sites)

Groups	Min	Max	Median	Mean (SD)	<i>n</i>
All Respondents	1.5	10	6	6.22 (1.85)	35
Rural Group	1.5	9.5	6	6.06 (1.93)	24
Urban Group	4.5	10	6.5	6.57 (1.69)	11
County-Specific Mapping Group	4.5	10	6.5	6.68 (1.58)	16
Regional Mapping Group	1.5	9.5	6	5.83 (2.01)	19

Table A2. Descriptive Statistics for Collaboration Scores Overall, by Respondent Location Type (Urban vs. Rural) and by Mapping Type (Regionally Mapped vs. County-Specific Sites)

Groups	Min	Max	Median	Mean (SD)	<i>n</i>
All Respondents	2.73	8.82	6.45	6.3 (1.47)	33
Rural Group	2.73	8.1	6.14	5.92 (1.54)	20
Urban Group	5.1	8.82	6.82	6.87 (1.21)	13
County-Specific Mapping Group	3.45	8.82	7.01	6.72 (1.46)	21
Regional Mapping Group	2.73	7.27	5.55	5.55 (1.22)	12

Table A3. Descriptive Statistics for Collaboration Scores for each Collaborator Category on a Scale of 1 to 10

Collaborator Types	Min	Max	Median	Mean (SD)	<i>n</i>
Formal or Informal Housing Authorities	1	9	5	4.67 (2.15)	43
Reentry Coalitions	1	10	5	5.15 (2.67)	40
Emergency Medical Services	1	9	6	5.95 (2.19)	42

Collaborator Types	Min	Max	Median	Mean (SD)	n
Hospital	3	9	7	6.33 (1.88)	45
Community Organizations	1	10	7	6.36 (2.06)	45
Probation and Parole	1	10	7	6.38 (2.27)	42
Social Services	2	10	7	6.4 (2)	42
Jail Staff	2	10	7	6.75 (2.01)	40
Judicial System	2	10	7	6.91 (1.93)	44
Behavioral Health Providers	2	10	7	6.98 (1.78)	46
Law Enforcement	3	10	7	7.2 (1.71)	45

Implementation Process Tables

Table A4. Descriptive Statistics for Implementation Process Scores Overall, by Respondent Location Type (Urban vs. Rural) and by Mapping Type (Regionally Mapped vs. County-Specific Sites)

Groups	Min	Max	Median	Mean (SD)	n
All Respondents	2.67	4.94	3.67	3.74 (0.54)	31
Rural Group	2.67	4.62	3.62	3.65 (0.49)	21
Urban Group	2.92	4.94	3.83	3.92(0.62)	10
County-Specific Mapping Group	2.83	4.94	3.62	3.8 (0.51)	17
Regional Mapping Group	2.67	4.62	3.72	3.66 (0.59)	14

Table A5. Descriptive Statistics for Implementation Process Scores across Constructs on a Scale of 1 to 5

Constructs	Min	Max	Median	Mean (SD)	n
Doing	1	5	3.5	3.22 (1.03)	36
Planning	2.667	5	3.67	3.77 (0.7)	39
Teaming	1.5	5	4	3.86 (0.67)	43

Constructs	Min	Max	Median	Mean (SD)	<i>n</i>
Reflecting and Evaluating	2	5	4	3.97 (0.66)	37

Inner Setting Tables

Table A6. Descriptive Statistics for Inner Setting Scores Overall, by Respondent Location Type (Urban vs. Rural) and by Mapping Type (Regionally Mapped vs. County-Specific Sites)

Groups	Min	Max	Median	Mean (SD)	<i>n</i>
All Respondents	2.52	4.93	3.75	3.75 (0.53)	34
Rural Group	2.52	4.45	3.73	3.69 (0.47)	22
Urban Group	2.67	4.93	3.77	3.86 (0.63)	12
County-Specific Mapping Group	3.02	4.93	3.74	3.82 (0.5)	19
Regional Mapping Group	2.52	4.4	3.76	3.65 (0.56)	15

Table A7. Descriptive Statistics for Inner Setting Scores Across Constructs on a Scale of 1 to 5

Constructs	Min	Max	Median	Mean (SD)	<i>n</i>
Work Infrastructure	2	4.5	4	3.67 (0.69)	44
Relative Priority	3	5	4	4.25 (0.72)	44
Incentive	2	5	4	3.64 (0.78)	39
Available Resources – Funding	1	5	3	2.9 (1.02)	41
Access to Knowledge and Information	2	5	4	3.74 (0.80)	42
Implementation Leads	3	5	4	4.2 (0.7)	44
Communication	2.67	5	3.83	3.93 (0.6)	42

Outer Setting Tables

Table A8. Descriptive Statistics for Outer Setting Scores Overall, by Respondent Location Type (Urban vs. Rural) and by Mapping Type (Regionally Mapped vs. County-Specific Sites)

Groups	Min	Max	Median	Mean (SD)	<i>n</i>
All Respondents	1	4	3	2.82 (0.73)	38
Rural Group	1	4	2.67	2.61 (0.78)	23
Urban Group	2	3.67	3.33	3.13 (0.52)	15
County-Specific Mapping Group	1.33	4	3	2.96 (0.62)	24
Regional Mapping Group	1	3.67	2.67	2.57 (0.84)	14

Table A9. Descriptive Statistics for Outer Setting Scores Across Constructs on a Scale of 1 to 5

Constructs	Min	Max	Median	Mean (SD)	<i>n</i>
Partnerships and Connections	1	4	3	2.79 (0.78)	42
Financing	1	5	3	2.83 (1.09)	41
Other Implementation Support	1	5	3	2.88 (1.09)	42